



Attachment D-4 – Baseline Information Form for Participants

First and Last Name \_\_\_\_\_  
 BEES ID Number \_\_\_\_\_ (Office Use Only)

OMB Control No: \_\_\_\_\_ - \_\_\_\_\_  
 Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

[If applicable to current state of pandemic, ask C6. Otherwise, skip to C7a.]	
C.6a Which of the following statements describes your current employment status due to the COVID-19 pandemic?	1 <input type="checkbox"/> You are working reduced hours due to the pandemic 2 <input type="checkbox"/> You are not working due to the pandemic 3 <input type="checkbox"/> Your employment status is not currently affected by the pandemic
(Ask if answered "You are working reduced hours" or "You are not working" to C6a) C.6b Are you [working reduced hours] because [OR: not working]: (Check all that apply)	1 <input type="checkbox"/> Your employer reduced employees or hours 2 <input type="checkbox"/> You need to care for your child or someone else 3 <input type="checkbox"/> You are concerned for your health or the health of others in your household 4 <input type="checkbox"/> You are sick with COVID-19 or its lingering symptoms 5 <input type="checkbox"/> None of these apply <span style="float: right;">9 <input type="checkbox"/> Decline to answer</span>
(If asked C6b, skip C7a & b) C.7a Which of the following statements describes your employment status at any point in the past year due to the COVID-19 pandemic?	1 <input type="checkbox"/> You worked reduced hours due to the pandemic 2 <input type="checkbox"/> You did not work due to the pandemic 3 <input type="checkbox"/> Your employment status was not affected by the pandemic in the past year 9 <input type="checkbox"/> Decline to answer
(Ask if answered "You worked reduced hours" or "You did not work" to C7a) C.7b Did you [work reduced hours] because [OR: not work]: (Check all that apply)	1 <input type="checkbox"/> Your employer reduced employees or hours 2 <input type="checkbox"/> You needed to care for your child or someone else 3 <input type="checkbox"/> You were concerned for your health or the health of others in your household 4 <input type="checkbox"/> You were sick with COVID-19 or its lingering symptoms 5 <input type="checkbox"/> None of these apply <span style="float: right;">9 <input type="checkbox"/> Decline to answer</span>

D. Benefit Receipt		
D.1 Do you or anyone in your household currently receive income or assistance from any of the following sources? (Check all that apply)	A <input type="checkbox"/> Disability benefits from SSA (SSI or SSDI) B <input type="checkbox"/> TANF or [state specific TANF name] C <input type="checkbox"/> Unemployment insurance (UI) D <input type="checkbox"/> Worker's compensation E <input type="checkbox"/> Short-term disability F <input type="checkbox"/> Food stamps/SNAP/[state specific program]	G <input type="checkbox"/> WIC H <input type="checkbox"/> Public housing I <input type="checkbox"/> Veterans benefits J <input type="checkbox"/> Medicaid or CHIP K <input type="checkbox"/> Child Support L <input type="checkbox"/> None of the above M <input type="checkbox"/> Other (specify): _____ N <input type="checkbox"/> Decline to answer

E. Health	
E.1 In general, would you say your health is:	1 <input type="checkbox"/> Excellent    2 <input type="checkbox"/> Very good    3 <input type="checkbox"/> Good    4 <input type="checkbox"/> Fair    5 <input type="checkbox"/> Poor 9 <input type="checkbox"/> Decline to answer
E.2 Do you have a physical problem that limits the kind or amount of work that you can do?	1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Don't know    9 <input type="checkbox"/> Decline to answer



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	[If Yes] How often did this happen in the past 12 months? 1 <input type="checkbox"/> 1 Month                      2 <input type="checkbox"/> 2 or 3 months 3 <input type="checkbox"/> 4 to 6 months                      4 <input type="checkbox"/> 7 or more months                      9 <input type="checkbox"/> Decline to answer
F.9b Pay your utility bills	1 <input type="checkbox"/> Yes   2 <input type="checkbox"/> No                      9 <input type="checkbox"/> Decline to answer
	[If Yes] How often did this happen in the past 12 months? 1 <input type="checkbox"/> 1 Month                      2 <input type="checkbox"/> 2 or 3 months 3 <input type="checkbox"/> 4 to 6 months                      4 <input type="checkbox"/> 7 or more months                      9 <input type="checkbox"/> Decline to answer
F.9c Pay for food needed	1 <input type="checkbox"/> Yes   2 <input type="checkbox"/> No                      9 <input type="checkbox"/> Decline to answer
	[If Yes] How often did this happen in the past 12 months? 1 <input type="checkbox"/> 1 time                      2 <input type="checkbox"/> 2 or 3 times 3 <input type="checkbox"/> 4 to 6 times                      4 <input type="checkbox"/> 7 or more times                      9 <input type="checkbox"/> Decline to answer
F.9d Pay for child care	1 <input type="checkbox"/> Yes   2 <input type="checkbox"/> No                      9 <input type="checkbox"/> Decline to answer
	[If Yes] How often did this happen in the past 12 months? 1 <input type="checkbox"/> 1 Month                      2 <input type="checkbox"/> 2 or 3 months 3 <input type="checkbox"/> 4 to 6 months                      4 <input type="checkbox"/> 7 or more months                      9 <input type="checkbox"/> Decline to answer
F.9e Pay to fill a prescription for medicine	1 <input type="checkbox"/> Yes   2 <input type="checkbox"/> No                      9 <input type="checkbox"/> Decline to answer
F.9f Pay to see a doctor or get medical assistance	1 <input type="checkbox"/> Yes   2 <input type="checkbox"/> No                      9 <input type="checkbox"/> Decline to answer

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F.10. "Now, I would like to ask you a set of questions for each child that currently lives in your household. Remind me how many children do you have?"

F.11. Child's name

1	2	3	4
First: _____ Last: _____ <input type="checkbox"/> Decline to answer	First: _____ Last: _____ <input type="checkbox"/> Decline to answer	First: _____ Last: _____ <input type="checkbox"/> Decline to answer	First: _____ Last: _____ <input type="checkbox"/> Decline to answer

F.12. Are you the parent/guardian of this child?

<input type="checkbox"/> Yes <input type="checkbox"/> No [SKIP to next child] <input type="checkbox"/> Decline to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No [SKIP to next child] <input type="checkbox"/> Decline to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No [SKIP to next child] <input type="checkbox"/> Decline to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No [SKIP to next child] <input type="checkbox"/> Decline to answer
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F.13. What is the child's age?

Age: _____ <input type="checkbox"/> Decline to answer	Age: _____ <input type="checkbox"/> Decline to answer	Age: _____ <input type="checkbox"/> Decline to answer	Age: _____ <input type="checkbox"/> Decline to answer
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F.14. What grade is he/she in?

<input type="checkbox"/> Not in school [SKIP to F16] <input type="checkbox"/> Early Head Start <input type="checkbox"/> Pre-school <input type="checkbox"/> Pre-K <input type="checkbox"/> Kindergarten <input type="checkbox"/> 1 <sup>st</sup> Grade <input type="checkbox"/> 2 <sup>nd</sup> Grade <input type="checkbox"/> 3 <sup>rd</sup> Grade <input type="checkbox"/> 4 <sup>th</sup> Grade <input type="checkbox"/> 5 <sup>th</sup> Grade <input type="checkbox"/> 6 <sup>th</sup> Grade <input type="checkbox"/> 7 <sup>th</sup> Grade <input type="checkbox"/> 8 <sup>th</sup> Grade <input type="checkbox"/> 9 <sup>th</sup> Grade	<input type="checkbox"/> Not in school [SKIP to F16] <input type="checkbox"/> Early Head Start <input type="checkbox"/> Pre-school <input type="checkbox"/> Pre-K <input type="checkbox"/> Kindergarten <input type="checkbox"/> 1 <sup>st</sup> Grade <input type="checkbox"/> 2 <sup>nd</sup> Grade <input type="checkbox"/> 3 <sup>rd</sup> Grade <input type="checkbox"/> 4 <sup>th</sup> Grade <input type="checkbox"/> 5 <sup>th</sup> Grade <input type="checkbox"/> 6 <sup>th</sup> Grade <input type="checkbox"/> 7 <sup>th</sup> Grade <input type="checkbox"/> 8 <sup>th</sup> Grade <input type="checkbox"/> 9 <sup>th</sup> Grade	<input type="checkbox"/> Not in school [SKIP to F16] <input type="checkbox"/> Early Head Start <input type="checkbox"/> Pre-school <input type="checkbox"/> Pre-K <input type="checkbox"/> Kindergarten <input type="checkbox"/> 1 <sup>st</sup> Grade <input type="checkbox"/> 2 <sup>nd</sup> Grade <input type="checkbox"/> 3 <sup>rd</sup> Grade <input type="checkbox"/> 4 <sup>th</sup> Grade <input type="checkbox"/> 5 <sup>th</sup> Grade <input type="checkbox"/> 6 <sup>th</sup> Grade <input type="checkbox"/> 7 <sup>th</sup> Grade <input type="checkbox"/> 8 <sup>th</sup> Grade <input type="checkbox"/> 9 <sup>th</sup> Grade	<input type="checkbox"/> Not in school [SKIP to F16] <input type="checkbox"/> Early Head Start <input type="checkbox"/> Pre-school <input type="checkbox"/> Pre-K <input type="checkbox"/> Kindergarten <input type="checkbox"/> 1 <sup>st</sup> Grade <input type="checkbox"/> 2 <sup>nd</sup> Grade <input type="checkbox"/> 3 <sup>rd</sup> Grade <input type="checkbox"/> 4 <sup>th</sup> Grade <input type="checkbox"/> 5 <sup>th</sup> Grade <input type="checkbox"/> 6 <sup>th</sup> Grade <input type="checkbox"/> 7 <sup>th</sup> Grade <input type="checkbox"/> 8 <sup>th</sup> Grade <input type="checkbox"/> 9 <sup>th</sup> Grade
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15 <input type="checkbox"/> 10 <sup>th</sup> Grade 16 <input type="checkbox"/> 11 <sup>th</sup> Grade 17 <input type="checkbox"/> 12 <sup>th</sup> Grade 18 <input type="checkbox"/> Post-secondary school Other (Specify): _____ 99 <input type="checkbox"/> Decline to answer	15 <input type="checkbox"/> 10 <sup>th</sup> Grade 16 <input type="checkbox"/> 11 <sup>th</sup> Grade 17 <input type="checkbox"/> 12 <sup>th</sup> Grade 18 <input type="checkbox"/> Post-secondary school Other (Specify): _____ 99 <input type="checkbox"/> Decline to answer	15 <input type="checkbox"/> 10 <sup>th</sup> Grade 16 <input type="checkbox"/> 11 <sup>th</sup> Grade 17 <input type="checkbox"/> 12 <sup>th</sup> Grade 18 <input type="checkbox"/> Post-secondary school Other (Specify): _____ 99 <input type="checkbox"/> Decline to answer	15 <input type="checkbox"/> 10 <sup>th</sup> Grade 16 <input type="checkbox"/> 11 <sup>th</sup> Grade 17 <input type="checkbox"/> 12 <sup>th</sup> Grade 18 <input type="checkbox"/> Post-secondary school Other (Specify): _____ 99 <input type="checkbox"/> Decline to answer
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F.15. What is the name of the school the child currently attends?

Name of school: _____ 9 <input type="checkbox"/> Decline to answer	Name of school: _____ 9 <input type="checkbox"/> Decline to answer	Name of school: _____ 9 <input type="checkbox"/> Decline to answer	Name of school: _____ 9 <input type="checkbox"/> Decline to answer
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F.16. Has a doctor or other health professional EVER told you that [CHILD] had asthma?

1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Don't know 9 <input type="checkbox"/> Decline to answer	1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Don't know 9 <input type="checkbox"/> Decline to answer	1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Don't know 9 <input type="checkbox"/> Decline to answer	1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Don't know 9 <input type="checkbox"/> Decline to answer
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F.17. How many attacks of wheezing has [CHILD] had in the last 12 months?

Number of attacks: _____ 9 <input type="checkbox"/> Decline to answer	Number of attacks: _____ 9 <input type="checkbox"/> Decline to answer	Number of attacks: _____ 9 <input type="checkbox"/> Decline to answer	Number of attacks: _____ 9 <input type="checkbox"/> Decline to answer
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YOUR CONTACT INFORMATION		
Current address:		
City:	State:	Zip Code:
Home phone #: (    )	Cell #: (    )	Work #: (    )
Is this address the best one to mail something to you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Alternative address:		
City:	State:	ZIP Code:
Email address:		
Which is the primary social network you use? <input type="checkbox"/> Facebook <input type="checkbox"/> Twitter <input type="checkbox"/> Instagram <input type="checkbox"/> Other (specify): _____ <div style="text-align: right; margin-right: 50px;"><input type="checkbox"/> Decline to answer</div>		
What name do you use in that social network?		
Can we contact you by text message? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer		
What is your preferred mode of contact? (Check all that apply) <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <div style="text-align: right; margin-right: 50px;"><input type="checkbox"/> Other (specify): _____</div>		
CONTACT INFORMATION: RELATIVES AND FRIENDS		
<b>INSTRUCTIONS:</b> In the space below, please provide contact information for three close relatives or friends who are likely to know how to reach you over the next year. We will only contact these people if we are unable to contact you directly. Please complete all three boxes if possible.		
1. Name:		
How is this person related to you? <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent <input type="checkbox"/> Sister/Brother <input type="checkbox"/> Adult child <input type="checkbox"/> Friend <input type="checkbox"/> Other		
Current address:		
City:	State:	ZIP Code:
Home phone #: (    )	Cell #: (    )	Work #: (    )
Email address:		
2. Name:		
How is this person related to you? <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent <input type="checkbox"/> Sister/Brother <input type="checkbox"/> Adult child <input type="checkbox"/> Friend <input type="checkbox"/> Other		
Current address:		
City:	State:	ZIP Code:
Home phone #: (    )	Cell #: (    )	Work #: (    )
Email address:		
3. Name:		
How is this person related to you? <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent <input type="checkbox"/> Sister/Brother <input type="checkbox"/> Adult child <input type="checkbox"/> Friend <input type="checkbox"/> Other		
Current address:		
City:	State:	ZIP Code:
Home phone #: (    )	Cell #: (    )	Work #: (    )
Email address:		

*The Paperwork Reduction Act Statement:* This collection of information is voluntary and will be used to understand programs that aim to improve employment outcomes for low-income adults. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB number and expiration date for this collection are OMB #: XXXX-XXXX, Exp: XX/XX/XXXX. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to Dan Bloom (MDRC); 200 Vesey Street, 23<sup>rd</sup> Floor, New York, NY 10281-2103.