

Attachment E – Baseline Information Form for Participants

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

OMB Control No: 0970-0537  
 Expiration Date: 11/30/2022

YOUR CONTACT INFORMATION		
Name:		
Date of birth:	SSN:	
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): _____ <input type="checkbox"/> Decline to answer		
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 <input type="checkbox"/> Other (specify): _____		

A. Demographic Information	
A.1 Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Decline to answer
A.2 What is your ethnicity?	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline to answer
A.3 What is your race? (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Decline to answer
A.4 Primary language spoken at home	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Decline to answer
A.5 How well do you speak English?	<input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not very well <input type="checkbox"/> Not at all <input type="checkbox"/> Decline to answer
B. Education	
B.1 What is the highest degree or year of school that you have attained?	<input type="checkbox"/> Less than a high school diploma <input type="checkbox"/> High school diploma or equivalent <input type="checkbox"/> Some college or technical training <input type="checkbox"/> Associate's degree or other two-year degree <input type="checkbox"/> Bachelor's degree or higher <input type="checkbox"/> Decline to answer
C. Employment History	
C.1 Are you currently working for pay?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer
C.2 Are you working 35 or more hours per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer
C.3 How many jobs did you work last week?	_____ <input type="checkbox"/> Decline to answer

Attachment E – Baseline Information Form for Participants

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

OMB Control No: 0970-0537  
 Expiration Date: 11/30/2022

<p>C.4 In total, how many months did you work for pay during the past year (including your current job)?</p>	<p>1 <input type="checkbox"/> Did not work      2 <input type="checkbox"/> Less than 4 months      3 <input type="checkbox"/> 4-6 months                  4 <input type="checkbox"/> 7-9 months      5 <input type="checkbox"/> 10 or more months      9 <input type="checkbox"/> Decline to answer</p>									
<p>C.5 Are you currently looking for work?</p>	<p>1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> Decline to answer</p>									
<p><i>[If applicable to current state of pandemic, ask C6. Otherwise, skip to C7a.]</i></p>										
<p>C.6a Which of the following statements describes your current employment status due to the COVID-19 pandemic?</p>	<p>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                  9 <input type="checkbox"/> Decline to answer</p>									
<p><i>(Ask if answered "You are working reduced hours" or "You are not working" to C6a)</i>                  C.6b Are you [working reduced hours] because [OR: not working]: (Check all that apply)</p>	<p>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      9 <input type="checkbox"/> Decline to answer</p>									
<p><i>(If asked C6b, skip C7a &amp; b)</i>                  C.7a Which of the following statements describes your employment status at any point in the past year due to the COVID-19 pandemic?</p>	<p>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</p>									
<p><i>(Ask if answered "You worked reduced hours" or "You did not work" to C7a)</i>                  C.7b Did you [work reduced hours] because [OR: not work]: (Check all that apply)</p>	<p>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      9 <input type="checkbox"/> Decline to answer</p>									
<p><b>D. Household Information</b></p>										
<p>D.1 Which of the following best describes your [current housing arrangement during the past month? [OR: housing arrangement prior to entering name of program?]</p>	<p>1 <input type="checkbox"/> Own your own home or apartment                  2 <input type="checkbox"/> Rent your home or apartment                  3 <input type="checkbox"/> Live in emergency or temporary housing, that is in a shelter or were homeless                  4 <input type="checkbox"/> Live in transitional housing or sober housing                  5 <input type="checkbox"/> Live in a group home                  6 <input type="checkbox"/> Live with friends or relatives and pay rent to them                  7 <input type="checkbox"/> Live with friends or relatives and not pay rent to them                  8 <input type="checkbox"/> Have some other housing arrangement? _____                  9 <input type="checkbox"/> Decline to answer</p>									
<p>D.2 Number of people in your household (including yourself):</p>	<table border="0"> <tr> <td colspan="2"> <p><u>Number of people</u></p> </td> <td></td> </tr> <tr> <td>Children under age 18: _____</td> <td></td> <td>9 <input type="checkbox"/> Decline to answer</td> </tr> <tr> <td>Adults age 18 or older: _____</td> <td></td> <td>9 <input type="checkbox"/> Decline to answer</td> </tr> </table>	<p><u>Number of people</u></p>			Children under age 18: _____		9 <input type="checkbox"/> Decline to answer	Adults age 18 or older: _____		9 <input type="checkbox"/> Decline to answer
<p><u>Number of people</u></p>										
Children under age 18: _____		9 <input type="checkbox"/> Decline to answer								
Adults age 18 or older: _____		9 <input type="checkbox"/> Decline to answer								
	<p>D.3 Do you have a spouse or partner who lives in your household?</p> <p>1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No                  9 <input type="checkbox"/> Decline to answer</p>									

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

OMB Control No: 0970-0537  
 Expiration Date: 11/30/2022

E. Justice Involvement			
E.1 Have you been arrested in the past 12 months?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer	E.2 Have you ever been convicted of a crime?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer	E.3 Are you currently on parole or probation?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer	E.4 Have you ever been incarcerated?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer

F. Benefit Receipt			
F.1 For this next question, please consider only yourself, not anyone else in your household. Have you received a check or electronic payment from the Social Security Administration because of a disability in the past year as an adult? (Probe: This could have been payments from Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Decline to answer		
F.2 Are you currently receiving checks or electronic payments from the Social Security Administration because of a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Decline to answer		
F.3 As an adult, in the past five years have you applied to the Social Security Administration to receive checks or electronic payments because of a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Decline to answer		
F.4 Are you currently awaiting a decision by the Social Security Administration on a pending disability application?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Decline to answer		
F.5 During the past year, did <u>you or anyone in your household</u> receive income or assistance from any of the following sources? (Check all that apply)	<table border="0"> <tr> <td> <input type="checkbox"/> Disability benefits from SSA (SSI or SSDI)  <input type="checkbox"/> TANF or [state specific TANF name]  <input type="checkbox"/> Unemployment insurance (UI)  <input type="checkbox"/> Worker's compensation  <input type="checkbox"/> Short-term disability  <input type="checkbox"/> Food stamps/SNAP/[state specific program]                             </td> <td> <input type="checkbox"/> WIC  <input type="checkbox"/> HCV/Section 8/public housing  <input type="checkbox"/> Veterans benefits  <input type="checkbox"/> Medicaid or CHIP  <input type="checkbox"/> None of the above   <input type="checkbox"/> Decline to answer                             </td> </tr> </table>	<input type="checkbox"/> Disability benefits from SSA (SSI or SSDI) <input type="checkbox"/> TANF or [state specific TANF name] <input type="checkbox"/> Unemployment insurance (UI) <input type="checkbox"/> Worker's compensation <input type="checkbox"/> Short-term disability <input type="checkbox"/> Food stamps/SNAP/[state specific program]	<input type="checkbox"/> WIC <input type="checkbox"/> HCV/Section 8/public housing <input type="checkbox"/> Veterans benefits <input type="checkbox"/> Medicaid or CHIP <input type="checkbox"/> None of the above  <input type="checkbox"/> Decline to answer
<input type="checkbox"/> Disability benefits from SSA (SSI or SSDI) <input type="checkbox"/> TANF or [state specific TANF name] <input type="checkbox"/> Unemployment insurance (UI) <input type="checkbox"/> Worker's compensation <input type="checkbox"/> Short-term disability <input type="checkbox"/> Food stamps/SNAP/[state specific program]	<input type="checkbox"/> WIC <input type="checkbox"/> HCV/Section 8/public housing <input type="checkbox"/> Veterans benefits <input type="checkbox"/> Medicaid or CHIP <input type="checkbox"/> None of the above  <input type="checkbox"/> Decline to answer		

G. Substance Use	
G.1 Are you currently taking opioid medications for pain that have been prescribed by a physician or dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer
IF YES, G.1a ...what is the name of that medication?	_____ <input type="checkbox"/> Decline to answer

Attachment E – Baseline Information Form for Participants

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

OMB Control No: 0970-0537  
 Expiration Date: 11/30/2022

G.1b ...how long have you been taking it?	<input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/> Decline to answer																																																						
G.2 Have you ever, even once, used any prescription pain reliever in any way a doctor did not direct you to use it?  (This would include using it without a prescription of your own; or using it in greater amounts, more often, or longer than you were told to take it; or using it in any other way a doctor did not direct you to use it.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer																																																						
G.3 How many days in the past 30 have you used....? How many years in your life have you regularly used....? ["Decline to answer" options will appear for each question and each substance below.]																																																							
<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:40%;"></th> <th style="width:10%; text-align: center;">Past 30 days</th> <th style="width:10%; text-align: center;">Lifetime (years)</th> <th style="width:40%;"></th> <th style="width:10%; text-align: center;">Past 30 days</th> <th style="width:10%; text-align: center;">Lifetime (years)</th> </tr> </thead> <tbody> <tr> <td>Alcohol – Any use at all</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td>Cocaine</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Alcohol – To Intoxication</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td>Methamphetamine</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Heroin</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td>Amphetamines (other than Methamphetamine)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Fentanyl</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td>Cannabis</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Methadone (outside of methadone maintenance treatment)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td>Hallucinogens</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Other opioids/opiates/painkillers</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td>Inhalants</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Barbiturates</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td>More than one substance per day (including alcohol)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Other sedatives, hypnotics, or tranquilizers</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td>Other (specify): _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		Past 30 days	Lifetime (years)		Past 30 days	Lifetime (years)	Alcohol – Any use at all	_____	_____	Cocaine	_____	_____	Alcohol – To Intoxication	_____	_____	Methamphetamine	_____	_____	Heroin	_____	_____	Amphetamines (other than Methamphetamine)	_____	_____	Fentanyl	_____	_____	Cannabis	_____	_____	Methadone (outside of methadone maintenance treatment)	_____	_____	Hallucinogens	_____	_____	Other opioids/opiates/painkillers	_____	_____	Inhalants	_____	_____	Barbiturates	_____	_____	More than one substance per day (including alcohol)	_____	_____	Other sedatives, hypnotics, or tranquilizers	_____	_____	Other (specify): _____	_____	_____	
	Past 30 days	Lifetime (years)		Past 30 days	Lifetime (years)																																																		
Alcohol – Any use at all	_____	_____	Cocaine	_____	_____																																																		
Alcohol – To Intoxication	_____	_____	Methamphetamine	_____	_____																																																		
Heroin	_____	_____	Amphetamines (other than Methamphetamine)	_____	_____																																																		
Fentanyl	_____	_____	Cannabis	_____	_____																																																		
Methadone (outside of methadone maintenance treatment)	_____	_____	Hallucinogens	_____	_____																																																		
Other opioids/opiates/painkillers	_____	_____	Inhalants	_____	_____																																																		
Barbiturates	_____	_____	More than one substance per day (including alcohol)	_____	_____																																																		
Other sedatives, hypnotics, or tranquilizers	_____	_____	Other (specify): _____	_____	_____																																																		
G.6 Which substance is the main problem? _____ <input type="checkbox"/> Decline to answer																																																							
G.7 How long was your last period of voluntary abstinence from this substance?	_____ months <input type="checkbox"/> Decline to answer																																																						
G.8 How many months ago did this abstinence end?	_____ months <input type="checkbox"/> Decline to answer																																																						
G.9 How many times have you:	a. Had alcohol DT's _____ <input type="checkbox"/> Decline to answer b. Overdosed on drugs _____ <input type="checkbox"/> Decline to answer																																																						
G.10 How many times in your life have you been treated for:	a. Alcohol abuse _____ <input type="checkbox"/> Decline to answer b. Drug abuse _____ <input type="checkbox"/> Decline to answer																																																						
G.11 How many of these were detox only?	a. Alcohol _____ <input type="checkbox"/> Decline to answer b. Drugs _____ <input type="checkbox"/> Decline to answer																																																						
G.12 How much money would you say you spent during the past 30 days on:	a. Alcohol \$ _____ <input type="checkbox"/> Decline to answer b. Drugs \$ _____ <input type="checkbox"/> Decline to answer																																																						

Attachment E – Baseline Information Form for Participants

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

OMB Control No: 0970-0537  
 Expiration Date: 11/30/2022

G.13 How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days?	_____ days	99 <input type="checkbox"/> Decline to answer
G.14 How many days in the past 30 have you experienced difficulty with alcohol?	_____ days	99 <input type="checkbox"/> Decline to answer
G.15 How many days in the past 30 have you experienced difficulty with drugs?	_____ days	99 <input type="checkbox"/> Decline to answer
G.16 How troubled or bothered have you been in the past 30 days by these alcohol problems?	1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> Slightly 3 <input type="checkbox"/> Moderately 4 <input type="checkbox"/> Considerably 5 <input type="checkbox"/> Extremely 9 <input type="checkbox"/>	Decline to answer
G.17 How troubled or bothered have you been in the past 30 days by these drug problems?	1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> Slightly 3 <input type="checkbox"/> Moderately 4 <input type="checkbox"/> Considerably 5 <input type="checkbox"/> Extremely 9 <input type="checkbox"/>	Decline to answer
G.18 How important to you now is treatment for these alcohol problems?	1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> Slightly 3 <input type="checkbox"/> Moderately 4 <input type="checkbox"/> Considerably 5 <input type="checkbox"/> Extremely 9 <input type="checkbox"/>	Decline to answer
G.19 How important to you now is treatment for these drug problems?	1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> Slightly 3 <input type="checkbox"/> Moderately 4 <input type="checkbox"/> Considerably 5 <input type="checkbox"/> Extremely 9 <input type="checkbox"/>	Decline to answer
G.20 Have you been taking any of the following while in the care of a medical professional during the past 30 days? (Check all that apply)	A <input type="checkbox"/> methadone B <input type="checkbox"/> buprenorphine (including Subutex®, Suboxone®) C <input type="checkbox"/> naltrexone (including Vivitrol®) D <input type="checkbox"/> None of the above E <input type="checkbox"/> Decline to answer	
G.21 Have you smoked any cigarettes in the past 2 years?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer	
G.22 How many cigarettes or packs do you currently smoke on an average day (a pack has 20 cigarettes)?	_____ cigarettes / packs (circle one)	99 <input type="checkbox"/> Decline to answer

**H. Mental Health**

H.1 During the last 30 days, about how often did

H.1a ...you feel so depressed that nothing could cheer you up?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
H.1b ...you feel hopeless?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
H.1c ...you feel restless or fidgety?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
H.1d ...you feel that everything was an effort?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
H.1e ...you feel worthless?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
H.1f ...you feel nervous?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer

**I. Disability Status**

I.1 Are you deaf or do you have serious difficulty hearing?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
---	--

Attachment E – Baseline Information Form for Participants

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

OMB Control No: 0970-0537  
 Expiration Date: 11/30/2022

I.2 Are you blind or do you have serious difficulty seeing, even when wearing glasses?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
I.3 Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
I.4 Do you have serious difficulty walking or climbing stairs?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
I.5 Do you have difficulty dressing or bathing?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
I.6 Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
I.7 Does a physical, mental, or emotional condition limit the kind or amount of work 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
<b>J. Health</b>	
J.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
J.2 The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?	
J.2a <u>Moderate</u> activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1 <input type="checkbox"/> Yes, limited a lot 2 <input type="checkbox"/> Yes, limited a little 3 <input type="checkbox"/> No, not limited at all 9 <input type="checkbox"/> Decline
J.2b Climbing <u>several</u> flights of stairs	1 <input type="checkbox"/> Yes, limited a lot 2 <input type="checkbox"/> Yes, limited a little 3 <input type="checkbox"/> No, not limited at all 9 <input type="checkbox"/> Decline
J.3 During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u> ?	
J.3a <u>Accomplished less</u> than you would like	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.3b Were limited in the <u>kind</u> of work or other activities	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.4 During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?	
J.4a <u>Accomplished less</u> than you would like	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.4b Did work or other activities less carefully than usual	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.5 During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?	1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> Slightly 3 <input type="checkbox"/> Moderately 4 <input type="checkbox"/> Considerably 5 <input type="checkbox"/> Extremely 9 <input type="checkbox"/> Decline to answer
J.6 These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...	
J.6a Have you felt calm and peaceful?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.6b Did you have a lot of energy?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.7 Have you felt downhearted and depressed?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer

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

OMB Control No: 0970-0537  
 Expiration Date: 11/30/2022

J.8 During the past 4 weeks, how much of the time have your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.9 During the past year, have you received help or treatment for mental health problems?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
<b>K. Housing and Household Information</b>	
K.1 During the past two years, have you ever been evicted or forced by your landlord to move when you didn't want to?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> In the midst of an eviction 4 <input type="checkbox"/> Don't know 9 <input type="checkbox"/> Decline to answer
K.2 In the past 12 months was there ever a time when, because of cost, you or your household was not able to:	
K.2a Pay your rent	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
K.2b 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
K.2c 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
K.2d 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
K.3 In the last 12 months, was there any time when you did not fill a prescription for medicine because of the cost?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know/Not sure 9 <input type="checkbox"/> Decline to answer

**CONTACT INFORMATION: RELATIVES AND FRIENDS**

**INSTRUCTIONS:** 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? 1  Spouse/Partner 2  Parent 3  Sister/Brother 4  Friend 5  Other

Current address:

Attachment E – Baseline Information Form for Participants

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

OMB Control No: 0970-0537  
 Expiration Date: 11/30/2022

City:	State:	ZIP Code:
Home phone #: ( )	Cell #: ( )	Work #: ( )
Email address:		
2. Name:		
How is this person related to you? <input type="checkbox"/> 1 Spouse/Partner <input type="checkbox"/> 2 Parent <input type="checkbox"/> 3 Sister/Brother <input type="checkbox"/> 4 Friend <input type="checkbox"/> 5 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"/> 1 Spouse/Partner <input type="checkbox"/> 2 Parent <input type="checkbox"/> 3 Sister/Brother <input type="checkbox"/> 4 Friend <input type="checkbox"/> 5 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 #: 0970-0537, Exp: 11/30/2022. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to Megan Millenky (MDRC); 200 Vesey Street, 23<sup>rd</sup> Floor, New York, NY 10281-2103.