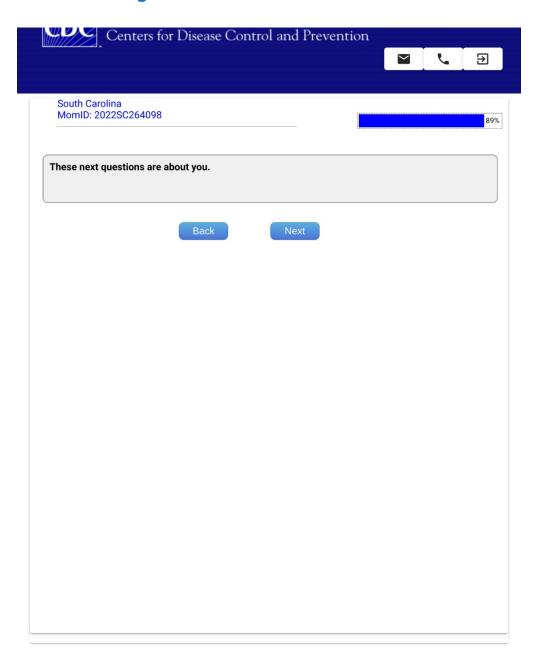
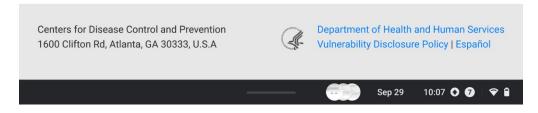
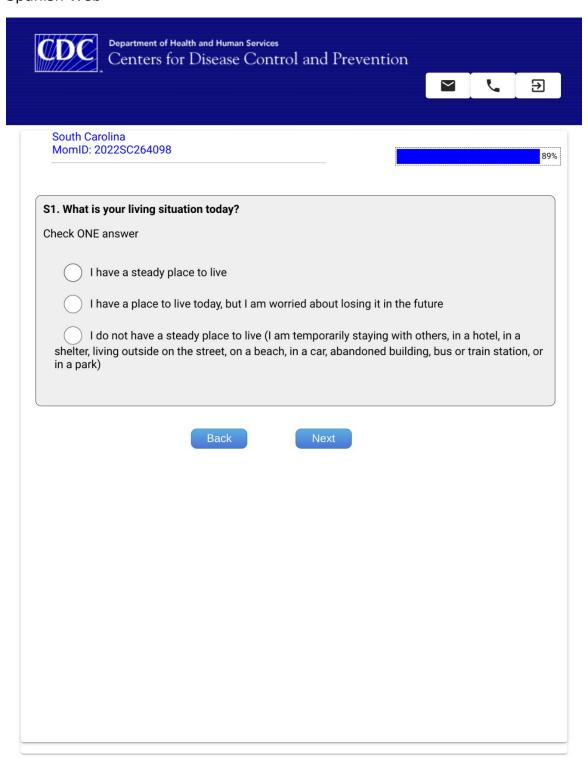
Form Approved OMB No. 0920-1273 Exp. Date xx/xx/xxx

## PRAMS Social Determinants of Health (SDOH) Supplemental Module

## PRAMS Social Determinants of Health Supplemental Module: English Web







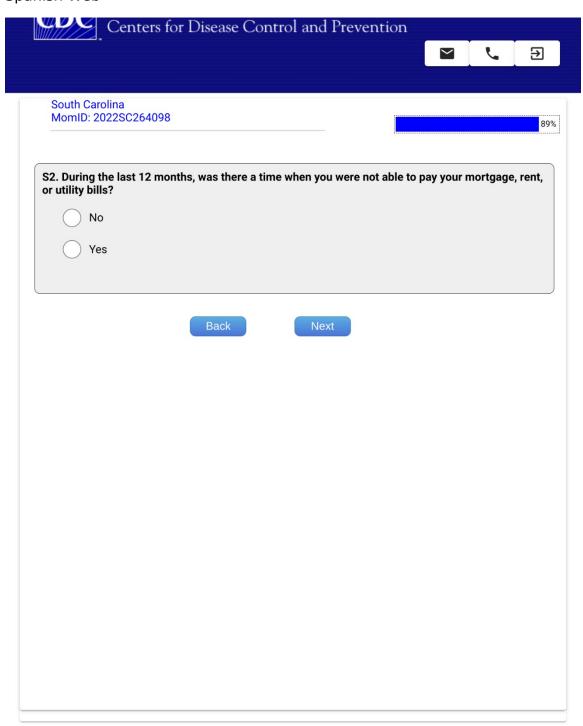


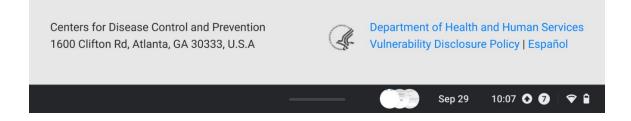


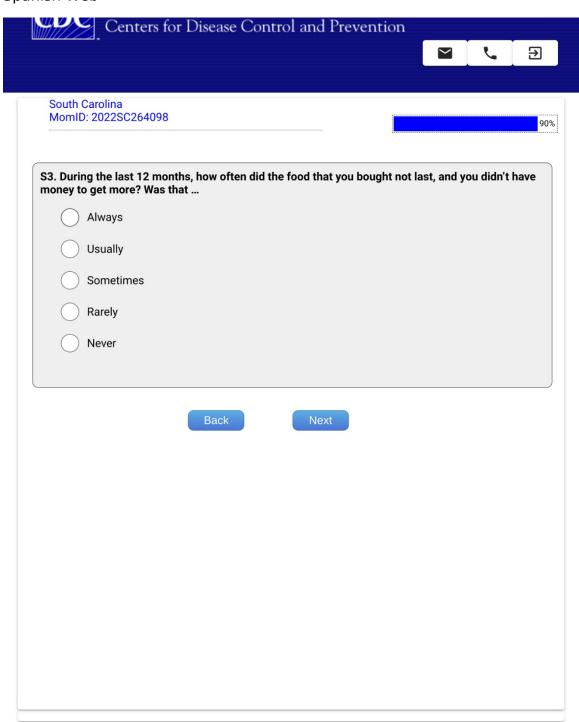


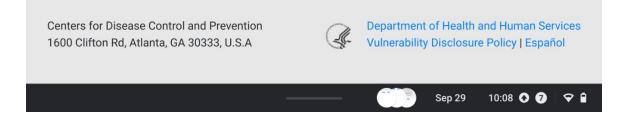


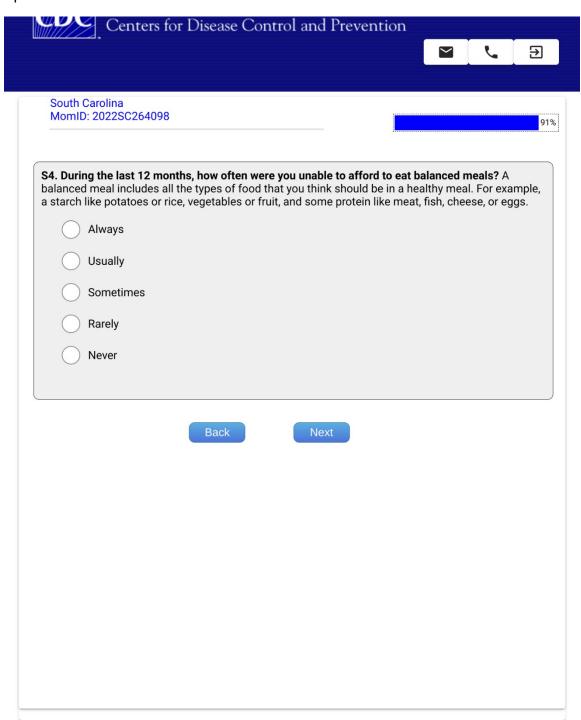












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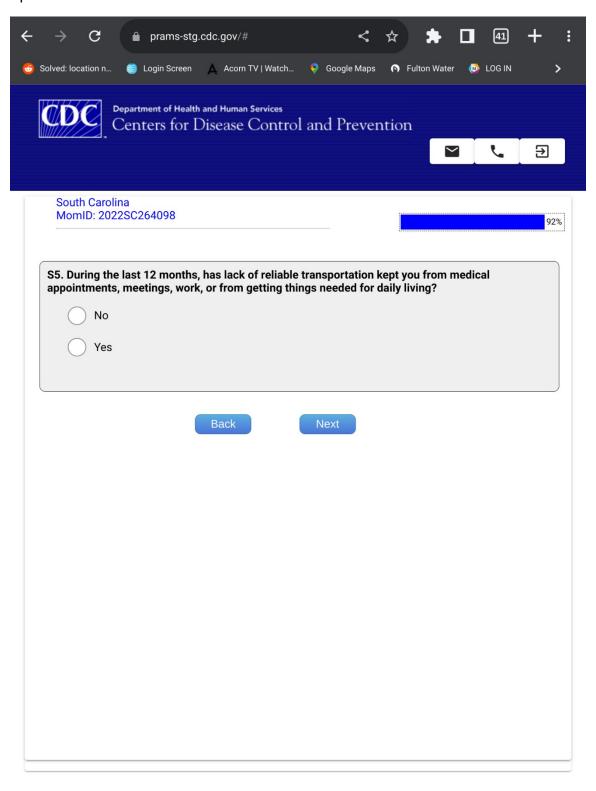
Department of Health and Human Services Vulnerability Disclosure Policy | Español



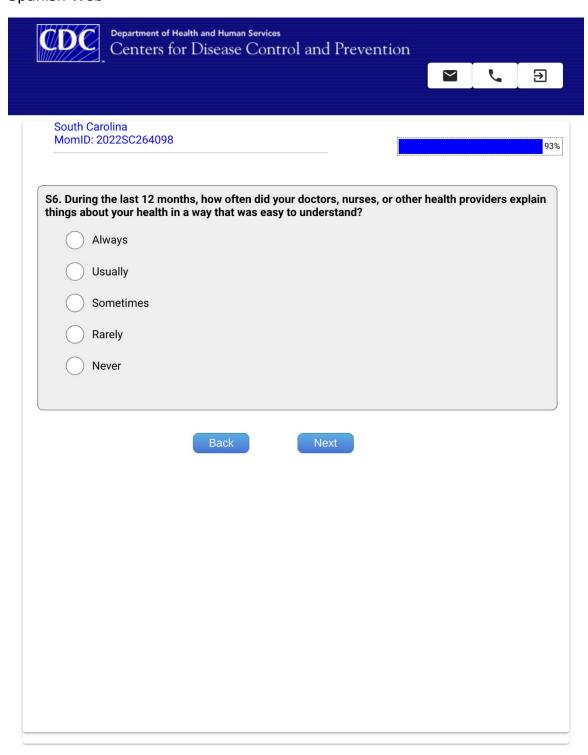


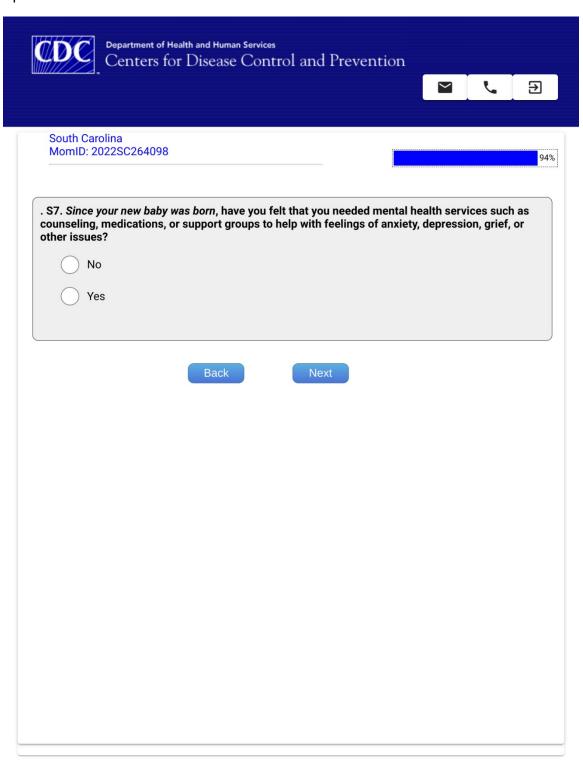












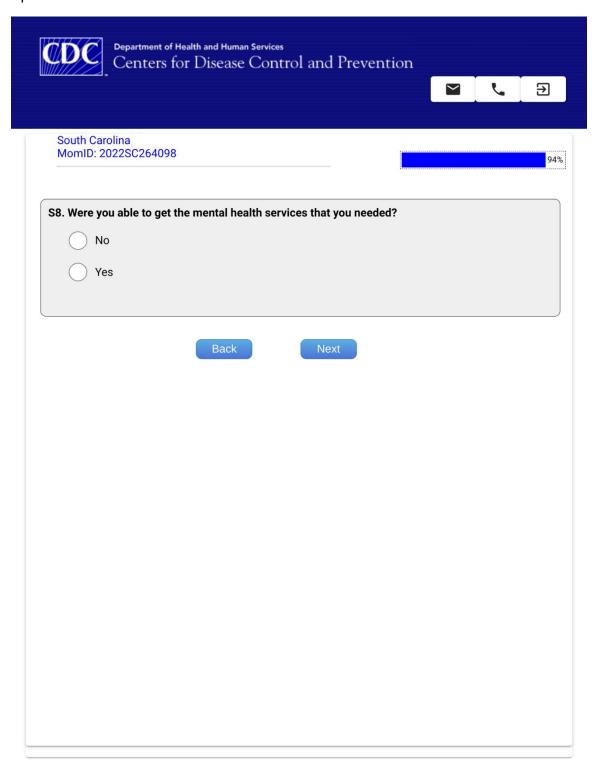


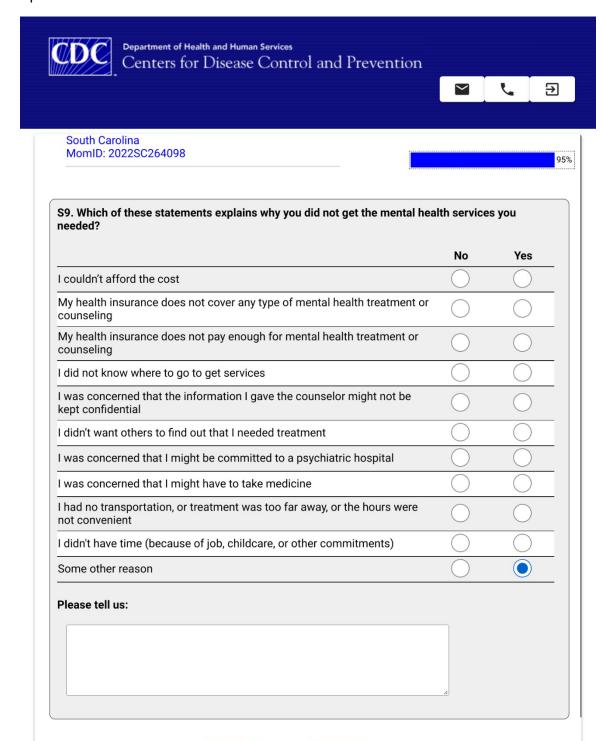










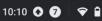


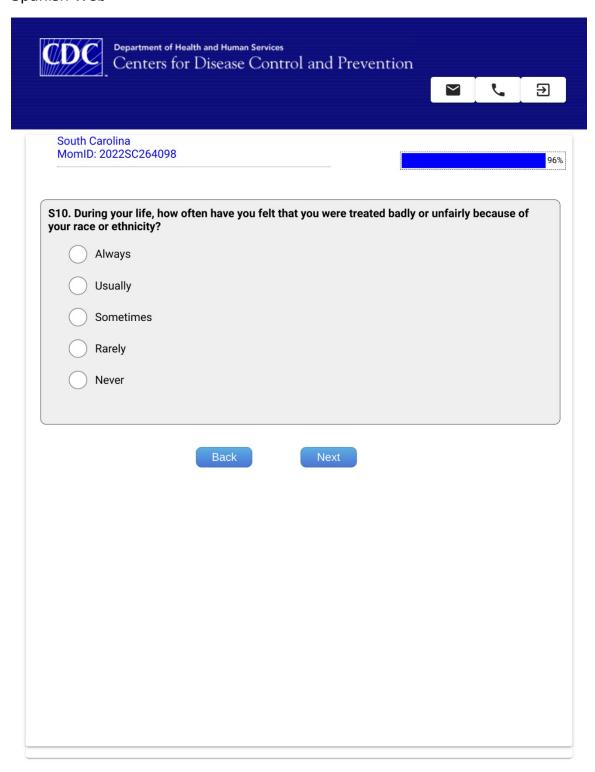










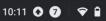


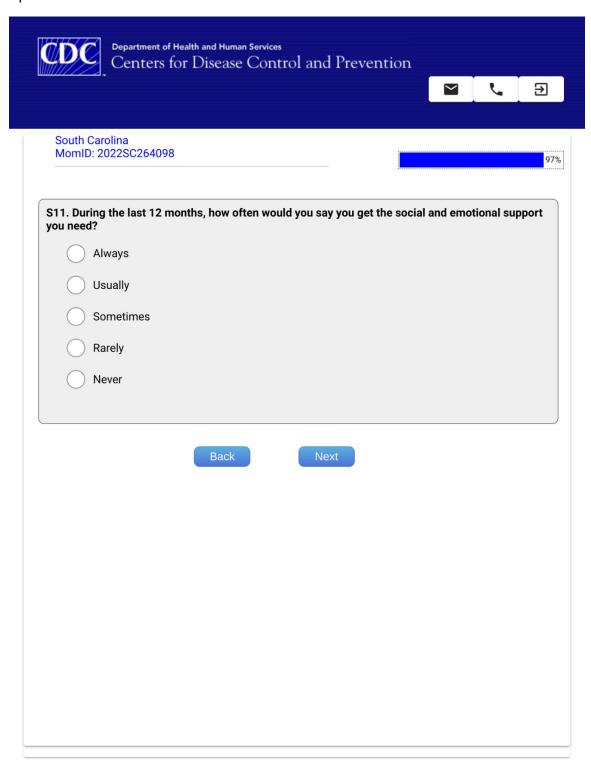












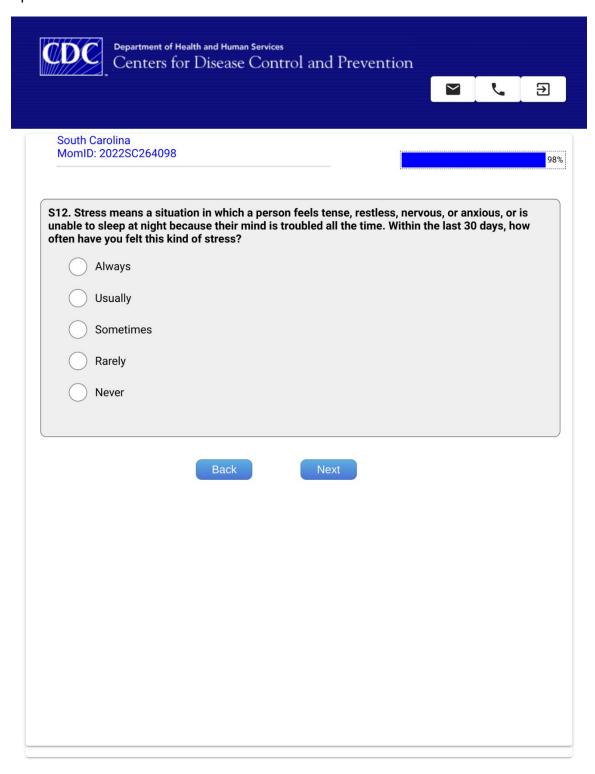










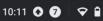




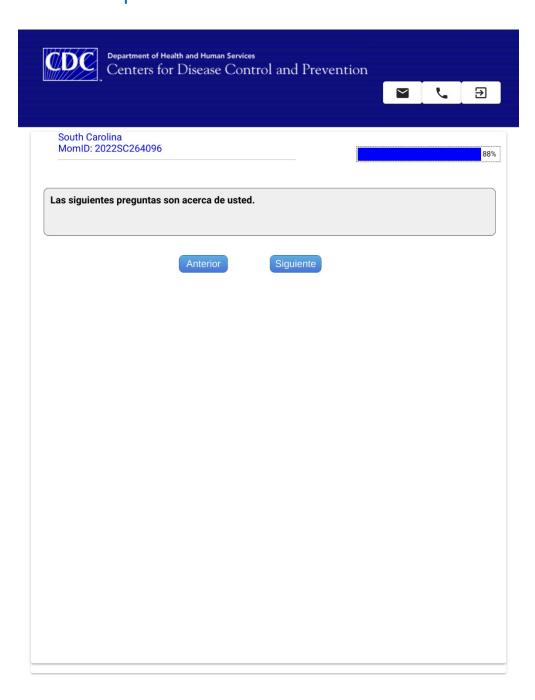


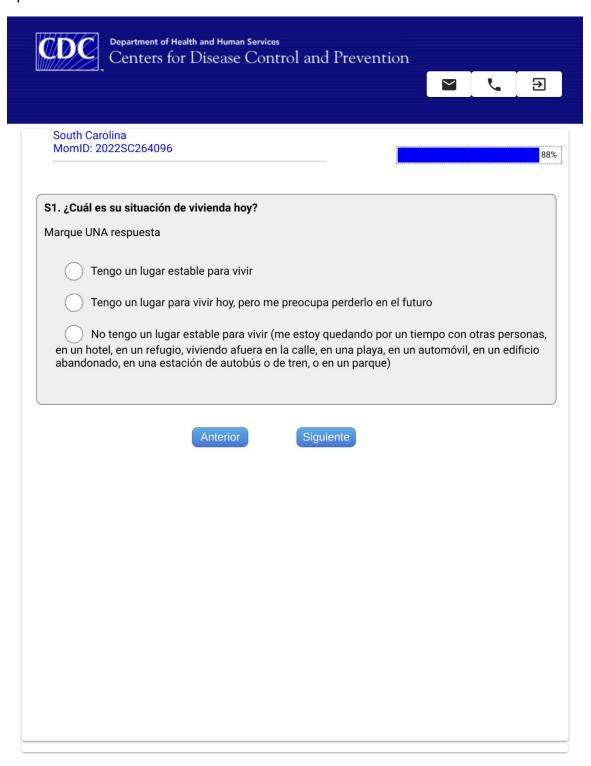






## PRAMS Social Determinants of Health Supplemental Module: Spanish Web



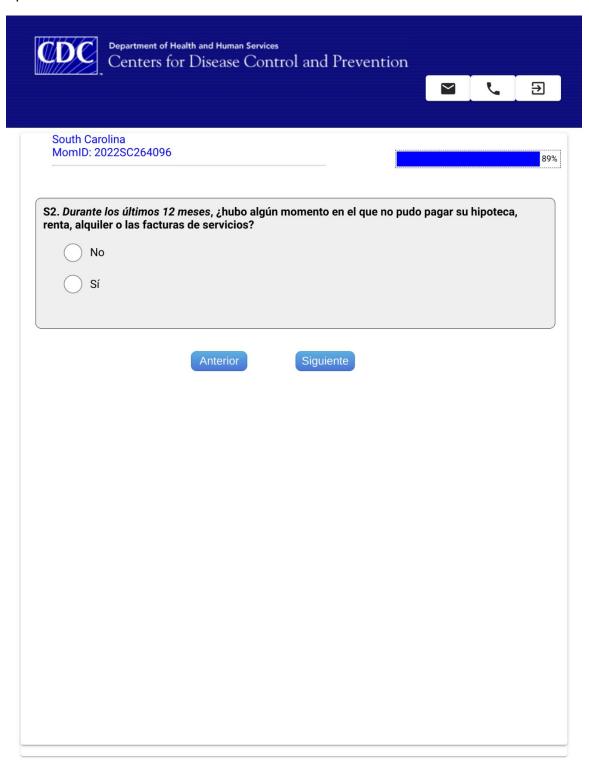












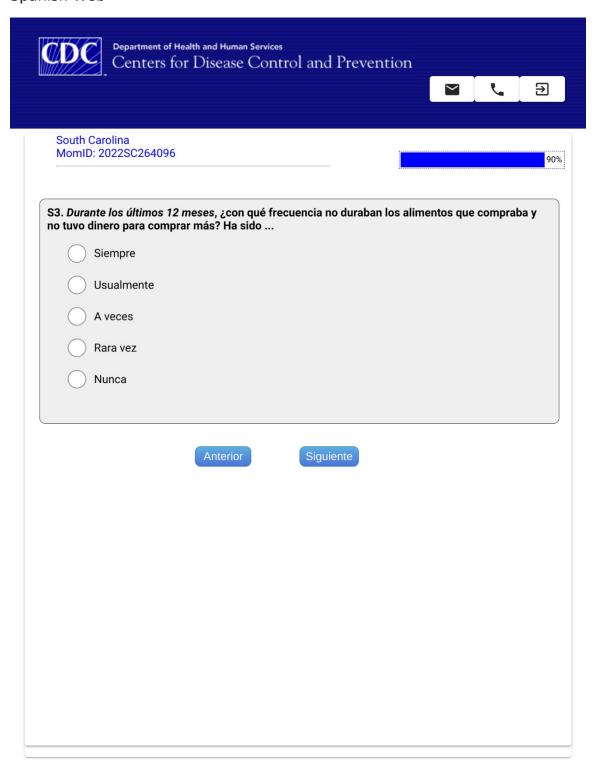








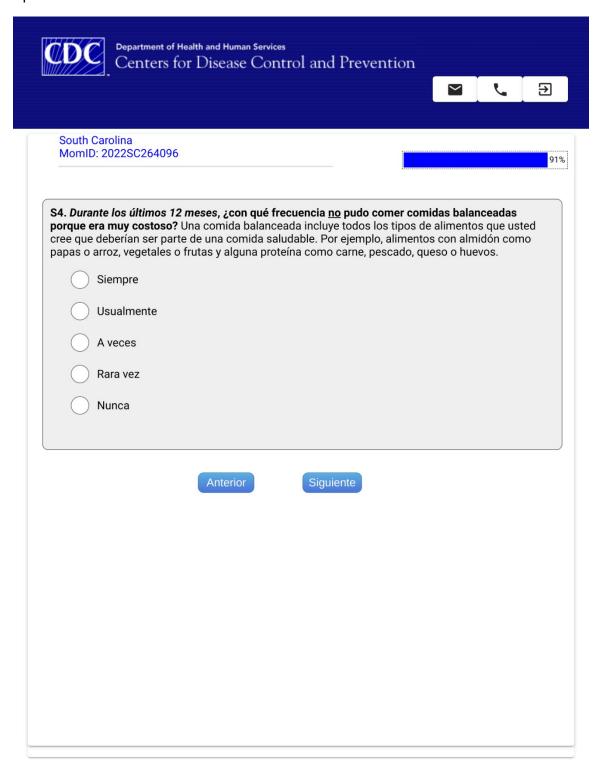






Oct 3



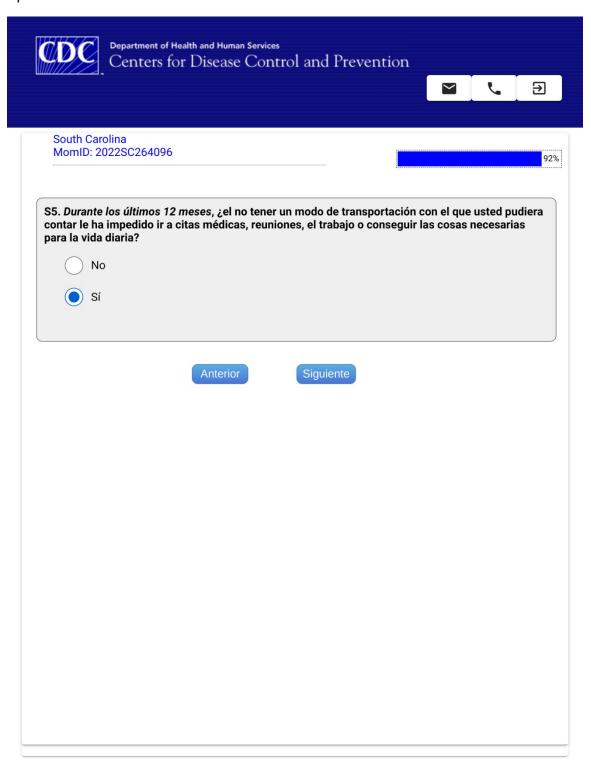








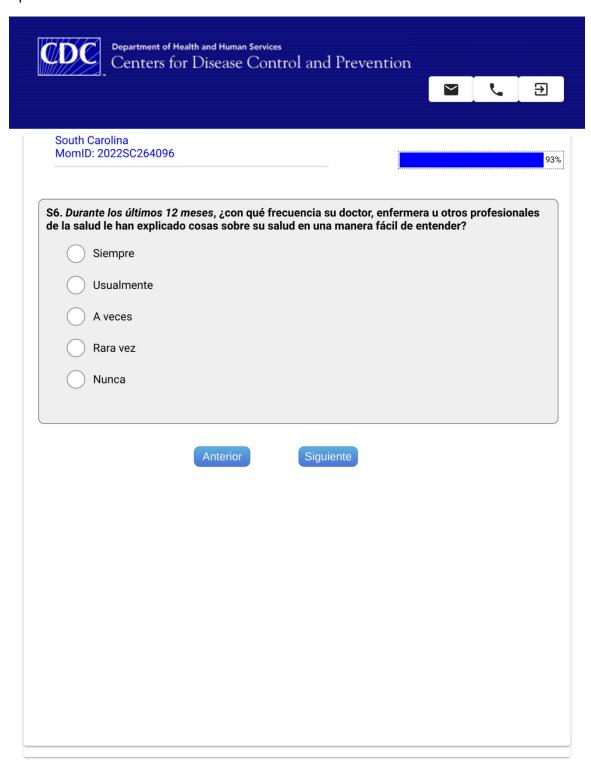










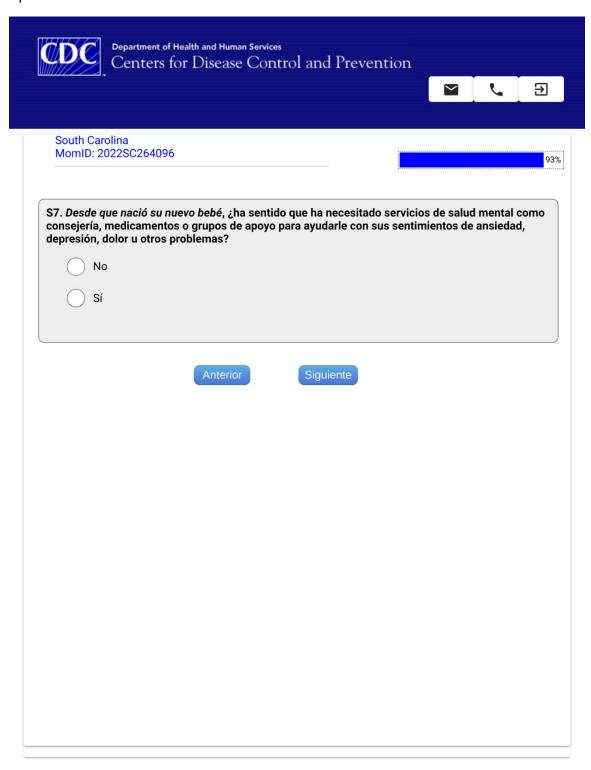












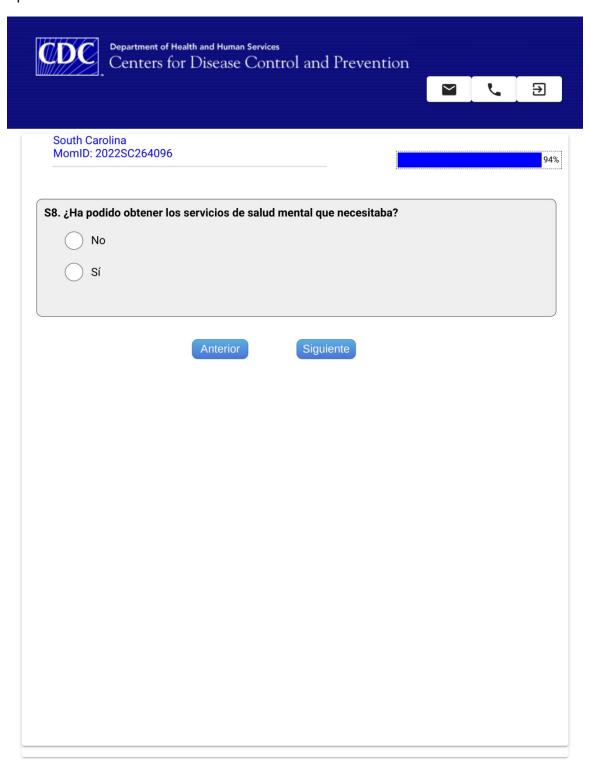












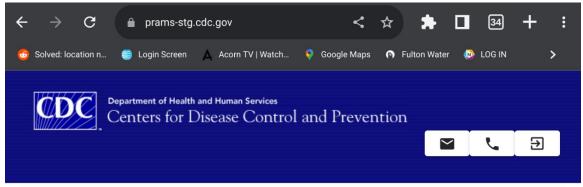












	No	Sí
No podía pagar lo que costaba		
Mi seguro médico no cubre los tratamientos o la consejería de salud mental	$\bigcirc$	$\bigcirc$
Mi seguro médico no paga lo suficiente por el tratamiento o la consejería de salud mental		
No sabía a donde ir para obtener servicios		
Me preocupaba que la información que le daría al consejero no se mantuviera confidencial		
No quería que otros supieran que necesitaba tratamiento		
Me preocupaba que me internaran en un hospital psiquiátrico	0	
Me preocupaba que tuviera que tomar medicamentos		
No tenía transporte, el tratamiento estaba demasiado lejos o el horario no era conveniente		$\bigcirc$
No tenía tiempo (por el trabajo, cuidado de niños u otros compromisos)		
Otra razón		
Por favor, escríbala:	Æ	

