61143

Form Approved
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2025

Draft

Understanding Your Health and Impacts of Healthcare Costs

Your opinion matters!

This survey asks about your general well-being and how health needs impact your time or your work. Your participation will help us better understand how health and health care affect people's lives.

Survey Instructions

- Please answer every question by marking one box "¤." If you are unsure about how to answer a question, please give the best answer you can.
- You are sometimes told to skip over some questions in this survey. When this happens you will see arrows that tell you what questions to answer next, like this:

☐ Yes

☐ No ➔ **If No, go to question 3**

Next Question

- Your participation is voluntary and all of your answers will be kept confidential as required by law. If you have any questions about this booklet, please call Alex Scott at 1-800-945-MEPS (6377).
- If you choose to complete the survey, MEPS will mail you a $20 debit card.

This Booklet Should Be Completed By

REGION: ☐ **RUID:** ☐☐☐☐☐☐☐☐☐ **PID:** ☐☐☐

NAME: _____

_____

DOB: ☐☐ / ☐☐ / ☐☐☐☐
MONTH DAY YEAR

This survey is authorized under 42 U.S [illegible] ected by Sections 944(c) and 308(d) of the Pub [illegible] t be disclosed unless you have consented to that disclosure. Public reporting burden for this collection of information is estimated to average 10 minutes per response, the estimated time required to complete the survey. 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 data you provide will help AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (OMB control number 0935-0118) AHRQ, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857 or by email at REPORTSCLEARANCEOFFICER@ahrq.hhs.gov.

The Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services

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Your Health

Under each heading, please check the **one** box that best describes your health **today**.

1. Mobility

- ☐ I have no problems walking
- ☐ I have slight problems walking
- ☐ I have moderate problems walking
- ☐ I have severe problems walking
- ☐ I am unable to walk

2. Self-Care

- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing or dressing myself
- ☐ I have severe problems washing or dressing myself
- ☐ I am unable to wash or dress myself

3. Usual activities (e.g., work, study, housework, family or leisure activities)

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

4. Pain/Discomfort

- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

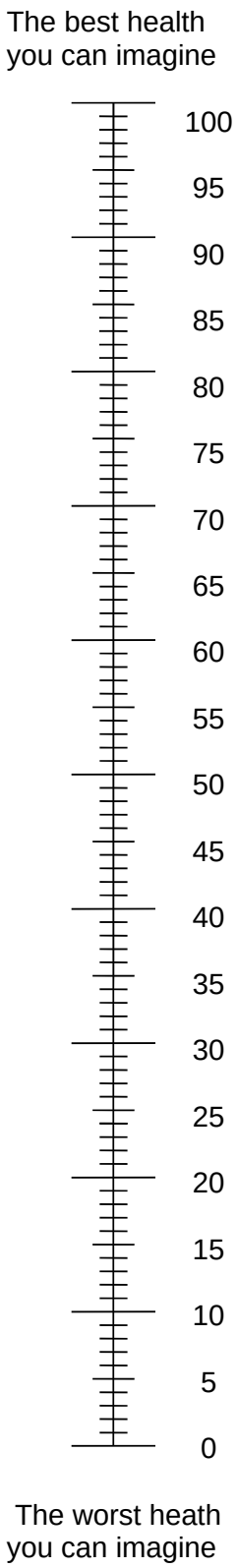
5. Anxiety/ Depression

- ☐ I am not anxious or depressed
- ☐ I am slightly anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am severely anxious or depressed
- ☐ I am extremely anxious or depressed

6.

- We would like to know how good or bad your health is **today**.
- This scale is numbered from 0 to 100.
- 100 means the **best** health you can imagine.
- 0 means the **worst** health you can imagine.
- Mark an X on the scale to indicate how your health is **today**.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐



Time and Paying for Health Care

For each item on this page, please report the total hours by week, by month, **or** for the last year.

7. Please think of how much time you spend seeing doctors, nurses, therapists or other health care providers about **your own health**, or going to the pharmacy for your own medications.

   During the past year, about how much time did you spend on average on these activities, including travel time?

_____**hours** **per week** **OR** _____**hours** **per month** **OR** _____**hours** **last year**

8. Please think of how much time you spend taking **other people** to see doctors, nurses, therapists or other health care providers, or going to the pharmacy for their medications.

   During the past year, about how much time did you spend on average on these activities, including travel time?

_____**hours** **per week** **OR** _____**hours** **per month** **OR** _____**hours** **last year**

9. During the past year, about how much time did you spend on average paying or managing medical bills, including dealing with insurance claims? If you helped another person manage his or her bills or claims, please include that time.

_____**hours** **per week** **OR** _____**hours** **per month** **OR** _____**hours** **last year**

10. During the past year, about how much time did you spend on average filling out forms, finding a doctor or other health provider who will see you, finding or understanding health plan information, and getting approval for any care, tests, or treatment? If you helped another person with these tasks, please include that time.

_____**hours** **per week** **OR** _____**hours** **per month** **OR** _____**hours** **last year**

11. In the past year, did your health insurance deny or delay prior approval for a treatment, service, visit, or drug **before you** received it?

- ☐ Yes
- ☐ No
- ☐ Never had health insurance during past year
- ☐ Not applicable/haven't used services

12. Suppose you had an unexpected medical bill, and the amount **not** covered by any insurance you may have came to $500, how would you pay the bill?

- ☐ Pay the bill right away by cash, check, or debit card
- ☐ Pay the bill right away out of your Health Savings Account or Flexible Savings Account
- ☐ Put it on a credit card and pay it off in full at the next statement
- ☐ Put it on a credit card and pay it off over time
- ☐ Borrow money from a bank, a payday lender, or friends or family to pay the bill
- ☐ Make a payment plan with provider
- ☐ Would not be able to pay the bill at all
- ☐ Something else

13. In the past year, have you or your family had to make any financial sacrifices because of your physical or mental health or its treatment?

Mark ☒ all that apply.

- ☐ Reduced spending on vacation or leisure activities
- ☐ Delayed large purchases (e.g., car)
- ☐ Reduced spending on basics (e.g., food and clothing)
- ☐ Used savings set aside for other purposes (e.g., retirement, educational funds, family support)
- ☐ Made a change to living situation (e.g., sold, refinanced, or moved to a smaller residence)
- ☐ Other
- ☐ No sacrifices

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Impacts On Work

14. At any time in the **past year**, were you working for pay at a job or business (including being self-employed)?

☐ Yes

☐ No ➔**If No, go to question 22 on page 9**

15. Because of your physical or mental health or its treatment, did any of your employers do anything to help you out so that you can continue working in the **past year**?

Mark ☒ all that apply.

☐ I didn't need any help from my employers
☐ Get someone to help me with my work duties
☐ Shorten my work days
☐ Allow me to change the time I came to and left work
☐ Allow me more breaks and rest periods
☐ Change the job to something I could do
☐ Help me learn new skills or get me special equipment or a computer for the job
☐ Assist me in receiving rehabilitative services from an external provider
☐ Allow me to work from home
☐ Something else to help me out
☐ My employers didn't offer me any help
☐ I'm self-employed

16. Because of your physical or mental health or its treatment, did you ask any of your employers for help to do your job that you did **not** receive in the past year?

☐ Yes
☐ No, because I didn't need any help from my employer
☐ No, because I received all the help I needed
☐ No, but I would have liked to get help (or more help) from my employer
☐ I'm self-employed

17. In the **past year**, did you stay at a job in part because you were concerned about losing health insurance for yourself or for the family?

- ☐ Yes
- ☐ No

18. Because of your physical or mental health or its treatment, have there been days in the past year when you needed to take off from work but **did not**?

- ☐ Yes
- ☐ No ➔**If No, go to question 20 on page 9**

19. Why did you decide **not** to take time off?

Mark ☒ all that apply.

- ☐ Too much work
- ☐ Wanted to save leave
- ☐ Leave was denied
- ☐ Did not have any paid or unpaid leave
- ☐ Did not have enough leave
- ☐ Fear of job loss or other negative employment-related consequence
- ☐ Could not afford the loss in income
- ☐ Other

20. Now thinking about the past **7 days**, were you working for pay at a job or business (including being self-employed)?

☐ Yes

☐ No ➔ **If No, go to question 22**

21. In the past 7 days, think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual.

During the past **7 days**, how much did your health problems or mental health affect your productivity **while you were working**?

If health problems or mental health affected your work only a little, choose a low number. Choose a high number if health problems or mental health affected your work a great deal.

Health problems had no effect on my work	0	1	2	3	4	5	6	7	8	9	10	Health problems completely prevented me from working

CIRCLE A NUMBER

22. In the past 7 days, think about times you were limited in the amount or kind of regular daily activities you could do (e.g., work around the house, shopping, childcare, exercising, or studying, etc.) and times you accomplished less than you would like.

During the **past 7 days**, how much did your health problems or mental health affect your ability to do **your regular daily activities, other than work at a job**?

If health problems or mental health affected your activities only a little, choose a low number. Choose a high number if health problems or mental health affected your activities a great deal.

Health problems had no effect on my daily activities	0	1	2	3	4	5	6	7	8	9	10	Health problems completely prevented me from doing my daily activities

CIRCLE A NUMBER

Informal Caregiving

23. During the past **30 days**, did you provide regular care or assistance to a friend or family member who has a health problem or disability?

- ☐ Yes
- ☐ No ➔ **If No, go to Date Completed on back cover**

24. What is his or her relationship to you? (If more than one person, please refer to the person to whom you are giving the most care.)

- ☐ Mother
- ☐ Father
- ☐ Child
- ☐ Husband
- ☐ Wife
- ☐ Live-in partner
- ☐ Other relative
- ☐ Non-relative/Family friend

25. Do you live with this person?

- ☐ Yes
- ☐ No

26. For how long have you provided care for that person?

- ☐ Less than 30 days
- ☐ 1 month to less than 6 months
- ☐ 6 months to less than 1 year
- ☐ 1 year to less than 2 years
- ☐ 2 years to less than 5 years
- ☐ 5 years or more

27. In the past **30 days**, did you provide care for this person by managing personal care such as giving medications, feeding, dressing, or bathing?

- ☐ Yes
- ☐ No

28. In the past **30 days**, did you provide care for this person by managing household tasks such as cleaning, managing money, or preparing meals?

- ☐ Yes
- ☐ No

29. In the past **30 days**, did you stay with this person to provide help when needed because they cannot be left alone?

- ☐ Yes
- ☐ No

30. In the past **30 days**, did helping this person ever keep you from working for pay (including being self-employed)?

- ☐ Yes
- ☐ No

31. In an **average week**, how many hours do you provide care or assistance?

- ☐ Up to 8 hours per week
- ☐ 9 to 19 hours per week
- ☐ 20 to 39 hours per week
- ☐ 40 hours or more

Questions 23, 24, 26, 27, 28, 31. Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Questionnaire. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, [2022]

Question 30. Freedman, Vicki A., Skehan, Maureen E., Hu, Mengyao, Wolff, Jennifer, Kasper, Judith D. 2019. National Study of Caregiving I-III User Guide. Baltimore: Johns Hopkins Bloomberg School of Public Health. Available at www.nhats.org

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Date completed:

MONTH / DAY / YEAR

Who completed this form?

- ☐ Person named on front of this form
- ☐ Someone else

If Someone Else, what is person's relationship to the person named on the front of this form?

- ☐ Husband or wife
- ☐ Unmarried partner
- ☐ Mother, father, or guardian
- ☐ Son or daughter
- ☐ Other relative
- ☐ Not related

THANK YOU FOR TAKING THE TIME TO COMPLETE THE QUESTIONNAIRE!

Please give your completed survey to your MEPS interviewer or place it in the return envelope and mail it back.

If the envelope is missing, mail this survey to:
MEPS
c/o Westat
1600 Research Blvd, RC B16
Rockville, MD 20850

MEPS will mail you a $20 debit card after we receive your completed survey.

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