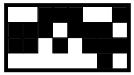


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Your Health

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

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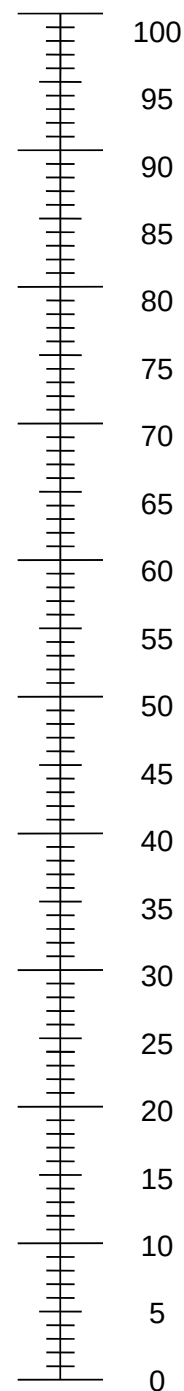
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6.

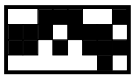
- We would like to know how good or bad your health is **today**.
- This scale is numbered from 0 to 100.
- 100 means the **best** health you can imagine.
- 0 means the **worst** health you can imagine.
- Mark an X on the scale to indicate how your health is **today**.
- Now, please write the number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

YOUR HEALTH TODAY =

The best health
you can imagine



The worst health
you can imagine



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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

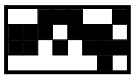
12. Suppose you had an unexpected medical bill, and the amount **not** covered by any insurance you may have came to \$500, how would you pay the bill?

- 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



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?

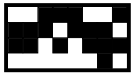
Yes

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



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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

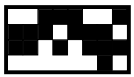
18. Because of your physical or mental health or its treatment, have there been days in the past year when you needed to take off from work but **did not**?

- 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



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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

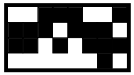
1 month to less than 6 months

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



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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)?

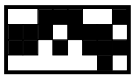
- Yes
- No

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:**

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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.