National Survey of Children’s Health

A study by the U.S. Department of Health and Human Services to better understand the health issues faced by children in the United States today.

The U.S. Census Bureau is required by law to protect your information and is not permitted to publicly release your responses in a way that could identify you or your household. The U.S. Census Bureau is conducting the National Survey of Children’s Health on behalf of the Department of Health and Human Services (HHS) under Title 13, United States Code, Section 8(b), which allows the Census Bureau to conduct surveys on behalf of other agencies. Title 42 U.S.C. Section 701(a)(2) allows HHS to collect information for the purpose of understanding the health and well-being of children in the United States. Federal law protects your privacy and keeps your answers confidential under 13 U.S.C. Section 9. Per the Federal Cybersecurity Enhancement Act of 2015, your data are protected from cybersecurity risks through screening of the systems that transmit your data.

Access to records maintained in the system is restricted to Census Bureau employees and certain individuals authorized by Title 13, U.S. Code (designated as Special Sworn Status individuals). These individuals are subject to the same confidentiality requirements as regular Census Bureau employees identified above and as permitted under the Privacy Act of 1974 (5 U.S.C. Section 552a) and SORN COMMERCE/CENSUS-3, Demographic Survey Collection (Census Bureau Sampling Frame).

Participation in this survey is voluntary and there are no penalties for refusing to answer questions. However, your cooperation in obtaining this much needed information is extremely important in order to ensure complete and accurate results.

NSCH-T1
(07/14/2020)
Recently, you completed a survey that asked about the children usually living or staying at this address. Thank you for taking the time to complete that survey.

We now have some follow-up questions to ask about:

If the name listed above is not correct or does not correspond to a child living in this household, please call 1-800-845-8241 for assistance.

We have selected only one child per household in an effort to minimize the amount of time you will need to complete the follow-up questions.

The survey should be completed by a parent or adult caregiver who lives in this household and who is familiar with this child’s health and health care.

Your participation is important. Thank you.

In general, how would you describe this child’s health (the one named above)?

- Excellent
- Very good
- Good
- Fair
- Poor

How would you describe the condition of this child’s teeth?

- This child does not have any teeth
- Excellent
- Very good
- Good
- Fair
- Poor

DURING THE PAST 12 MONTHS, has this child had FREQUENT or CHRONIC difficulty with any of the following?

- a. Breathing or other respiratory problems (such as wheezing or shortness of breath)
- b. Eating or swallowing because of a health condition
- c. Digesting food, including stomach/intestinal problems, constipation, or diarrhea
- d. Repeated or chronic physical pain, including headaches or other back or body pain
- e. Using their hands
- f. Coordination or moving around
- g. Toothaches
- h. Bleeding gums
- i. Decayed teeth or cavities

Does this child have any of the following?

- a. Deafness or problems with hearing
- b. Blindness or problems with seeing, even when wearing glasses

Has a doctor or other health care provider EVER told you that this child has...

- Allergies (including food, drug, insect, or other)?
- Arthritis?

If yes, does this child CURRENTLY have the condition?

- If yes, is it:
  - Mild
  - Moderate
  - Severe
Has a doctor or other health care provider EVER told you that this child has...

<table>
<thead>
<tr>
<th>A7</th>
<th>Asthma?</th>
<th>Yes □ No □</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If yes, does this child CURRENTLY have the condition?</td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
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<td></td>
<td>If yes, is it:</td>
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<td></td>
<td>□ Mild □ Moderate □ Severe</td>
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<thead>
<tr>
<th>A8</th>
<th>Cerebral Palsy?</th>
<th>Yes □ No □</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>If yes, does this child CURRENTLY have the condition?</td>
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<td></td>
<td>□ Yes □ No</td>
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<td></td>
<td>If yes, is it:</td>
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<td></td>
<td>□ Mild □ Moderate □ Severe</td>
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<thead>
<tr>
<th>A9</th>
<th>Diabetes?</th>
<th>Yes □ No □</th>
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<tbody>
<tr>
<td></td>
<td>If yes, does this child CURRENTLY have the condition?</td>
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<td></td>
<td>□ Yes □ No</td>
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<tr>
<td></td>
<td>If yes, is it:</td>
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<td></td>
<td>□ Mild □ Moderate □ Severe</td>
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<tr>
<th>A10</th>
<th>Epilepsy or Seizure Disorder?</th>
<th>Yes □ No □</th>
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<tbody>
<tr>
<td></td>
<td>If yes, does this child CURRENTLY have the condition?</td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
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<tr>
<td></td>
<td>If yes, is it:</td>
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<td></td>
<td>□ Mild □ Moderate □ Severe</td>
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<tr>
<th>A11</th>
<th>Heart Condition?</th>
<th>Yes □ No □</th>
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<tbody>
<tr>
<td></td>
<td>If yes, was this child born with the condition?</td>
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<td></td>
<td>□ Yes □ No</td>
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<td></td>
<td>Does this child CURRENTLY have the condition?</td>
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<td></td>
<td>□ Yes □ No</td>
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<td></td>
<td>If yes, is it:</td>
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<td>□ Mild □ Moderate □ Severe</td>
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<tr>
<th>A12</th>
<th>Frequent or severe headaches, including migraine?</th>
<th>Yes □ No □</th>
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<tbody>
<tr>
<td></td>
<td>If yes, does this child CURRENTLY have the condition?</td>
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<td>□ Yes □ No</td>
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<td></td>
<td>If yes, is it:</td>
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<td></td>
<td>□ Mild □ Moderate □ Severe</td>
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<tr>
<th>A13</th>
<th>Tourette Syndrome?</th>
<th>Yes □ No □</th>
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<tbody>
<tr>
<td></td>
<td>If yes, does this child CURRENTLY have the condition?</td>
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<td></td>
<td>□ Yes □ No</td>
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<td></td>
<td>If yes, is it:</td>
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<td></td>
<td>□ Mild □ Moderate □ Severe</td>
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<tr>
<th>A14</th>
<th>Anxiety Problems?</th>
<th>Yes □ No □</th>
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<tbody>
<tr>
<td></td>
<td>If yes, does this child CURRENTLY have the condition?</td>
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<td>□ Yes □ No</td>
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<td></td>
<td>If yes, is it:</td>
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<td></td>
<td>□ Mild □ Moderate □ Severe</td>
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<tr>
<th>A15</th>
<th>Depression?</th>
<th>Yes □ No □</th>
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<tr>
<td></td>
<td>If yes, does this child CURRENTLY have the condition?</td>
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<td></td>
<td>□ Yes □ No</td>
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<tr>
<td></td>
<td>If yes, is it:</td>
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<tr>
<td></td>
<td>□ Mild □ Moderate □ Severe</td>
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<tr>
<th>A16</th>
<th>Down Syndrome?</th>
<th>Yes □ No □</th>
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<td></td>
<td>If yes, was this child born with the condition?</td>
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<td></td>
<td>□ Yes □ No</td>
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<tr>
<td></td>
<td>Does this child CURRENTLY have the condition?</td>
<td></td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
<td></td>
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<tr>
<td></td>
<td>If yes, is it:</td>
<td></td>
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<tr>
<td></td>
<td>□ Mild □ Moderate □ Severe</td>
<td></td>
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</tbody>
</table>
Has a doctor or other health care provider EVER told you that this child has...

A20 Behavioral or Conduct Problems?
- Yes
- No
  - If yes, does this child CURRENTLY have the condition?
    - Yes
    - No
      - If yes, is it:
        - Mild
        - Moderate
        - Severe

A21 Developmental Delay?
- Yes
- No
  - If yes, does this child CURRENTLY have the condition?
    - Yes
    - No
      - If yes, is it:
        - Mild
        - Moderate
        - Severe

A22 Intellectual Disability (formerly known as Mental Retardation)?
- Yes
- No
  - If yes, does this child CURRENTLY have the disability?
    - Yes
    - No
      - If yes, is it:
        - Mild
        - Moderate
        - Severe

A23 Speech or other language disorder?
- Yes
- No
  - If yes, does this child CURRENTLY have the condition?
    - Yes
    - No
      - If yes, is it:
        - Mild
        - Moderate
        - Severe

A24 Learning Disability?
- Yes
- No
  - If yes, does this child CURRENTLY have the disability?
    - Yes
    - No
      - If yes, is it:
        - Mild
        - Moderate
        - Severe

A19 Other genetic or inherited condition?
- Yes
- No
  - If yes, specify:

A18 Cystic Fibrosis?
- Yes
- No
  - If yes, is it:
    - Mild
    - Moderate
    - Severe

A17 Blood Disorders (such as Sickle Cell Disease, Thalassemia, or Hemophilia)?
- Yes
- No
  - If yes, is it:
    - Mild
    - Moderate
    - Severe

  Was this child diagnosed with:
  - Sickle Cell Disease?
    - Yes
    - No
  - Thalassemia?
    - Yes
    - No
  - Hemophilia?
    - Yes
    - No
  - Other Blood Disorders?
    - Yes
    - No

Were any of these blood disorders identified through a blood test done shortly after birth? These tests are sometimes called newborn screening.
- Yes
- No

Cystic Fibrosis?
- Yes
- No
  - If yes, is it:
    - Mild
    - Moderate
    - Severe

Other genetic or inherited condition?
- Yes
- No
  - If yes, specify:

Is it:
- Mild
- Moderate
- Severe

Was this condition identified through a blood test done shortly after birth? These tests are sometimes called newborn screening.
- Yes
- No
At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for Autism, ASD, Asperger's Disorder or PDD, such as training or an intervention that you or this child received to help with their behavior?

- Yes
- No

If yes, does this child CURRENTLY have the condition?

- Yes
- No

If yes, is it:

- Mild
- Moderate
- Severe

Is this child CURRENTLY taking medication for Autism, ASD, Asperger's Disorder or PDD?

- Yes
- No

What type of doctor or other health care provider was the FIRST to tell you that this child had Autism, ASD, Asperger's Disorder or PDD?

- Primary Care Provider
- Specialist
- School Psychologist/Counselor
- Other Psychologist (Non-School)
- Psychiatrist
- Other, specify:

- Don't know

Has a doctor or other health care provider EVER told you that this child has Autism or Autism Spectrum Disorder (ASD)? Include diagnoses of Asperger's Disorder or Pervasive Developmental Disorder (PDD).

- Yes
- No → SKIP to question A30

If yes, does this child CURRENTLY have the condition?

- Yes
- No

If yes, is it:

- Mild
- Moderate
- Severe

Is this child CURRENTLY taking medication for ADD or ADHD?

- Yes
- No

Do you think this child has EVER had a concussion or brain injury? A concussion or brain injury is when a blow or jolt to the head causes problems such as headaches, dizziness, being dazed or confused, difficulty remembering or concentrating, vomiting, blurred vision, changes in mood or behavior, or being knocked out.

- Yes
- No

If yes, did you seek medical care from a doctor or other health care provider?

- Yes
- No

If yes, did a doctor or other health care provider tell you that your child had a concussion or brain injury?

- Yes
- No

DURING THE PAST 12 MONTHS, how often have this child’s health conditions or problems affected their ability to do things other children their age do?

- This child does not have any health conditions → SKIP to question A31 on page 6
- Never
- Sometimes
- Usually
- Always

To what extent do this child’s health conditions or problems affect their ability to do things?

- Very little
- Somewhat
- A great deal

How old was this child when a doctor or other health care provider FIRST told you that they had Autism, ASD, Asperger's Disorder or PDD?

- Age in years
- Don’t know
B. This Child as an Infant

B1 Was this child born more than 3 weeks before their due date?
- Yes
- No

B2 What month and year was this child born?
Birth Month / 4-Digit Birth Year

B3 How much did they weigh when born? Answer in pounds and ounces OR kilograms and grams. Your best estimate is fine.
- pounds
- ounces

B4 What was the age of the mother when this child was born? Your best estimate is fine.
- Age in years

B5 Was this child EVER breastfed or fed breast milk?
- Yes
- No → SKIP to question B7

B6 If yes, how old was this child when they COMPLETELY stopped breastfeeding or being fed breast milk? Your best estimate is fine.
- This child is still breastfeeding
- days
- weeks
- months

B7 How old was this child when they were FIRST fed formula? Your best estimate is fine.
- This child has never been fed formula
- At birth
- days
- weeks
- months

B8 How old was this child when they were FIRST fed anything other than breast milk or formula? Include water, juice, cow’s milk, sugar water, baby food, or anything else that your child might have been given. Your best estimate is fine.
- This child has never been fed anything other than breast milk or formula
- At birth
- days
- weeks
- months
C. Health Care Services

C1 DURING THE PAST 12 MONTHS, did this child see a doctor, nurse, or other health care professional for sick-child care, well-child check-ups, physical exams, hospitalizations or any other kind of medical care?

☐ Yes
☐ No → SKIP to question C4

C2 If yes, DURING THE PAST 12 MONTHS, how many times did this child visit a doctor, nurse, or other health care professional to receive a PREVENTIVE check-up?

A preventive check-up is when this child was not sick or injured, such as an annual or sports physical, or well-child visit.

☐ 0 visits
☐ 1 visit
☐ 2 or more visits

C3 Thinking about the LAST TIME you took this child for a PREVENTIVE check-up, about how long was the doctor or health care provider who examined this child in the room with you? Your best estimate is fine.

☐ Less than 10 minutes
☐ 10-20 minutes
☐ More than 20 minutes

C4 Are you concerned about this child’s weight?

☐ Yes, it’s too high
☐ Yes, it’s too low
☐ No, I am not concerned

C5 Has a doctor or other health care provider ever told you that this child is overweight?

☐ Yes
☐ No

C6 DURING THE PAST 12 MONTHS, did this child’s doctors or other health care providers ask if you have concerns about this child’s learning, development, or behavior?

☐ Yes
☐ No

C7 Answer the following question only if this child is at least 9 months old. Otherwise skip to question C8.

DURING THE PAST 12 MONTHS, did a doctor or other health care provider have you or another caregiver fill out a questionnaire about observations or concerns you may have about this child’s development, communication, or social behaviors? Sometimes a child’s doctor or other health care provider will ask a parent to do this at home or during a child’s visit.

☐ Yes
☐ No

If yes, and this child is 9-23 Months:

Did the questionnaire ask about your concerns or observations about:

Mark (X) ALL that apply.

☐ How this child talks or makes speech sounds?
☐ How this child interacts with you and others?

If yes, and this child is 2-5 Years:

Did the questionnaire ask about your concerns or observations about:

Mark (X) ALL that apply.

☐ Words and phrases this child uses and understands?
☐ How this child behaves and gets along with you and others?

C8 Is there a place you or another caregiver USUALLY take this child when they are sick or you need advice about their health?

☐ Yes
☐ No → SKIP to question C10 on page 8

C9 If yes, where does this child USUALLY go first?

Mark (X) ONE box.

☐ Doctor’s Office
☐ Hospital Emergency Room
☐ Hospital Outpatient Department
☐ Clinic or Health Center
☐ Retail Store Clinic or “Minute Clinic”
☐ School (Nurse’s Office, Athletic Trainer’s Office)
☐ Some other place
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
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</thead>
<tbody>
<tr>
<td>Is there a place that this child USUALLY goes when they need routine preventive care, such as a physical examination or well-child check-up?</td>
<td>Yes, No → Skip to question C12</td>
</tr>
<tr>
<td>If yes, is this the same place this child goes when they are sick?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>DURING THE PAST 12 MONTHS, has this child had their vision tested, such as with pictures, shapes, or letters?</td>
<td>Yes, No → Skip to question C14</td>
</tr>
<tr>
<td>If yes, where was this child’s vision tested?</td>
<td>Eye doctor or eye specialist (ophthalmologist, optometrist) office, Pediatrician or other general doctor’s office, Clinic or health center, School, Other, specify:</td>
</tr>
<tr>
<td>DURING THE PAST 12 MONTHS, did this child see a dentist or other oral health care provider for any kind of dental or oral health care?</td>
<td>Yes, saw a dentist, Yes, saw other oral health care provider, No → Skip to question C17</td>
</tr>
<tr>
<td>If yes, DURING THE PAST 12 MONTHS, did this child see a dentist or other oral health care provider for PREVENTIVE dental care, such as check-ups, dental cleanings, dental sealants, or fluoride treatments?</td>
<td>No preventive visits in the past 12 months, Yes, 1 visit, Yes, 2 or more visits</td>
</tr>
<tr>
<td>If yes, DURING THE PAST 12 MONTHS, what PREVENTIVE dental service(s) did this child receive?</td>
<td>Mark (X) ALL that apply. Check-up, Cleaning, Instruction on tooth brushing and oral health care, X-Rays, Fluoride treatment, Sealant (plastic coatings on back teeth), Don’t know</td>
</tr>
<tr>
<td>DURING THE PAST 12 MONTHS, has this child received any treatment or counseling from a mental health professional?</td>
<td>Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers. Yes, No, but this child needed to see a mental health professional, No, this child did not need to see a mental health professional → Skip to question C19</td>
</tr>
<tr>
<td>How difficult was it to get the mental health treatment or counseling that this child needed?</td>
<td>Not difficult, Somewhat difficult, Very difficult, It was not possible to obtain care</td>
</tr>
<tr>
<td>DURING THE PAST 12 MONTHS, did this child see a specialist other than a mental health professional?</td>
<td>Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care. Yes, No, but this child needed to see a specialist, No, this child did not need to see a specialist → Skip to question C22 on page 9</td>
</tr>
</tbody>
</table>
Has this child EVER had a special education or early intervention plan? Children receiving these services often have an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP).

- Yes
- No

If yes, how old was this child at the time of the FIRST plan?

- [ ] Not difficult
- [ ] Somewhat difficult
- [ ] Very difficult
- [ ] It was not possible to obtain care

During the past 12 months, did this child use any type of alternative health care or treatment? Alternative health care can include acupuncture, chiropractic care, relaxation therapies, herbal supplements, and others. Some therapies involve seeing a health care provider, while others can be done on your own.

- Yes
- No

During the past 12 months, was there any time when this child needed health care but it was not received? By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services.

- Yes
- No

If yes, which types of care were not received? Mark (X) ALL that apply.

- Medical Care
- Dental Care
- Vision Care
- Hearing Care
- Mental Health Services
- Other, specify:  

During the past 12 months, how difficult was it to get the specialist care that this child needed?

- Not difficult
- Somewhat difficult
- Very difficult
- It was not possible to obtain care

During the past 12 months, how often were you frustrated in your efforts to get services for this child?

- Never
- Sometimes
- Usually
- Always

During the past 12 months, how many times did this child visit a hospital emergency room?

- None
- 1 time
- 2 or more times

During the past 12 months, was this child admitted to the hospital to stay for at least one night?

- Yes
- No

Has this child EVER had a special education or early intervention plan? Children receiving these services often have an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP).

- Yes
- No

During the past 12 months, was this child admitted to the hospital to stay for at least one night?

- Yes
- No

Has this child EVER received special services to meet their developmental needs such as speech, occupational, or behavioral therapy?

- Yes
- No

During the past 12 months, was this child admitted to the hospital to stay for at least one night?

- Yes
- No

During the past 12 months, how many times did this child visit a hospital emergency room?

- None
- 1 time
- 2 or more times

If yes, which types of care were not received? Mark (X) ALL that apply.

- Medical Care
- Dental Care
- Vision Care
- Hearing Care
- Mental Health Services
- Other, specify:  

If yes, how old was this child at the time of the FIRST plan?

- [ ] years AND [ ] months

If yes, how old was this child at the time of the FIRST plan?

- [ ] years AND [ ] months

Is this child CURRENTLY receiving services under one of these plans?

- Yes
- No

Has this child EVER received special services to meet their developmental needs such as speech, occupational, or behavioral therapy?

- Yes
- No

If yes, how old was this child at the time of the FIRST plan?

- [ ] years AND [ ] months

Is this child CURRENTLY receiving these special services?

- Yes
- No
### D. Experience with This Child's Health Care Providers

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
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<tbody>
<tr>
<td><strong>D1</strong> Do you have one or more persons you think of as this child's personal doctor or nurse? A personal doctor or nurse is a health professional who knows this child well and is familiar with this child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician assistant.</td>
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<tr>
<td>Yes, one person</td>
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<tr>
<td>Yes, more than one person</td>
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<td>No</td>
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<td><strong>D2</strong> DURING THE PAST 12 MONTHS, did this child need a referral to see any doctors or receive any services?</td>
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<tr>
<td>Yes</td>
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<tr>
<td>No → <strong>SKIP to question D4</strong></td>
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<tr>
<td><strong>D3</strong> How difficult was it to get referrals?</td>
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<tr>
<td>Not difficult</td>
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<tr>
<td>Somewhat difficult</td>
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<tr>
<td>Very difficult</td>
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<tr>
<td>It was not possible to get a referral</td>
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</tbody>
</table>

**Answer the following questions only if this child had a health care visit IN THE PAST 12 MONTHS. Otherwise, skip to question D4 on page 11.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
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</thead>
<tbody>
<tr>
<td><strong>D4</strong> DURING THE PAST 12 MONTHS, how often did this child's doctors or other health care providers...</td>
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<tr>
<td>a. Spend enough time with this child?</td>
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<tr>
<td>b. Listen carefully to you?</td>
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<tr>
<td>c. Show sensitivity to your family's values and customs?</td>
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<tr>
<td>d. Provide the specific information you needed concerning this child?</td>
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<tr>
<td>e. Help you feel like a partner in this child's care?</td>
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<tbody>
<tr>
<td><strong>D5</strong> DURING THE PAST 12 MONTHS, did this child need any decisions to be made regarding their health care, such as whether to get prescriptions, referrals, or procedures?</td>
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<tr>
<td>Yes</td>
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<tr>
<td>No → <strong>SKIP to question D7</strong></td>
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<th>Question</th>
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<tbody>
<tr>
<td><strong>D6</strong> If yes, DURING THE PAST 12 MONTHS, how often did this child's doctors or other health care providers...</td>
<td></td>
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<tr>
<td>a. Discuss with you the range of options to consider for their health care or treatment?</td>
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<tr>
<td>b. Make it easy for you to raise concerns or disagree with recommendations for this child's health care?</td>
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<tr>
<td>c. Work with you to decide together which health care and treatment choices would be best for this child?</td>
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<tbody>
<tr>
<td><strong>D7</strong> DURING THE PAST 12 MONTHS, did anyone help you arrange or coordinate this child's care among the different doctors or services that this child uses?</td>
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<tr>
<td>Yes</td>
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<tr>
<td>No → <strong>SKIP to question D4</strong></td>
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<tbody>
<tr>
<td><strong>D8</strong> DURING THE PAST 12 MONTHS, have you felt that you could have used extra help arranging or coordinating this child's care among the different health care providers or services?</td>
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<tr>
<td>Yes</td>
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</tr>
<tr>
<td>No → <strong>SKIP to question D4</strong></td>
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<th>Sometimes</th>
<th>Never</th>
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<tbody>
<tr>
<td><strong>D9</strong> If yes, DURING THE PAST 12 MONTHS, how often did you get as much help as you wanted with arranging or coordinating this child's health care?</td>
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<td>Never</td>
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<tr>
<th>Question</th>
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<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
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<tbody>
<tr>
<td><strong>D10</strong> DURING THE PAST 12 MONTHS, how satisfied were you with the communication between this child's doctors and other health care providers?</td>
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<td></td>
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<tr>
<td>Very satisfied</td>
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<tr>
<td>Somewhat satisfied</td>
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<tr>
<td>Somewhat dissatisfied</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td></td>
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</tbody>
</table>
E. This Child’s Health Insurance Coverage

DURING THE PAST 12 MONTHS, was this child EVER covered by ANY kind of health insurance or health coverage plan?

☐ Yes, this child was covered all 12 months  □   SKIP to question E4

☐ Yes, but this child had a gap in coverage

☐ No

Indicate whether any of the following is a reason this child was not covered by health insurance at any time DURING THE PAST 12 MONTHS:

a. Change in employer or employment status
b. Cancellation due to overdue premiums
c. Dropped coverage because it was unaffordable
d. Dropped coverage because benefits were inadequate
e. Dropped coverage because choice of health care providers was inadequate
f. Problems with application or renewal process

g. Other, specify:

How often does this child’s health insurance offer benefits or cover services that meet this child’s needs?

☐ Always

☐ Usually

☐ Sometimes

☐ Never

How often does this child’s health insurance allow them to see the health care providers they need?

☐ Always

☐ Usually

☐ Sometimes

☐ Never

Thinking specifically about this child’s mental or behavioral health needs, how often does this child’s health insurance offer benefits or cover services that meet these needs?

☐ Always

☐ Usually

☐ Sometimes

☐ Never

This child does not use mental or behavioral health services
F. Providing for This Child’s Health

Including co-pays and amounts reimbursed from Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA), how much money did you pay for this child’s medical, health, dental, and vision care DURING THE LAST 12 MONTHS? Do not include health insurance premiums or costs that were or will be reimbursed by insurance or another source.

- $0 (No medical or health-related expenses) ⇒ SKIP to question F4
- $1-$249
- $250-$499
- $500-$999
- $1,000-$5,000
- More than $5,000

How often are these costs reasonable?

- Always
- Usually
- Sometimes
- Never

DURING THE PAST 12 MONTHS, did your family have problems paying for any of this child’s medical or health care bills?

- Yes
- No

DURING THE PAST 12 MONTHS, have you or other family members...

- a. Left a job or taken a leave of absence because of this child’s health or health conditions?
- b. Cut down on the hours you work because of this child’s health or health conditions?
- c. Avoided changing jobs because of concerns about maintaining health insurance for this child?

IN AN AVERAGE WEEK, how many hours do you or other family members spend providing health care at home for this child? Care might include changing bandages, or giving medication and therapies when needed.

- This child does not need health care provided at home on a weekly basis
- Less than 1 hour per week
- 1-4 hours per week
- 5-10 hours per week
- 11 or more hours per week

IN AN AVERAGE WEEK, how many hours do you or other family members spend arranging or coordinating health or medical care for this child, such as making appointments or locating services?

- This child does not need health care coordinated on a weekly basis
- Less than 1 hour per week
- 1-4 hours per week
- 5-10 hours per week
- 11 or more hours per week

G. This Child’s Learning

Answer the following question only if this child is at least 1 year old. Otherwise skip to G2 on page 15.

Is this child able to do the following...

Mark (X) Yes or No for EACH item.

- a. Say at least one word, such as “hi” or “dog”?
- b. Use 2 words together, such as “car go”?
- c. Use 3 words together in a sentence, such as, “Mommy come now.”?
- d. Ask questions like “who,” “what,” “when,” “where”?
- e. Ask questions like “why” and “how”?
- f. Tell a story with a beginning, middle, and end?
- g. Understand the meaning of the word “no”?
- h. Follow a verbal direction without hand gestures, such as “Wash your hands.”?
- i. Point to things in a book when asked?
- j. Follow 2-step directions, such as “Get your shoes and put them in the basket.”?
- k. Understand words such as “in,” “on,” and “under”?
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2 Are you concerned about how this child is learning to do things for themselves?</td>
<td>☐ No → <strong>SKIP to question G2</strong> on page 15</td>
</tr>
<tr>
<td>G3 Has this child started school? Include any formal home schooling.</td>
<td>☐ Yes, preschool</td>
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<tr>
<td></td>
<td>☐ Yes, kindergarten</td>
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<tr>
<td></td>
<td>☐ Yes, first grade</td>
</tr>
<tr>
<td></td>
<td>☐ No</td>
</tr>
<tr>
<td>G4 Are you concerned about how this child is learning to do things for themselves?</td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td>☐ Yes, somewhat concerned</td>
</tr>
<tr>
<td></td>
<td>☐ Yes, very concerned</td>
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<tr>
<td>G5 How confident are you that this child is ready to be in school?</td>
<td>☐ Completely confident</td>
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<tr>
<td></td>
<td>☐ Mostly confident</td>
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<tr>
<td></td>
<td>☐ Somewhat confident</td>
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<tr>
<td></td>
<td>☐ Not at all confident</td>
</tr>
<tr>
<td>G6 How often can this child recognize the beginning sound of a word?</td>
<td>☐ Always</td>
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<tr>
<td></td>
<td>☐ Most of the time</td>
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<tr>
<td></td>
<td>☐ About half the time</td>
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<td></td>
<td>☐ Sometimes</td>
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<td></td>
<td>☐ Never</td>
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<tr>
<td>G7 About how many letters of the alphabet can this child recognize?</td>
<td>☐ All of them</td>
</tr>
<tr>
<td></td>
<td>☐ Most of them</td>
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<tr>
<td></td>
<td>☐ About half of them</td>
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<td></td>
<td>☐ Some of them</td>
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<tr>
<td></td>
<td>☐ None of them</td>
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<tr>
<td>G8 Can this child rhyme words?</td>
<td>☐ Yes</td>
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<tr>
<td></td>
<td>☐ No</td>
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<tr>
<td>G9 How often can this child explain things they have seen or done so that you get a very good idea what happened?</td>
<td>☐ Always</td>
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<tr>
<td></td>
<td>☐ Most of the time</td>
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<tr>
<td></td>
<td>☐ About half the time</td>
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<td></td>
<td>☐ Sometimes</td>
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<td></td>
<td>☐ Never</td>
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<tr>
<td>G10 How often can this child write their first name, even if some of the letters aren’t quite right or are backwards?</td>
<td>☐ Always</td>
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<tr>
<td></td>
<td>☐ Most of the time</td>
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<tr>
<td></td>
<td>☐ About half the time</td>
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<td></td>
<td>☐ Sometimes</td>
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<td></td>
<td>☐ Never</td>
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<tr>
<td>G11 How high can this child count?</td>
<td>☐ This child cannot count</td>
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<tr>
<td></td>
<td>☐ Up to five</td>
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<tr>
<td></td>
<td>☐ Up to ten</td>
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<td></td>
<td>☐ Up to 20</td>
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<td></td>
<td>☐ Up to 50</td>
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<td></td>
<td>☐ Up to 100 or more</td>
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<tr>
<td>G12 How often can this child identify basic shapes such as a triangle, circle, or square?</td>
<td>☐ Always</td>
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<tr>
<td></td>
<td>☐ Most of the time</td>
</tr>
<tr>
<td></td>
<td>☐ About half the time</td>
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<tr>
<td></td>
<td>☐ Sometimes</td>
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<tr>
<td></td>
<td>☐ Never</td>
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Note: The questions and options are designed to assess the child's readiness and development in various aspects related to learning and school readiness.
<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>Can this child identify the colors red, yellow, blue, and green by name?</td>
<td>Yes, all of them, Yes, some of them, No, none of them</td>
</tr>
<tr>
<td>How often is this child easily distracted?</td>
<td>Always, Most of the time, About half the time, Sometimes, Never</td>
</tr>
<tr>
<td>How often does this child keep working at something until they are finished?</td>
<td>Always, Most of the time, About half the time, Sometimes, Never</td>
</tr>
<tr>
<td>When this child is paying attention, how often can they follow instructions to complete a simple task?</td>
<td>Always, Most of the time, About half the time, Sometimes, Never</td>
</tr>
<tr>
<td>How does this child usually hold a pencil?</td>
<td>Uses fingers to hold the pencil, Grips the pencil in their fist, This child cannot hold a pencil</td>
</tr>
<tr>
<td>How often does this child play well with others?</td>
<td>Always, Most of the time, About half the time, Sometimes, Never</td>
</tr>
<tr>
<td>How often does this child become angry or anxious when going from one activity to another?</td>
<td>Always, Most of the time, About half the time, Sometimes, Never</td>
</tr>
<tr>
<td>How often does this child show concern when others are hurt or unhappy?</td>
<td>Always, Most of the time, About half the time, Sometimes, Never</td>
</tr>
<tr>
<td>When excited or all wound up, how often can this child calm down quickly?</td>
<td>Always, Most of the time, About half the time, Sometimes, Never</td>
</tr>
<tr>
<td>How often does this child lose control of their temper when things do not go their way?</td>
<td>Always, Most of the time, About half the time, Sometimes, Never</td>
</tr>
<tr>
<td>Compared to other children their age, how much difficulty does this child have making or keeping friends?</td>
<td>No difficulty, A little difficulty, A lot of difficulty</td>
</tr>
</tbody>
</table>
G24 Compared to other children their age, how often is this child able to sit still?

- Always
- Most of the time
- About half the time
- Sometimes
- Never

G25 How often...

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<th>Always</th>
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<tbody>
<tr>
<td>a.</td>
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<td>b.</td>
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<td>c.</td>
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<td>d.</td>
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H5 DURING THE PAST WEEK, how many hours of sleep did this child get during an average day (count both nighttime sleep and naps)?

- Less than 7 hours
- 7 hours
- 8 hours
- 9 hours
- 10 hours
- 11 hours
- 12 or more hours

H6 Answer the next question only if this child is LESS THAN 12 MONTHS OLD. Otherwise, SKIP to question H8.

In which position do you most often lay this baby down to sleep now?

- On their back
- On their side
- On their stomach

H7 ON MOST WEEKDAYS, about how much time did this child spend in front of a TV, computer, cellphone or other electronic device watching programs, playing games, accessing the internet or using social media? Do not include time spent doing schoolwork.

- Less than 1 hour
- 1 hour
- 2 hours
- 3 hours
- 4 or more hours

H8 DURING THE PAST WEEK, how many days did you or other family members read to this child?

- 0 days
- 1-3 days
- 4-6 days
- Every day

H1 Was this child born in the United States?

- Yes → SKIP to question H3
- No

H2 If no, how long has this child been living in the United States?

- Number of years AND Number of months

H3 How many times has this child moved to a new address since they were born?

- Number of times

H4 How often does this child go to bed at about the same time on weeknights?

- Always
- Usually
- Sometimes
- Rarely
- Never
I. About Your Family and Household

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<th>Question</th>
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<tbody>
<tr>
<td>DURING THE PAST WEEK, how many days did you or other family members tell stories or sing songs to this child?</td>
<td>0 days, 1-3 days, 4-6 days, Every day</td>
</tr>
<tr>
<td>How well do you think you are handling the day-to-day demands of raising children?</td>
<td>Very well, Somewhat well, Not very well, Not well at all</td>
</tr>
<tr>
<td>DURING THE PAST WEEK, on how many days did all the family members who live in the household eat a meal together?</td>
<td>0 days, 1-3 days, 4-6 days, Every day</td>
</tr>
<tr>
<td>Does this child receive care for at least 10 hours per week from someone other than their parent or guardian?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>DURING THE PAST 12 MONTHS, did you or anyone in the family have to quit a job, not take a job, or greatly change your job because of problems with child care for this child?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Does anyone living in your household use cigarettes, cigars, or pipe tobacco?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>If yes, does anyone smoke inside your home?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>SINCE THIS CHILD WAS BORN, how often has it been very hard to cover the basics, like food or housing, on your family’s income?</td>
<td>Never, Rarely, Somewhat often, Very often</td>
</tr>
</tbody>
</table>
Which of these statements best describes your household’s ability to afford the food you need DURING THE PAST 12 MONTHS?

- We could always afford to eat good nutritious meals.
- We could always afford enough to eat but not always the kinds of food we should eat.
- Sometimes we could not afford enough to eat.
- Often we could not afford enough to eat.

At any time DURING THE PAST 12 MONTHS, even for one month, did anyone in your family receive...

  a. Cash assistance from a government welfare program?  
     Yes  No
  b. Food Stamps or Supplemental Nutrition Assistance Program (SNAP) benefits?  
     Yes  No
  c. Free or reduced-cost breakfasts or lunches at school?  
     Yes  No
  d. Benefits from the Women, Infants, and Children (WIC) Program?  
     Yes  No

In your neighborhood, is/are there...

  a. Sidewalks or walking paths?  
     Yes  No
  b. A park or playground?  
     Yes  No
  c. A recreation center, community center, or boys’ and girls’ club?  
     Yes  No
  d. A library or bookmobile?  
     Yes  No
  e. Litter or garbage on the street or sidewalk?  
     Yes  No
  f. Poorly kept or rundown housing?  
     Yes  No
  g. Vandalism such as broken windows or graffiti?  
     Yes  No

To what extent do you agree with these statements about your neighborhood or community?

  a. People in this neighborhood help each other out  
     Definitely agree  Somewhat agree  Somewhat disagree  Definitely disagree
  b. We watch out for each other’s children in this neighborhood  
     Definitely agree  Somewhat agree  Somewhat disagree  Definitely disagree
  c. This child is safe in our neighborhood  
     Definitely agree  Somewhat agree  Somewhat disagree  Definitely disagree
  d. When we encounter difficulties, we know where to go for help in our community  
     Definitely agree  Somewhat agree  Somewhat disagree  Definitely disagree

The next questions are about events that may have happened during this child’s life. These things can happen in any family, but some people may feel uncomfortable with these questions. You may skip any questions you do not want to answer.

To the best of your knowledge, has this child EVER experienced any of the following?

  a. Parent or guardian divorced or separated  
     Yes  No
  b. Parent or guardian died  
     Yes  No
  c. Parent or guardian served time in jail  
     Yes  No
  d. Saw or heard parents or adults slap, hit, kick, punch one another in the home  
     Yes  No
  e. Was a victim of violence or witnessed violence in their neighborhood  
     Yes  No
  f. Lived with anyone who was mentally ill, suicidal, or severely depressed  
     Yes  No
  g. Lived with anyone who had a problem with alcohol or drugs  
     Yes  No
  h. Treated or judged unfairly because of their race or ethnic group  
     Yes  No

When your family faces problems, how often are you likely to do each of the following?

  a. Talk together about what to do  
     All of the time  Most of the time  Some of the time  None of the time
  b. Work together to solve our problems  
     All of the time  Most of the time  Some of the time  None of the time
  c. Know we have strengths to draw on  
     All of the time  Most of the time  Some of the time  None of the time
  d. Stay hopeful even in difficult times  
     All of the time  Most of the time  Some of the time  None of the time

J. Child’s Caregivers

About You

How are you related to this child?

- Biological or Adoptive Parent
- Step-parent
- Grandparent
- Foster Parent
- Other: Relative
- Other: Non-Relative
When did you come to live in the United States?
Indicate the 4-digit year in which you came to live in the United States.

What is your sex?

- Male
- Female

What is your age?

Age in years

Where were you born?

- In the United States → SKIP to question J6
- Outside of the United States

When did you come to live in the United States?
Indicate the 4-digit year in which you came to live in the United States.

4-Digit Year

What is the highest grade or level of school you have completed?
Mark (X) ONE box.

- 8th grade or less
- 9th-12th grade; No diploma
- High School Graduate or GED Completed
- Completed a vocational, trade, or business school program
- Some College Credit, but no Degree
- Associate Degree (AA, AS)
- Bachelor’s Degree (BA, BS, AB)
- Master’s Degree (MA, MS, MEd, MBA)
- Doctorate (PhD, EdD), or Professional Degree (MD, DDS, DVM, JD)

What is your marital status?

- Married
- Not married, but living with a partner
- Never Married
- Divorced
- Separated
- Widowed

In general, how is your physical health?

- Excellent
- Very good
- Good
- Fair
- Poor

In general, how is your mental or emotional health?

- Excellent
- Very good
- Good
- Fair
- Poor

Which of the following best describes your current employment status?
Mark (X) ONE box.

- Employed full-time
- Employed part-time
- Working WITHOUT pay
- Not employed but looking for work
- Not employed and not looking for work

Have you ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard?
Mark (X) ONE box.

- Never served in the military → SKIP to question J13
- Only on active duty for training in the Reserves or National Guard → SKIP to question J13
- Now on active duty
- On active duty in the past, but not now

Were you deployed at any time during this child’s life?

- Yes
- No

Does this child have another parent or adult caregiver who lives in this household?

- Yes → Complete questions J14 - J25 for this other parent or adult caregiver
- No → SKIP to question K1 on page 20
Other Parent or Caregiver in the Household

J14 How is this other caregiver related to this child?
- Biological or Adoptive Parent
- Step-parent
- Grandparent
- Foster Parent
- Other: Relative
- Other: Non-Relative

J15 What is this caregiver's sex?
- Male
- Female

J16 What is this caregiver's age?
- Age in years

J17 Where was this caregiver born?
- In the United States
- Outside of the United States

J18 When did this caregiver come to live in the United States? Indicate the 4-digit year in which this caregiver came to live in the United States.

J19 What is the highest grade or level of school this caregiver has completed? Mark (X) ONE box.
- 8th grade or less
- 9th-12th grade; No diploma
- High School Graduate or GED Completed
- Completed a vocational, trade, or business school program
- Some College Credit, but no Degree
- Associate Degree (AA, AS)
- Bachelor's Degree (BA, BS, AB)
- Master's Degree (MA, MS, MSW, MBA)
- Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)

J20 What is this caregiver's marital status?
- Married
- Not married, but living with a partner
- Never Married
- Divorced
- Separated
- Widowed

J21 In general, how is this caregiver's physical health?
- Excellent
- Very good
- Good
- Fair
- Poor

J22 In general, how is this caregiver's mental or emotional health?
- Excellent
- Very good
- Good
- Fair
- Poor

J23 Which of the following best describes this caregiver's current employment status? Mark (X) ONE box.
- Employed full-time
- Employed part-time
- Working WITHOUT pay
- Not employed but looking for work
- Not employed and not looking for work

J24 Has this caregiver ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard? Mark (X) ONE box.
- Never served in the military
- Only on active duty for training in the Reserves or National Guard
- Now on active duty
- On active duty in the past, but not now
Was this caregiver deployed at any time during this child’s life?

☐ Yes
☐ No

**K. Household Information**

How many people are living or staying at this address? Include everyone who usually lives or stays at this address. Do NOT include anyone who is living somewhere else for more than two months, such as a college student living away or someone in the Armed Forces on deployment.

Number of people

How many of these people in your household are family members? Family is defined as anyone related to this child by blood, marriage, adoption, or through foster care.

Number of people

Income in 2019

Mark (X) the "Yes" box for EACH type of income this child’s family received, and give your best estimate of the TOTAL AMOUNT IN THE LAST CALENDAR YEAR. Mark (X) the “No” box to show types of income NOT received.

a. Wages, salary, commissions, bonuses, or tips for all jobs.

☐ Yes ➔ $________,________.00
☐ No

TOTAL AMOUNT in the last calendar year

b. Self-employment income from own nonfarm businesses or farm business, including proprietorships and partnerships.

☐ Yes ➔ $________,________.00
☐ No

TOTAL AMOUNT in the last calendar year

c. Interest, dividends, net rental income, royalty income, or income from estates and trusts.

☐ Yes ➔ $________,________.00
☐ No

TOTAL AMOUNT in the last calendar year

d. Social security or railroad retirement; retirement, survivor, or disability pensions.

☐ Yes ➔ $________,________.00
☐ No

TOTAL AMOUNT in the last calendar year

e. Supplemental security income (SSI); any public assistance or welfare payments from the state or local welfare office.

☐ Yes ➔ $________,________.00
☐ No

TOTAL AMOUNT in the last calendar year

f. Any other sources of income received regularly such as Veterans’ (VA) payments, unemployment compensation, child support, or alimony.

☐ Yes ➔ $________,________.00
☐ No

TOTAL AMOUNT in the last calendar year

The following question is about your 2019 income. Think about your total combined family income IN THE LAST CALENDAR YEAR for all members of the family. What is that amount before taxes? Include money from jobs, child support, social security, retirement income, unemployment payments, public assistance, and so forth. Also, include income from interest, dividends, net income from businesses, farm or rent, and any other money income received.

$________,________.00

TOTAL AMOUNT in the last calendar year

COPY INFORMATIONAL
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Thank you for your participation.

On behalf of the U.S. Department of Health and Human Services, we would like to thank you for the time and effort you have spent sharing information about this child and your family.

Your answers are important to us and will help researchers, policymakers, and family advocates to better understand the health and health care needs of children in our diverse population.

Place the completed questionnaire in the postage-paid return envelope. If the envelope has been misplaced, mail the questionnaire to:

U.S. Census Bureau
ATTN: DCB 60-A
1201 E. 10th Street
Jeffersonville, IN 47132-0001

We estimate that completing the National Survey of Children’s Health will take 33 minutes on average. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to U.S. Department of Commerce, Paperwork Project 0607-0990, U.S. Census Bureau, 4600 Silver Hill Road, Room 8H590, Washington, DC 20233. You may e-mail comments to DEMO.Paperwork@census.gov; use "Paperwork Project 0607-0990" as the subject. This collection has been approved by the Office of Management and Budget (OMB). The eight-digit OMB approval number that appears at the upper left of the form confirms this approval. If this number were not displayed, we could not conduct this survey.