



## Children's Access to Healthcare Survey Survey Instructions

This survey is about only the one child who is named on the letter and the envelope that you just opened. **For every question that refers to YOUR CHILD, please answer for the one child who is named on the envelope and the letter.**

- For the questions that ask you to **mark only one**, check **only one** of the boxes to the left of your answer. For the questions that ask you to **mark all that apply**, check the boxes to the left of **all** answers that are true for you.
- If you see questions that do not apply to you, please check the box next to the statement that says “Does not apply.”
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:
  - Yes → [GO TO QUESTION 16]
  - No

All information that would let someone identify you or your family will be kept private. Your personal information will not be shared with anyone. You may choose to answer this survey or not. If you choose not to, this will not affect the healthcare benefits that you and your family currently receive.

You may notice a number on the back of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders. If you want to know more about this study or if you have any trouble filling out this survey, please call Jessica Miller at The Office for Oregon Health Policy and Research at (503) 731-3005, ext 355.

- Please check this box if you would like to request a survey in Spanish. Return this blank survey to us and we will send a replacement survey in Spanish.
- Please check this box if you would like to request a survey in Russian. Return this blank survey to us and we will send a replacement survey in Russian.



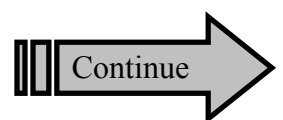
## Children's Access to Healthcare Survey

This survey is about only the one child who is named on the letter and the envelope that you just opened. **For every question that refers to YOUR CHILD, please answer for the one child who is named on the envelope and the letter.**

### YOUR CHILD'S HEALTH INSURANCE

1. At this time, what type of health insurance is YOUR CHILD covered by?  
*(DO NOT include dental, vision, or accident insurance. DO NOT include the limited insurance available through your child's school to cover sports or extramural activities.) Mark all that apply.*
  - <sup>88</sup> Does not apply. My child is not currently covered by any kind of health insurance.
  - <sup>1</sup> Health insurance from parent's or guardian's employer or union
  - <sup>2</sup> Health Insurance purchased privately (not related to employment)
  - <sup>3</sup> Oregon Health Plan/OHP/Medicaid/OMAP
  - <sup>4</sup> Oregon Medical Insurance Pool (OMIP)
  - <sup>5</sup> Medicare (for people over age 64 or people with severe disabilities)
  - <sup>6</sup> CHAMPUS, CHAMP-VA, or other type of military insurance
  - <sup>7</sup> Indian Health Service (IHS)
  - <sup>8</sup> Other type of insurance, please specify \_\_\_\_\_
  - <sup>99</sup> Don't know
2. At any time in the **last 12 months**, was YOUR CHILD **without** health insurance?  
*(DO NOT include dental, vision, accident insurance, or the limited coverage available through your child's school for sports or extramural activities.) Mark only one.*
  - <sup>1</sup> Yes
  - <sup>2</sup> No
  - <sup>99</sup> Don't know
3. **In the last 12 months**, about how many months was YOUR CHILD **without** any health insurance coverage? ***Mark only one.***
  - <sup>88</sup> Does not apply. My child was covered by health insurance for all of the past 12 months.
  - <sup>1</sup> Less than 1 month
  - <sup>2</sup> 1-6 months
  - <sup>3</sup> 7-12 months
  - <sup>4</sup> My child has never had health insurance.
  - <sup>99</sup> Don't know

4. About **how long** has it been since YOUR CHILD last had health insurance coverage? **Mark only one.**
- <sup>88</sup> Does not apply. My child currently has health insurance.
  - <sup>1</sup> One year or less
  - <sup>2</sup> More than 1 year
  - <sup>3</sup> My child has never had health insurance coverage.
  - <sup>99</sup> Don't know
5. What are the **main reasons** YOUR CHILD went without health insurance some time **in the last 12 months**? **Mark all that apply.**
- <sup>88</sup> Does not apply. My child had health insurance for all of the last 12 months.
  - <sup>1</sup> The person whose health insurance covered my child was no longer eligible for coverage (due to reasons like job change or part-time work).
  - <sup>2</sup> The employer of the person with coverage stopped providing insurance.
  - <sup>3</sup> The health insurance provided by an employer or union does NOT cover children.
  - <sup>4</sup> We could not afford to pay the premiums for insurance provided at work.
  - <sup>5</sup> My child does not need health insurance because my child does not get sick.
  - <sup>6</sup> My child was refused health insurance because of a medical problem.
  - <sup>7</sup> My child is not eligible for the Oregon Health Plan because of my income.
  - <sup>8</sup> I am not a U.S. citizen.
  - <sup>9</sup> My child is not a U.S. citizen.
  - <sup>10</sup> Other, please tell us \_\_\_\_\_
  - <sup>99</sup> Don't know
6. If your child does not currently have health insurance, what was the **most recent** type of insurance that YOUR CHILD had in the past? **Mark all that apply.**
- <sup>88</sup> Does not apply. My child currently has health insurance.
  - <sup>1</sup> My child had health insurance from an employer or union.
  - <sup>2</sup> My child had health insurance purchased privately (not related to employment).
  - <sup>3</sup> My child had Oregon Health Plan/OHP/Medicaid/OMAP.
  - <sup>4</sup> My child had Oregon Medical Insurance Pool (OMIP).
  - <sup>5</sup> My child had Medicare (for people over age 64 or people with severe disabilities).
  - <sup>6</sup> My child had CHAMPUS, CHAMP-VA, or other type of military insurance.
  - <sup>7</sup> My child had Indian Health Service (IHS) benefits.
  - <sup>8</sup> My child had another type of insurance, please tell us \_\_\_\_\_
  - <sup>9</sup> My child has never had health insurance coverage.
  - <sup>99</sup> Don't know



## FOOD STAMP PROGRAM

One of the places that individuals and families can apply for state medical benefits such as the Oregon Health Plan is at the food stamp office.

7. Did you understand when you filled out the **Food Stamp application** that you could also apply for medical benefits at that time? *Mark only one.*
- <sup>1</sup>  Yes  
<sup>2</sup>  No  
<sup>99</sup>  Don't know
8. Did your **Food Stamp worker** ask you if you wanted to apply for medical benefits for your children? *Mark only one.*
- <sup>1</sup>  Yes  
<sup>2</sup>  No  
<sup>99</sup>  Don't know

## THE OREGON HEALTH PLAN / OHP / MEDICAID / OMAP

The Oregon Health Plan is sometimes called "OHP" or "OMAP" or "Medicaid." This survey refers to the Oregon Health Plan, which is the same as OHP, Medicaid, and OMAP.

9. **Before today**, had you ever heard of the Oregon Health Plan? *Mark only one.*
- <sup>1</sup>  Yes  
<sup>2</sup>  No  
<sup>99</sup>  Don't know
10. Where did you **first hear** about the Oregon Health Plan? *Mark all that apply.*
- <sup>88</sup>  Does not apply. I have not heard of the Oregon Health Plan before today.  
<sup>1</sup>  Radio, TV  
<sup>2</sup>  Newspaper, magazine  
<sup>3</sup>  Flyer, poster  
<sup>4</sup>  Welfare office/Case Worker  
<sup>5</sup>  County Health Department/WIC  
<sup>6</sup>  Health care provider, clinic, or hospital  
<sup>7</sup>  Your child's school  
<sup>8</sup>  Friend or family member  
<sup>9</sup>  Other, please tell us \_\_\_\_\_  
<sup>99</sup>  Don't know
11. Has YOUR CHILD **ever been enrolled** in the Oregon Health Plan? *Mark only one.*
- <sup>1</sup>  My child is **currently enrolled** in the Oregon Health Plan. → [GO TO QUESTION 16]  
<sup>2</sup>  My child **used to be enrolled** in the Oregon Health Plan, but not currently.  
<sup>3</sup>  My child has **never been enrolled** in the Oregon Health Plan.  
<sup>99</sup>  Don't know

12. When was **the last time you applied** for the Oregon Health Plan for YOUR CHILD?  
**Mark only one.**

<sup>88</sup> Does not apply. I have never applied for the Oregon Health Plan for my child.

<sup>1</sup> Less than one month ago

<sup>2</sup> Between 1 and 6 months ago

<sup>3</sup> More than 6 months ago, but less than 1 year ago

<sup>4</sup> More than 1 year ago

<sup>99</sup> Don't know

13. Based on what you know about the Oregon Health Plan, do you think YOUR CHILD is eligible **now**? **Mark only one.**

<sup>1</sup> Yes

<sup>2</sup> No

<sup>99</sup> Don't know

14. If you were told that YOUR CHILD was eligible **now** for the Oregon Health Plan, would you want to enroll him or her? **Mark only one.**

<sup>1</sup> Yes → [GO TO QUESTION 16]

<sup>2</sup> No

<sup>99</sup> Don't know

15. What are the **main reasons** you would **NOT** try to enroll YOUR CHILD in the Oregon Health Plan? **Mark all that apply.**

<sup>1</sup> My child is already enrolled in the Oregon Health Plan.

<sup>2</sup> My child does not need health insurance.

<sup>3</sup> My child already has health insurance.

<sup>4</sup> I think the Oregon Health Plan is closed to all new enrollees.

<sup>5</sup> It is too difficult to see a provider when you have the Oregon Health Plan.

<sup>6</sup> It takes too much time to apply.

<sup>7</sup> The rules change too often.

<sup>8</sup> The application asks for too much private information.

<sup>9</sup> I do not want welfare or public assistance.

<sup>10</sup> Our family does not need the help.

<sup>11</sup> I do not qualify, so my children probably would not qualify either.

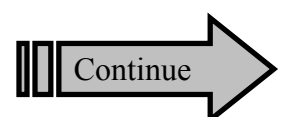
<sup>12</sup> It costs too much.

<sup>13</sup> I am not a U.S. citizen.

<sup>14</sup> My child is not a U.S. citizen.

<sup>15</sup> Other, please tell us \_\_\_\_\_

<sup>99</sup> Don't know



16. Of the following changes to the Oregon Health Plan application process, which three would be the most **helpful to you in getting or keeping** health insurance for your child? **Mark only THREE.**

<sup>1</sup> If you could apply for the Oregon Health Plan for your child online.

<sup>2</sup> If you did not have to re-enroll your child in the Oregon Health Plan every 6 months.

<sup>3</sup> If your child did not have to be without insurance for 6 months before getting the Oregon Health Plan.

<sup>4</sup> If Oregon Health Plan coverage started the same day that your child visits a health care provider.

<sup>5</sup> If Oregon Health Plan applications were available at your child's clinic or doctor's office.

<sup>6</sup> If Oregon Health Plan applications were available at your child's school.

<sup>99</sup> Don't know

<sup>7</sup> Other changes that would be helpful, please tell us \_\_\_\_\_

17. Based on what you know about the Oregon Health Plan, **how easy or difficult** do you think it is to complete an application for your child for this program? **Mark only one.**

<sup>88</sup> Does not apply. I have never completed this application for my child.

<sup>1</sup> Very easy

<sup>2</sup> Somewhat easy

<sup>3</sup> Somewhat difficult

<sup>4</sup> Very difficult

<sup>99</sup> Don't know

18. What was difficult about the Oregon Health Plan application process? **Mark all that apply.**

<sup>88</sup> Does not apply. I have never tried to apply for the Oregon Health Plan.

<sup>1</sup> I did not have any difficulties.

<sup>2</sup> It takes too much time.

<sup>3</sup> It was difficult to gather all the paperwork I needed to enroll.

<sup>4</sup> The people at the application office are not helpful.

<sup>5</sup> The forms are too hard to understand.

<sup>6</sup> I could not get to the application office when it was open.

<sup>7</sup> I have transportation problems getting to the office.

<sup>8</sup> I could not get through on the telephone.

<sup>9</sup> It was too difficult to find out if my child qualifies for the Oregon Health Plan.

<sup>10</sup> Anything else? Please tell us \_\_\_\_\_

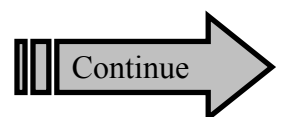
<sup>99</sup> Don't know

## FAMILY HEALTH INSURANCE ASSISTANCE PROGRAM (FHIAP)

19. **Before today**, had you ever heard of the Family Health Insurance Assistance Program (FHIAP)? *Mark only one.*
- <sup>1</sup>  Yes  
<sup>2</sup>  No  
<sup>99</sup>  Don't know
20. Has YOUR CHILD **ever received** premium assistance from the Family Health Insurance Assistance Program (FHIAP)? *Mark only one.*
- <sup>1</sup>  My child is **currently receiving** premium assistance from the Family Health Insurance Assistance Program (FHIAP).  
<sup>2</sup>  My child **used to receive** premium assistance from the Family Health Insurance Assistance Program (FHIAP) but not currently.  
<sup>4</sup>  My child has **never received** this premium assistance.  
<sup>99</sup>  Don't know

## YOUR CHILD'S HEALTH CARE

21. Where do you **usually** take YOUR CHILD for needed medical care?  
*Mark only one.*
- <sup>1</sup>  I do not have a usual place to take my child.  
<sup>2</sup>  A private doctor's office or clinic  
<sup>3</sup>  A public health clinic, community health center or tribal health clinic  
<sup>4</sup>  A school-based health clinic  
<sup>5</sup>  A hospital-based clinic  
<sup>6</sup>  A hospital emergency room  
<sup>7</sup>  An urgent care clinic  
<sup>8</sup>  Some other place, please tell us \_\_\_\_\_  
<sup>99</sup>  Don't know
22. Have you ever had to **change** YOUR CHILD's regular clinic because your child's health insurance changed or because your child lost health insurance? *Mark only one.*
- <sup>1</sup>  Yes  
<sup>2</sup>  No  
<sup>99</sup>  Don't know



23. **In the last 12 months**, was there any time when YOUR CHILD needed medical care, but did **NOT** get it? **Mark only one.**

<sup>1</sup> Yes

<sup>2</sup> No

<sup>99</sup> Don't know

24. What are the **main reasons** YOUR CHILD did **NOT** get the medical care that was needed **most recently**? **Mark all that apply.**

<sup>88</sup> Does not apply. My child did not need medical care in the last 12 months.

<sup>1</sup> Does not apply. My child got all needed medical care in the last 12 months.

<sup>2</sup> We owed money to the doctor, the clinic or hospital.

<sup>3</sup> The doctor or hospital would not accept my child's health insurance.

<sup>4</sup> I did not have the money to pay for the visit.

<sup>5</sup> My health plan would not pay for the treatment.

<sup>6</sup> My child does not have a personal health care provider.

<sup>7</sup> It takes too long to travel to the doctor's office or clinic.

<sup>8</sup> I could not get an appointment soon enough.

<sup>9</sup> The office was not open when I could take my child.

<sup>10</sup> I could not get through on the telephone.

<sup>11</sup> I did not have childcare for my other children.

<sup>12</sup> I did not have transportation.

<sup>13</sup> Some other reason (please tell us) \_\_\_\_\_

<sup>99</sup> Don't know

25. **In the last 12 months**, was there ever a time YOUR CHILD needed prescription medicines but you could **NOT** afford to fill the prescription? (*DO NOT count free samples as a filled prescription.*) **Mark only one.**

<sup>1</sup> Yes

<sup>2</sup> No

<sup>99</sup> Don't know

26. **In the last 12 months**, was there ever a time YOUR CHILD had to **skip doses or take less medication** because you couldn't afford the medicine? **Mark only one.**

<sup>1</sup> Yes

<sup>2</sup> No

<sup>99</sup> Don't know

27. **In the last 12 months**, when YOUR CHILD **needed care right away** for an illness, injury, or condition, how often did your child get care as soon as you wanted it? ***Mark only one.***

<sup>88</sup> Does not apply. My child did not need care right away.

<sup>1</sup> Never

<sup>2</sup> Sometimes

<sup>3</sup> Usually

<sup>4</sup> Always

28. **In the last 12 months**, how many times did you take YOUR CHILD to a **doctor's office or clinic** for care? (*DO NOT include emergency room or hospital visits. Your best estimate is fine.*) ***Mark only one.***

<sup>0</sup> None

<sup>1</sup> 1

<sup>2</sup> 2

<sup>3</sup> 3-4

<sup>4</sup> 5-6

<sup>5</sup> 7 or more times

29. **In the last 12 months**, did you or a doctor think that YOUR CHILD needed care from a **specialist**? (*Specialists are doctors like surgeons, allergy doctors, skin doctors, and others who specialize in one area of health care.*) ***Mark only one.***

<sup>1</sup> Yes

<sup>2</sup> No

<sup>99</sup> Don't know

30. **In the last 12 months**, how much of a problem, if any, was it to see the **specialist** that your child needed to see? ***Mark only one.***

<sup>88</sup> Does not apply. My child did not need to see a specialist.

<sup>3</sup> A big problem.

<sup>2</sup> A small problem.

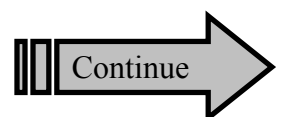
<sup>1</sup> Not a problem.

31. **In the last 12 months**, did YOUR CHILD receive **all of the dental care** that he or she needed, including check-ups? ***Mark only one.***

<sup>1</sup> Yes

<sup>2</sup> No

<sup>99</sup> Don't know

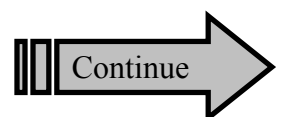


32. **In the last 12 months**, how much of a problem, was it to get **dental care** for your child? ***Mark only one.***
- <sup>3</sup> A big problem.
  - <sup>2</sup> A small problem.
  - <sup>1</sup> Not a problem.
33. Does your child have any kind of developmental, emotional, or mental health condition **now** for which he or she needs treatment or counseling? ***Mark only one.***
- <sup>1</sup> Yes
  - <sup>2</sup> No
  - <sup>99</sup> Don't know
34. **In the last 12 months**, how much of a problem, if any, was it for you to get this treatment or counseling for your child? ***Mark only one.***
- <sup>88</sup> Does not apply. My child did not need treatment or counseling.
  - <sup>3</sup> A big problem.
  - <sup>2</sup> A small problem.
  - <sup>1</sup> Not a problem.
35. **In the last 12 months**, how many times did you take YOUR CHILD to an emergency room to get care? (*Your best estimate is fine.*) ***Mark only one.***
- <sup>0</sup> None
  - <sup>1</sup> 1
  - <sup>2</sup> 2
  - <sup>3</sup> 3-4
  - <sup>4</sup> 5-6
  - <sup>5</sup> 7 or more times
36. **In the last 12 months**, how much did you spend on all medical care for YOUR CHILD? (*Include anything you paid for YOUR CHILD's health care, including premiums and co-pays. Your best estimate is fine.*) ***Mark only one.***
- <sup>0</sup> None
  - <sup>1</sup> \$1 to \$50
  - <sup>2</sup> \$51 to \$100
  - <sup>3</sup> \$101 to \$200
  - <sup>4</sup> \$201 to \$400
  - <sup>5</sup> \$401 to \$800
  - <sup>6</sup> \$801 to \$1000
  - <sup>7</sup> \$1001 or more

## HEALTH CARE SERVICES IN SCHOOLS

This section is about health clinics in schools that provide medical care different from the basic care provided by a school nurse. School medical clinics are like a regular doctor's office or community health clinic with health care providers such as doctors, nurse practitioners or physician's assistants.

37. Is there a medical clinic at YOUR CHILD's school? **Mark only one.**
- <sup>1</sup>  Yes
  - <sup>2</sup>  No
  - <sup>99</sup>  Don't know
38. When YOUR CHILD needs medical care, does he or she ever use a medical clinic at the school? **Mark only one.**
- <sup>88</sup>  Does not apply. There is not a medical clinic at my child's school.
  - <sup>1</sup>  Yes, my child uses the school medical clinic.
  - <sup>2</sup>  No, my child does not use the school medical clinic.
  - <sup>99</sup>  Don't know
39. What health care services would you like to have at your child's school?  
(Select everything you would like to have available, even if the service is already available to you). **Mark all that apply.**
- <sup>1</sup>  Physical examinations/check-ups
  - <sup>2</sup>  Immunizations (shots to protect against diseases such as measles)
  - <sup>3</sup>  Routine care, such as laboratory tests or prescription medications
  - <sup>4</sup>  Chronic care, such as treatment for asthma and diabetes
  - <sup>5</sup>  Family planning, such as pregnancy tests and pregnancy prevention
  - <sup>6</sup>  Tests and prevention information for sexually transmitted infections
  - <sup>7</sup>  Preventive dental care, such as cleaning, fluoride, and exams
  - <sup>8</sup>  Physical or occupational therapy
  - <sup>9</sup>  Vision exams and eyeglasses
  - <sup>10</sup>  Hearing aids or hearing care
  - <sup>11</sup>  Other services, please tell us \_\_\_\_\_
  - <sup>12</sup>  I am not interested in any health care services for my child at school.



## YOUR CHILD'S HEALTH

40. In general, how would you rate YOUR CHILD's health now? *Mark only one.*
- <sup>1</sup> Excellent
  - <sup>2</sup> Very Good
  - <sup>3</sup> Good
  - <sup>4</sup> Fair
  - <sup>5</sup> Poor
41. Does YOUR CHILD have a physical, emotional, or mental health condition now that seriously interferes with your child's ability to do the things most children his or her age can do? *Mark only one.*
- <sup>1</sup> Yes
  - <sup>2</sup> No
  - <sup>99</sup> Don't know
42. In general, how is YOUR CHILD's health now compared to 12 months ago? *Mark only one.*
- <sup>1</sup> Much better
  - <sup>2</sup> Somewhat better
  - <sup>3</sup> About the same
  - <sup>4</sup> Somewhat worse
  - <sup>5</sup> Much worse
43. During the last 12 months, about how many days did YOUR CHILD miss school because of illness or injury? *Mark only one.*
- <sup>0</sup> None
  - <sup>1</sup> 1 to 5 days
  - <sup>2</sup> 6 to 10 days
  - <sup>3</sup> 11 to 20 days
  - <sup>4</sup> 21 or more days
  - <sup>5</sup> My child did not go to school in the last 12 months.
  - <sup>6</sup> My child is home schooled.
  - <sup>99</sup> Don't know

## ABOUT YOUR CHILD

44. Is YOUR CHILD male or female?
- <sup>1</sup> Male
  - <sup>2</sup> Female
45. What is YOUR CHILD's date of birth? \_\_\_\_\_  
mm/dd/yyyy

46. Would you describe YOUR CHILD as Spanish, Hispanic or Latino?

**Mark only one.**

- <sup>1</sup> Yes
- <sup>2</sup> No
- <sup>99</sup> Don't know

47. How would you describe YOUR CHILD's race? **Mark all that apply.**

- <sup>1</sup> White
- <sup>2</sup> American Indian or Alaskan Native
- <sup>3</sup> Asian
- <sup>4</sup> Black or African American
- <sup>5</sup> Native Hawaiian or Other Pacific Islander
- <sup>6</sup> Some other race, please tell us \_\_\_\_\_
- <sup>99</sup> Don't know

### ABOUT YOU AND YOUR ENTIRE FAMILY

48. Are **YOU** male or female?

- <sup>1</sup> Male
- <sup>2</sup> Female

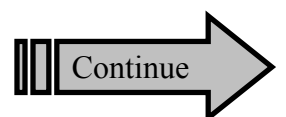
49. What is **your** date of birth? \_\_\_\_\_  
mm/dd/yyyy

50. What is **your** relationship to YOUR CHILD (*the child you described in this survey*)?  
**Mark only one.**

- <sup>1</sup> Mother (including step, foster, adoptive) or female guardian
- <sup>2</sup> Father (including step, foster, adoptive) or male guardian
- <sup>3</sup> Sister or brother (including step, foster, half, adoptive)
- <sup>4</sup> Grandparent
- <sup>5</sup> Aunt or uncle
- <sup>6</sup> Other family member, please tell us \_\_\_\_\_
- <sup>7</sup> Other, **NOT** a family member, please tell us \_\_\_\_\_

51. Would you describe **yourself** as Spanish, Hispanic or Latino? **Mark only one.**

- <sup>1</sup> Yes
- <sup>2</sup> No
- <sup>99</sup> Don't know



52. How would you describe your race? *Mark all that apply.*

- <sup>1</sup> White
- <sup>2</sup> American Indian or Alaskan Native
- <sup>3</sup> Asian
- <sup>4</sup> Black or African American
- <sup>5</sup> Native Hawaiian or Other Pacific Islander
- <sup>6</sup> Some other race, please tell us \_\_\_\_\_
- <sup>99</sup> Don't know

53. At this time, what type of health insurance are you covered by? *Mark all that apply.*

- <sup>88</sup> Does not apply. I am not currently covered by any type of health insurance.
- <sup>1</sup> Health insurance from an employer or union
- <sup>2</sup> Insurance purchased directly from an insurance company (not related to current or past employment)
- <sup>3</sup> Oregon Health Plan/OHP/Medicaid/OMAP
- <sup>4</sup> Oregon Medical Insurance Pool
- <sup>5</sup> Medigap
- <sup>6</sup> Medicare (for people over age 64 or people with severe disabilities)
- <sup>7</sup> CHAMPUS, CHAMP-VA, or other type of military insurance
- <sup>8</sup> Indian Health Service (IHS)
- <sup>9</sup> Other type of insurance, please tell us \_\_\_\_\_
- <sup>99</sup> Don't know

54. Are you currently employed or self-employed? *Mark only one.*

- <sup>1</sup> Yes, employed
- <sup>2</sup> Yes, self-employed
- <sup>3</sup> Not currently employed

55. What is your current marital status? *Mark only one.*

- <sup>1</sup> Now married
- <sup>2</sup> Divorced
- <sup>3</sup> Separated
- <sup>4</sup> Widowed
- <sup>5</sup> Never married

56. What is your current living arrangement? *Mark only one.*

- <sup>1</sup> Live with my children only
- <sup>2</sup> Live with my children and spouse or partner
- <sup>3</sup> Live with other relatives and my children
- <sup>4</sup> Live with friends and my children
- <sup>5</sup> Other, please tell us \_\_\_\_\_

57. What is **your** current zip code? \_\_\_\_\_

58. How many adults and children (**including yourself**) are living in your home?  
(Please include anyone who is in the hospital for a short time, or away at school.)

**Mark only one.**

1

2

3

4

5

6

7

8

9

10 or more

59. Of the family members living in your house, how many are **under 19 years of age**?  
**Mark only one.**

1

2

3

4

5

6 or more

60. Do all of the children in your household **under age 19** have health insurance **now**?  
**Mark only one.**

Yes, all of my children currently have health insurance.

No, I have at least one child who currently does not have health insurance.

61. Do all of the **adults (19 years of age and older)** in your household have health insurance **now**?

Yes, all of the adults currently have health insurance.

No, there is at least one adult in our household who currently does not have health insurance.

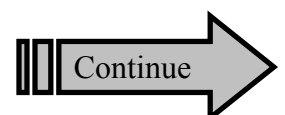
62. **Since January 2003**, did any **adults (19 years and older)** in your household lose **Oregon Health Plan (OHP)** health insurance coverage?

Yes, at least one adult in our household has recently lost OHP health insurance.

No adults in our household recently lost OHP health insurance.

Don't know

63. Is there anything else you would like to tell us? **Please attach additional pages if more space is needed.**



Thank you very much for taking the time to complete this survey. **Everyone who returns a completed survey by May 31, 2005 will be entered into a drawing to receive a Fred Meyer \$100 gift card.** Please return it in the envelope provided

to:       The Office for Oregon Health Policy & Research  
          Portland State Office Building  
          800 Oregon St Room 607  
          Portland, Oregon 97232

If you have further questions, please call our office at (503) 731-3005, ext 355.

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