

Section M. HEALTH INSURANCE

RT 63
3-4

Read to respondents: Medicare is a Social Security health insurance program for disabled persons and for persons 65 years old and over. People covered by Medicare have a card that looks like this. Show card.

1a. Is anyone in this family, that is (use names), now covered by Medicare? Yes No (4) DK

b. Is --- now covered? Covered DK Not covered

2a. Is --- now covered by the part of Social Security Medicare which pays for hospital bills? Yes DK No

b. Is --- now covered by that part of Medicare which pays for doctor's bills? This is the Medicare plan for which --- or some agency must pay a certain amount each month. Yes DK No

3. May I please see the Social Security Medicare card(s) for --- (and ---) to determine the type of coverage? Transcribe the information from the card or mark the "Card N.A." box.

1 Hospital 2 Medical 3 Card N.A.

4a. We are interested in all kinds of health insurance plans except those which pay only for accidents. (Not counting Medicare) Is anyone in the family now covered by a health insurance plan which pays any part of a hospital, doctor's, surgeon's or dentist's bill? Yes No (M1) DK (M1)

b. What is the name of the plan? Record in Table H.I.

c. Is anyone in the family now covered by any other health insurance plan which pays any part of a hospital, doctor's, surgeon's or dentist's bill? Yes (Reask 4b and c) No

TABLE H.I.

PLAN 1 NAME	10	11	12	13	14	15	16	7. Is --- covered under this (name) plan?	17			
5a. Is this (name) plan a Health Maintenance Organization or HMO?	Yes No DK	11	5b. Was this plan obtained through an employer or union?	12	6a. Does this (name) plan pay any part of hospital expenses?	14	6b. Does this plan pay any part of doctor's or surgeon's bills for operations?	15	6c. Does it pay for any DENTAL services other than oral surgery?	16	7. Is --- covered under this (name) plan?	17
5a. Is this (name) plan a Health Maintenance Organization or HMO?	Yes No DK	19	5b. Was this plan obtained through an employer or union?	20	6a. Does this (name) plan pay any part of hospital expenses?	22	6b. Does this plan pay any part of doctor's or surgeon's bills for operations?	23	6c. Does it pay for any DENTAL services other than oral surgery?	24	7. Is --- covered under this (name) plan?	25
5a. Is this (name) plan a Health Maintenance Organization or HMO?	Yes No DK	27	5b. Was this plan obtained through an employer or union?	28	6a. Does this (name) plan pay any part of hospital expenses?	30	6b. Does this plan pay any part of doctor's or surgeon's bills for operations?	31	6c. Does it pay for any DENTAL services other than oral surgery?	32	7. Is --- covered under this (name) plan?	33

Section M. HEALTH INSURANCE, Continued

<p>11a. There is a national program called Medicaid which pays for health care for persons in need. (In this State it is also called <i>(name)</i>) During the past 12 months, has anyone in this family received health care which has been or will be paid for by Medicaid (or <i>(name)</i>)? <input type="checkbox"/> Yes <input type="checkbox"/> No (12) <input type="checkbox"/> DK</p> <p>b. Has --- received this care in the past 12 months?</p>	<p>11b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 61 2 <input type="checkbox"/> No</p>
<p>12a. Does anyone in the family now have a Medicaid (or <i>(name)</i>) card which looks like this? Show Medicaid card(s). <input type="checkbox"/> Yes <input type="checkbox"/> No (13) <input type="checkbox"/> DK</p> <p>b. Does --- now have this card?</p> <p>Ask for each person with "Yes" in 12b:</p> <p>c. May I please see --- (and ---) card(s)? Mark appropriate box(es) in person's column.</p>	<p>12b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 62 2 <input type="checkbox"/> No</p> <p>c. <input type="checkbox"/> Medicaid card seen <input checked="" type="checkbox"/> 1 <input type="checkbox"/> Current 2 <input type="checkbox"/> Expired 3 <input type="checkbox"/> No card seen 4 <input type="checkbox"/> Other card seen <input checked="" type="checkbox"/> Specify</p>
<p>13a. Is anyone in the family now covered by any other public assistance program that pays for health care? <input type="checkbox"/> Yes <input type="checkbox"/> No (14) <input type="checkbox"/> DK</p> <p>b. Is --- now covered?</p>	<p>13b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 64 2 <input type="checkbox"/> No</p>
<p>14a. Does anyone in the family now receive military retirement payments from any branch of the Armed Forces or a pension from the Veterans' Administration? Do not include VA disability compensation. <input type="checkbox"/> Yes <input type="checkbox"/> No (15) <input type="checkbox"/> DK</p> <p>b. Does --- now receive military retirement or a VA pension?</p> <p>Ask for each person with "Yes" in 14b:</p> <p>c. Which does --- receive - the Armed Forces retirement, the VA pension or both?</p>	<p>14b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 65 2 <input type="checkbox"/> No</p> <p>c. 1 <input type="checkbox"/> Armed Forces 66 2 <input type="checkbox"/> VA 3 <input type="checkbox"/> Both</p>
<p>15a. Is anyone in the family now covered by CHAMPUS, which is a program of medical care for dependents of military personnel? <input type="checkbox"/> Yes <input type="checkbox"/> No (15c) <input type="checkbox"/> DK</p> <p>b. Is --- now covered by CHAMPUS?</p> <p>c. Is anyone in the family now covered by CHAMP-VA, which is medical insurance for dependents or survivors of disabled veterans? <input type="checkbox"/> Yes <input type="checkbox"/> No (16) <input type="checkbox"/> DK</p> <p>d. Is --- now covered by CHAMP-VA?</p>	<p>15b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 67 2 <input type="checkbox"/> No</p> <p>d. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 68 2 <input type="checkbox"/> No</p>
<p>16a. Is anyone in the family now covered by any other program that provides health care for military dependents or survivors of military persons? <input type="checkbox"/> Yes <input type="checkbox"/> No (162) <input type="checkbox"/> DK</p> <p>b. Is --- now covered?</p>	<p>16b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 69 2 <input type="checkbox"/> No</p>

Section M. HEALTH INSURANCE, Continued

M2	Refer to "AF" box above person's column.	M2	1 <input type="checkbox"/> AF box marked (17) 70 2 <input type="checkbox"/> Other (NP)
17a. Does --- have a disability related to --- service in the Armed Forces of the United States? b. Does --- now receive compensation for this disability from the Veterans' Administration? c. Has --- ever applied for a service-connected disability rating from the Veterans' Administration? d. Was it approved or denied?	17a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP) 71 b. 1 <input type="checkbox"/> Yes (NP) 2 <input type="checkbox"/> No 72 c. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP) 3 <input type="checkbox"/> DK (NP) 73 d. 1 <input type="checkbox"/> Approved 2 <input type="checkbox"/> Pending 3 <input type="checkbox"/> Denied 4 <input type="checkbox"/> DK 74		
18a. During the past 12 months, that is since (12-month date) a year ago, have (read names of related HH members 18 or over) been laid off from a job or lost a job? <input type="checkbox"/> Yes <input type="checkbox"/> No (Supplement Booklet) <input type="checkbox"/> DK (Supplement Booklet) b. Who was this? Mark "Laid off/lost job" box in person's column. c. Anyone else? <input type="checkbox"/> Yes (Reask 18b and c) <input type="checkbox"/> No d. How many times has --- been laid off or lost a job during the past 12 months? e. In what month and year was --- laid off or did --- lose a job (the last time/the time before that)? f. For ANYTIME during (that/those) job layoff(s) or job loss(es), did --- receive unemployment insurance benefits?	18b. 1 <input type="checkbox"/> Laid off/lost job 75 d. _____ Times 76 e. Mo. Yr. 19__ Time 1 77-80 Mo. Yr. 19__ Time 2 81-84 Mo. Yr. 19__ Time 3 85-88 f. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 89		
19a. Because of (names of persons in 18b) job layoff(s) or job loss(es), did anyone in the family lose any health insurance coverage that had been carried through (that/those) job(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No (Supplement Booklet) <input type="checkbox"/> DK (Supplement Booklet) b. Who was this? Mark "Lost coverage" box in person's column. c. Anyone else? <input type="checkbox"/> Yes (Reask 19b and c) <input type="checkbox"/> No	19b. 1 <input type="checkbox"/> Lost coverage 90		
M3	Refer to 19b and mark appropriate box.	M3	1 <input type="checkbox"/> Lost coverage (20) 91 2 <input type="checkbox"/> Did not lose coverage (NP)
20a. For ANYTIME during (that/those) job layoff(s) or job loss(es), was --- without any type of health insurance coverage? (Do not include health care programs, such as Medicaid, AFDC, or military benefit programs, as health insurance coverage.) b. For how long was --- without some type of health insurance coverage? (How many months is that?)	20a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (21) 92 b. 00 <input type="checkbox"/> Less than 1 month 93-94 _____ Months		
21a. For ANYTIME during (that/those) job layoff(s) or job loss(es), was --- covered by any health care program, such as Medicaid, AFDC, or a military benefit program? b. How long was --- covered by some health care program? (How many months is that?)	21a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP) 95 b. 00 <input type="checkbox"/> Less than 1 month 96-97 _____ Months		