

NEW YORK STATE DEPARTMENT OF HEALTH

A Request for Proposal for

Bureau of Chronic Disease Epidemiology and Surveillance

FAU Control #: 0705070232 – Task ID: 4518

Behavioral Risk Factor Surveillance System (BRFSS)

Schedule of Key Events

Letter of Interest Due (optional)	December 14, 2007
Registration for Bidders Conference Required by	No bidders conference
Bidders Conference	No bidders conference
Written Questions Due	January 11, 2008
Response to Written Questions and Questions Received at Bidders Conference	February 1, 2008
Proposal Due Date	February 15, 2008

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Contacts Pursuant to State Finance Law § 139-j and 139-k

DESIGNATED CONTACTS:

Pursuant to State Finance Law §§ 139-j and 139-k, the Department of Health identifies the following designated contacts to whom all communications attempting to influence this procurement must be made:

Tom Melnik
Bureau of Chronic Disease Epidemiology and Surveillance
565 Corning Tower
Albany, NY 12237-0679
tmm02@health.state.ny.us

Colleen Baker
Bureau of Chronic Disease Epidemiology and Surveillance
565 Corning Tower
Albany, NY 12237-0679
ctb01@health.state.ny.us

Permissible Subject Matter Contacts:

Pursuant to State Finance Law § 139-j(3)(a), the Department of Health also identifies the following allowable contacts for communications related to the following subjects:

RFP Release Date:

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565 Corning Tower
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Colleen Baker
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Submission of written proposals or bids:

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Submission of Written Questions:

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Participation in the Pre-Bid Conference:

Not applicable

Debriefings:

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Negotiation of Contract Terms after Award:

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565 Corning Tower
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tmm02@health.state.ny.us

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For further information regarding these statutory provisions, see the Lobbying Statute summary in Section E, 10 of this solicitation.

A. INTRODUCTION

The purpose of this request for proposals (RFP) is to select a vendor to assist the New York State Department of Health (DOH) and Health Research, Inc. with conducting the New York State (NYS) Behavioral Risk Factor Surveillance System (BRFSS) according to the standardized protocol developed by the Centers for Disease Control and Prevention (CDC). The anticipated five year and six month contract period is October 2008 through March 2014, and work beginning with the preparation, planning, and execution of the 2009 NYS BRFSS. This will cover five years of annual January 1 through December 31 data collection plus three months of startup before the first year of data collection and three months of data processing after the end of the fifth year of data collection to deliver final products. Continued work with the selected contractor beyond the first year and for each subsequent year of data collection is contingent upon performance of the required activities on schedule and within cost, adherence to CDC's BRFSS protocol, and availability of funds.

The Asthma Call Back Survey has been conducted as a component of the NYS BRFSS since 2006, and will be part of the 2008 survey. This RFP includes criteria and scoring to assess the experience and ability of bidders to conduct the Asthma Call Back Survey should there be the need and funding available to conduct the Asthma Call Back Survey or other call back surveys within the contract period.

The BRFSS methodology has been used by the NYSDOH to survey counties and other sub-state areas, and targeted to specific population groups defined by socio-economic and demographic characteristics. These surveys require using stratification, over-sampling, and other survey and sampling strategies to improve survey efficiency and reduce bias. This RFP includes criteria and scoring to assess the experience and ability of bidders using the BRFSS methodology to conduct surveys in sub-state geographic areas and defined population groups should there be the need and funding available to have such surveys conducted within the contract period.

Finally, the BRFSS is used to address state and national emerging issues of public health importance. This may require making mid-year changes to the questionnaire and/or sampling plan in order to meet the need for information on emerging issues. This RFP includes criteria and scoring to assess the experience and ability of bidders to accommodate mid-year changes in the BRFSS survey design should there be the need and funding available for these purposes within the contract period.

B. BACKGROUND

1. Scope of Work

The BRFSS is conducted by all 50 states in the nation. The DOH has conducted the statewide BRFSS according to CDC protocol since 1985. The annual statewide telephone survey of adults is administered by the Bureau of Chronic Disease Epidemiology and Surveillance, Division of Chronic Disease Prevention and Adult

Health. Information obtained from the BRFSS is critically needed and used by multiple DOH programs and partners around New York State for surveillance, planning, policy, and evaluation purposes. Information regarding the BRFSS including the CDC protocol may be found on the CDC website at <http://www.cdc.gov/brfss/> and for the NYS BRFSS on the DOH website at <http://www.health.state.ny.us/DOH/brfss/index.htm>.

The CDC BRFSS methodology and protocol has also been applied to a number of other NYSDOH telephone surveys. These include the current Asthma Call Back Survey designed to re-contact BRFSS respondents with asthma to obtain additional information related to asthma history and care. It is anticipated that the Asthma Call Back Survey as a component of the NYS BRFSS will continue through the 2008 survey year pending funding availability. The CDC BRFSS methodology was also used for the 2003 Expanded BRFSS project for county and local-level BRFSS surveillance. Information regarding the Expanded BRFSS project may be found on the DOH website at <http://www.health.state.ny.us/DOH/brfss/expanded/index.htm>. Although the DOH is not currently conducting local-level BRFSS data collection, these activities may continue in the future should funds become available.

The BRFSS was developed by CDC with considerable flexibility to meet the yearly information needs of the DOH and others. The BRFSS questionnaire, for example, was designed to include a Core set of questions used by all participating states within a given year. Individual states also have the ability to add CDC-developed Optional questions of specific interest. Finally, states can address their emerging public health issues through the use of State-added questions. States also have the option of running a dual survey running two questionnaires simultaneously each having a common Core set of questions and a different mix of Optional and State-added questions. This allows states to obtain information on a greater variety of topics and, importantly, for a larger sample. The DOH makes every effort to maximize BRFSS sample size with the resources available. Increasing sample size has the advantage of providing greater power and precision for reporting results with respect to gender, age, and the racial/ethnic composition of the population. The plan for the 2007 BRFSS now in the field is to complete an estimated 6,400 interviews using a single questionnaire design. NYS BRFSS surveys are conducted in both English and Spanish language. (See the attached 2007 NYS BRFSS English language questionnaire.)

2. Eligible Bidders

Eligible bidders include any US company or other US organization with demonstrated previous experience, ability and capacity to conduct population-based random digit dialing (RDD) telephone surveys according to the CDC BRFSS protocol using computer assisted telephone interviewing (CATI) methodology. Bidders must demonstrate experience and ability in all areas of conducting BRFSS surveys including survey sampling, questionnaire development, sample management, interviewing using CATI, data management and processing, quality control, and human subjects protection and confidentiality procedures. Bidders should demonstrate experience and ability to conduct call back surveys according to the BRFSS protocol and Asthma Call Back Survey methodology. Bidders should demonstrate experience and ability to conduct the BRFSS at sub-state levels and in population groups defined by socio-economic and

demographic characteristics. Finally, bidders to this RFP must have the ability to develop questionnaires and conduct interviews in both English and Spanish languages.

Note: The requirement for previous experience with the BRFSS is necessary because the CDC protocol is demanding and complex with respect to sampling, calling rules, questionnaire development, call disposition monitoring, data processing, and protection of human subjects involved in research. In addition, the BRFSS is conducted according to a very strict timeline requiring that each year's survey be prepared to go into the field with limited lead time, and monthly survey replicates be completed on schedule. The BRFSS data are critical to state and national public health priorities, and the State must work with an experience BRFSS vendor in order to meet these demands and obtain valid and complete information according to protocol and on schedule.

C. DETAILED SPECIFICATIONS

1. Annual Statewide NYS BRFSS

The contractor selected through this competitive RFP process will be responsible for completing the following activities to conduct the annual NYS BRFSS according to the CDC protocol anticipated to begin with the 2009 survey:

- Develop a methodology using list-assisted random digit dialing (RDD) telephone survey procedures to select a statewide probability sample of the non-institutionalized, civilian adult population aged 18 years and over.
- Design and test the survey questionnaire to be conducted using computer assisted telephone interviewing (CATI) methods in both English and Spanish languages, and describe procedures that will be used for conducting Spanish speaking interviews.
- Collect questionnaire data from adult respondents by trained interviewers in English and Spanish languages using CATI methodology adhering to the BRFSS protocol. The contractor's responsibilities will include all aspects of data collection using CATI including computerization of the questionnaire, interviewer training, interview administration, and CATI data management.
- Produce clean monthly data files for submission to CDC according to BRFSS specifications.
- Describe procedures that will be employed to ensure the quality of the survey, and how survey quality will be monitored using widely recognized quality control indicators, disposition codes, and response rate measures common to telephone survey methodologies and in accordance with BRFSS protocol. Every effort should be made to minimize both sampling and non-sampling error while maximizing the sample size achievable with the funding available.
- Describe procedures that will be employed to ensure informed consent, respondent confidentiality and data security for the purposes of Institutional Review Board for human subjects protection.

2. Asthma Call Back Survey

The selected contractor will also be responsible for conducting all aspects of the Asthma Call Back Survey in English and Spanish language as a component of the 2009 NYS BRFSS according the CDC guidelines included with this RFP should funds be made available for this purpose. Continuation of this project beyond 2009 is also contingent upon the need for the data and availability of funding.

3. Bid Price

One contractor will be selected through this RFP bidding process to perform the work and provide deliverables. The amount of annual funding made available for the project will also vary from year to year. The NYS BRFSS is financed through a mix of state, federal, and other funding sources. State BRFSS funds are administered under the terms of a state miscellaneous services contract. Federal and other funds to support the BRFSS are administered under the terms of a contract with Health Research, Incorporated (HRI) a not-for-profit organization responsible for grants administration of non-state funding sources for the DOH. Therefore, this RFP will be used to establish contracting mechanisms through New York State and HRI to conduct each year's statewide survey. The one contractor selected as a result of this competitive solicitation must be prepared to work with the DOH to manage and track payment through these two mechanisms.

For the purpose of selecting a contractor through this RFP process on a level playing field, bidders are asked to submit a unit price per interview based on a statewide BRFSS representative survey of respondents using a single questionnaire design without geographic stratification for hypothetical sample sizes of 4,000-4,499, 4,500-4,999, 5,000-5,499, 5,500-5,999, 6,000-6,499, 6,500-6,999, 7,000-7,499, and 7,500-8,000 completed interviews based on the attached 2007 NYS BRFSS questionnaire as a typical example of an annual survey.

Note: Escalation of costs for Years Two through Five will be allowed and will be based on the National Consumer Price Index for All Urban Consumers (CPI-U) as published sixty (60) days prior to price increase request in the U.S. Bureau of Labor Statistics, Washington, D.C. 20212. No increase will exceed 5% without prior approval from the Office of the State Comptroller. Any other price increases for Years Two through Five due to change in scope of work will require a waiver from the Office of the State Comptroller for state funding sources.

Similarly, bidders are asked to submit the price per completed interview for a sample size of an estimated 500 completed Asthma Call Back Survey interviews as a component of the 2009 BRFSS should funding be made available for that purpose. The actual number of call back surveys completed in 2009 will be contingent upon the BRFSS sample size for that year, and the precise number cannot be known at this time. Any price escalation that differs from the specified bid price must be fully justified and must be approved by DOH and the Office of the State Comptroller. (Refer to the attached 2007 Asthma Call Back Survey questionnaire and CDC guidelines.)

Finally, should the need arise and funds become available to conduct surveys in

sub-state geographic areas, within population groups defined by socio-economic and demographic characteristics, or emerging issues involving mid-year modifications to the BRFSS survey, the price per completed interview submitted by the successful bidder will be used as a reasonable guide to determine the price for these services.

D. PROPOSAL REQUIREMENTS

Up to 10 points will be deducted from the total score for failing to follow the prescribed proposal requirements.

The technical proposal and the financial proposal must be bound separately. No cost information should be in the technical proposal.

The technical proposal should be no longer than 35 double-spaced pages excluding appendices. The proposal should use a Times Roman font with a minimum size of 10. Appendices directly relevant to the proposal should be attached. Proposal pages must be numbered and on 8.5 by 11 inch paper with one inch margins. Evaluation points will be deducted from any bid failing to provide all response requirements of the RFP and in the prescribed format. A header with the bidder's organization name should be placed within the margin of each page.

All evidence and documentation (e.g., resumes) requested under this RFP must be provided at the time the proposal is submitted.

DOH reserves the right to change requirements at any time during the process provided the changes are justified and that modifications would not materially benefit or disadvantage a bidder. Any modifications and/or amendments to the RFP will be made prior to receipt of proposals and all potential bidders made aware of the changes. Additionally, the modifications and/or amendments will be posted on the DOH website.

Submission of proposals indicates acceptance of all conditions contained in this request for proposals.

1. Cover Page

The proposal cover page should include the following information:

- Title of proposal
- Name of bidder firm, address, phone number, fax number, and E-mail address.
- Bidder firm's federal tax identification number.
- Name of person authorized to sign a contract for this firm, address, telephone, fax number and E-mail address including original signature.
- Project manager for this proposal, address, telephone, fax number, and email address.
- Contact person for this proposal, address, telephone, fax number, and email address.

2. Instructions for Completing the Technical Proposal

The Technical Proposal must be submitted separately from the Financial Proposal.

At least two corporate references or letters of support (within the United States) are a requirement of the bid and must be included with the Technical Proposal or as attachments.

Proposals submitted in response to the RFP must fully describe the proposed methodology for conducting random digit dialing (RDD) telephone surveys adhering to CDC BRFSS protocol to produce high quality population-based estimates, representative of New York State adults aged 18 years and older in proportion to the age, sex, and race (white vs. non-white) distribution of the population. Proposals should address experience and ability to conduct BRFSS surveys in the range 4,000 to 8,000 completed interviews, and proposed sample size of 500 completed Asthma Call Back Survey interviews. Proposals should also clearly demonstrate previous experience in successfully conducting the statewide BRFSS and the Asthma Call Back Survey in at least one state for at least one year.

a. Mandatory Requirements (Pass/Fail)

- Bidders must demonstrate experience and ability in all areas of conducting BRFSS surveys according to CDC protocol including survey sampling, questionnaire development, sample management, interviewing using CATI, data management and processing, quality control, and confidentiality procedures
- Ability to conduct telephone survey interviews in English and Spanish
- All requested RFP information, evidence, and documentation provided at the time the proposal submitted
- Bid Form completed
- Technical and financial proposals bound separately

The technical proposals must address the following areas and will be scored by the proposal review team accordingly:

b. Organizational Experience, Capacity, and Ability (40 %)

This includes, but is not limited to a discussion of the following:

- Organizational experience, capacity, and ability in the following areas:
 - Conducting the BRFSS according to CDC protocol using CATI;
 - Conducting the Asthma Call Back Survey according to CDC guidelines or other call back surveys as a component of population-based telephone surveys.
 - Conducting BRFSS surveys in sub-state geographic areas, and among population groups defined by socio-economic and demographic characteristics.
 - Making mid-year changes to modify the BRFSS to meet the need for information on emerging public health issues.
- Adequate staffing to include project management, supervisors, interviewers

(including Spanish speaking), statistical and sampling support, and others as needed. Resumes of key staff should be included as attachments;

- Experience, capacity, and ability to develop questionnaires and conduct interviews in English and Spanish languages;
- Detailed description and availability of equipment, facilities, capacity, and administrative support to conduct the BRFSS and call-back surveys. This section should clearly indicate how the organization will utilize existing or new equipment, facilities, and administrative support for completing all aspects of this project within the specified time period. Include a description of computer technical support and backup systems to prevent loss of data when systems fail;

c. Methodology (35 %)

- Provide a detailed methodology using list-assisted random digit dialing telephone survey procedures following CDC BRFSS protocol to obtain probability samples representative of New York State adults with respect to the age, sex, and race/ethnicity (white/non-white). This should include a description of procedures employed to obtain information from Spanish speaking respondents;
- Provide a detailed methodology to conduct the Asthma Call Back Survey as a possible component of the 2009 NYS BRFSS referring to the CDC guidelines included with this RFP.
- Provide a detailed discussion of survey procedures and operations to ensure maximum survey quality and minimum error. This may include but is not limited to a discussion of the expected success with respect to indicators of survey quality, training, and uniform procedures to conduct the survey such as call scheduling, callback verification, refusal conversion, handling ring-no-answers, business numbers, refusals, and documentation of calls made. This section should also include a discussion of procedures to ensure confidentiality and issues related to informed consent.
- Provide a description of procedures to be used in producing final products of this project including compiling, editing, and transmitting monthly and annual datasets according to BRFSS protocol.
- Describe procedures to ensure informed consent, respondent confidentiality and data security for the purposes of Institutional Review Board human subject protection.

Note: Bidders are strongly encouraged to submit documentation supporting their experience and ability to successfully conduct the BRFSS, including computer reports and other documentation demonstrating adherence to protocol and quality control. Such documentation may be included in the narrative or as attachments.

3. Bid Price (25%)

Bidders must complete the Bid Form provided with this RFP. Each bidder should also submit evidence of the bidder's ability to maintain cash flow and payroll given no advance payment for the project and monthly vouchering for completed deliverables.

Bidders should also include audited financial statements for the three most recent years, and/or Dunn and Bradstreet report .

E. METHOD OF AWARD

1. Vendor Selection

At the discretion of the Department of Health, all bids may be rejected. The evaluation of the bids will include, but not be limited to the following considerations:

Technical Evaluation Committee (TEC) will evaluate and score each bidder's ability to provide the technical assistance and services based on the scoring system described in this RFP. The scoring will be based on a number of factors including the technical merit and clarity of the proposal, an assessment of past experience and current qualifications of the bidder, responses to any clarifying questions, and reference checks. Information from the financial proposal, or evaluation thereof, will not be available to the TEC during their evaluation.

In evaluating each Financial Proposal, the Financial Evaluator will assess the documentation provided by the bidder demonstrating the firm's ability to maintain cash flow and payroll. For those bids meeting the requirements of the Financial Proposal, the Evaluator will score the price per completed interview using the formula described below.

Final selection will be based on a number of factors including the technical merit and clarity of the proposal, an assessment of past experience and current qualifications of the vendor, price per completed interview and Total Combined Score as follows:

1) Price per completed BRFSS interview for each of the eight sample size bands (4,000-4,499, 4,500-4,999, 5000-5,499, 5,500-5,999, 6,000-6,499, 6,500-6,999, 7,000-7,499, and 7,500-8,000 completed interviews) and the price per completed Asthma Call Back Survey interview will be summed. The lowest summed price will receive the maximum score (25), and the other bidders will receive a proportional score using the following formula:

BRFSS Interview Financial Score = $(a/b) \times 25$ where:

a = total cost of lowest cost proposal

b = total cost of proposal being scored

2) The Technical Proposal evaluation score will be ranked based on the average of the evaluators' ratings. The highest ranking average score will receive the maximum score (75), and other bidders will receive a proportional score, as calculated using the following formula:

Technical Score = $(x/y) \times 75$, where:

x = raw score of proposal being scored

y = raw score of highest scoring proposal

3) The bidder's technical score and financial score will be combined using the following formula:

$$\text{Technical Score (maximum 75) + Financial Score (maximum 25)} = \text{Total Combined Score = (maximum 100)}$$

The Selection Committee will select the bidder with the highest Total Combined Score whose proposal in the Committee's judgment, reflects the best value. Prior to selection, this RFP and all responses thereto are subject to review by the Governor's Task Force on Information Resource Management. The State contract will be approved by DOH, the Attorney General, and the Office of the State Comptroller. The HRI contract will be approved by DOH and HRI.

F. ADMINISTRATIVE

1. Issuing Agency

This Request for Proposal (RFP) is a solicitation issued by the NYS Department of Health. The Department is responsible for the requirements specified herein and for the evaluation of all proposals.

2. Inquiries

Any questions concerning this solicitation must be directed to:

Tom Melnik
NYS Department of Health
Bureau of Chronic Disease Epidemiology and Surveillance
Empire State Plaza
Corning Tower Building, Room 565
Albany, New York 12237-0679
tmm02@health.state.ny.us

Questions and answers, as well as any RFP updates and/or modifications, will be posted on the Department of Health's website at <http://www.nyhealth.gov/funding/> by February 1, 2008. Bidders wishing to receive these documents via mail must send a request, in writing, to the Department at the address above.

3. Submission of Proposals

Interested vendors should submit 6 originals and 1 signed copy of their Bid Proposal not later than February 15, 2008.

Responses to this solicitation should be clearly marked and directed to:

New York State Department of Health
Bureau of Chronic Disease Epidemiology and Surveillance
GNARESP, Room 565
Albany, NY 12237-0679
Attention: Tom Melnik

It is the bidders' responsibility to see that bids are delivered to Room 565 Corning Tower prior to the date and time of the bid due date. Late bids due to delay by the carrier or not received in the Department's mail room in time for transmission to Room 565 Corning Tower will not be considered.

1. The Bid Form must be filled out in its entirety.
2. The responsible corporate officer for contract negotiation must be listed. This document must be signed by the responsible corporate officer.
3. All evidence and documentation requested under Section D, Proposal Requirements must be provided at the time the proposal is submitted.
4. THE DEPARTMENT OF HEALTH RESERVES THE RIGHT TO
 - a. Reject any or all proposals received in response to this RFP.
 - b. Waive or modify minor irregularities in proposals received after prior notification to the bidder.
 - c. Adjust or correct cost or cost figures with the concurrence of bidder if errors exist and can be documented to the satisfaction of DOH and the State Comptroller.
 - d. Negotiate with vendors responding to this RFP within the requirements to serve the best interests of the State.
 - e. Eliminate mandatory requirements unmet by all offerers.
 - f. If the Department of Health is unsuccessful in negotiating a contract with the selected vendor within an acceptable time frame, the Department of Health may begin contract negotiations with the next qualified vendor(s) in order to serve and realize the best interests of the State.
5. Payment

If awarded a contract, the contractor shall submit invoices to the State's designated payment office:

Division of Chronic Disease Prevention and Adult Health Fiscal Unit
NYS Department of Health
GNARESP Corning Tower Building

Room 515
Albany, NY 12237-0679

Payment of such invoices by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be:

The CONTRACTOR shall submit invoices to the STATE'S designated payment office:

Robert Dwore, Finance Director
Division of Chronic Disease Prevention and Adult Health
NYS Department of Health
Empire State Plaza, Corning Tower, Room 515
Albany, NY 12237-0675

a. Contractor will be reimbursed at the price per completed interview specified in the Proposal (Appendix C), Attachment A (Bid Specification Form). Total reimbursement will not exceed the value shown on the face page of the contract. The price per interview may increase annually as allowed in the 'Note' section on page 8 of the Request For Proposal (Appendix B). Any increases exceeding 5% will be approved in writing by the State's Division of Chronic Disease Prevention and Adult Health. Any changes exceeding 5%, or modification to the not - to - exceed value, must be incorporated into the contract via a contract amendment using the NYS standard Appendix X format.

b. Payment of such invoices by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the NYS Finance Law. Vouchers may be submitted monthly. Vouchers for the completed interviews must be accompanied with documentation of completion of each of the monthly sampling replicates and submission of quality assurance reports. There will be no advance of funding under this contract. The final voucher must be submitted within 30 days of the end of the contract period.

6. Term of Contract

This agreement shall be effective upon approval of the NYS office of the State Comptroller.

The anticipated time period of this contract is October 2008 through March 2014.

This agreement may be canceled at any time by the Department of Health giving to the contractor not less than thirty (30) days written notice that on or after a date therein specified this agreement shall be deemed terminated and canceled.

7. Debriefing

Once an award has been made, bidders may request a debriefing of their proposal. Please note the debriefing will be limited only to the strengths and weaknesses of the bidder's proposal, and will not include any discussion of other proposals.

Requests must be received no later than three months from date of award announcement.

8. Vendor Responsibility Questionnaire

New York State Procurement Law requires that state agencies award contracts only to responsible vendors. Vendors are invited to file the required Vendor Responsibility Questionnaire online via the New York State VendRep System or may choose to complete and submit a paper questionnaire. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at www.osc.state.ny.us/vendrep or go directly to the VendRep system online at <https://portal.osc.state.ny.us>. For direct VendRep System user assistance, the OSC Help Desk may be reached at 866-370-4672 or 518-408-4672 or by email at helpdesk@osc.state.ny.us. Vendors opting to file a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the Department of Health or the Office of the State Comptroller for a copy of the paper form. Bidders must also complete and submit the Vendor Responsibility Attestation (Attachment 10).

9. State Consultant Services Reporting

Chapter 10 of the Laws of 2006 amended certain sections of State Finance Law and Civil Service Law to require disclosure of information regarding contracts for consulting services in New York State.

The winning bidders for procurements involving consultant services must complete a "State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term" in order to be eligible for a contract.

Winning bidders must also agree to complete a "State Consultant Services Form B, Contractor's Annual Employment Report" for each state fiscal year included in the resulting contract. This report must be submitted annually to the Department of Health, the Office of the State Comptroller, and Department of Civil Service.

Both of these forms are included as attachments to this document.

10. Lobbying Statute

Chapter 1 of the Laws of 2005, as amended by Chapter 596 of the Laws of 2005, provides, among other things, the following as pertains to development of procurement contracts with governmental entities:

- a. makes the lobbying law applicable to attempts to influence procurement contracts once the procurement process has been commenced by a state agency, unified court system, state legislature, public authority, certain industrial development agencies and local benefit corporations;
- b. requires the above mentioned governmental entities to record all contacts

- made by lobbyists and contractors about a governmental procurement so that the public knows who is contacting governmental entities about procurements;
- c. requires governmental entities to designate persons who generally may be the only staff contacted relative to the governmental procurement by that entity in a restricted period;
 - d. authorizes the Temporary State Commission on Lobbying to impose fines and penalties against persons/organizations engaging in impermissible contacts about a governmental procurement and provides for the debarment of repeat violators;
 - e. directs the Office of General Services to disclose and maintain a list of non-responsible bidders pursuant to this new law and those who have been debarred and publish such list on its website;
 - f. requires the timely disclosure of accurate and complete information from offerers with respect to determinations of non-responsibility and debarment;
 - g. expands the definition of lobbying to include attempts to influence gubernatorial or local Executive Orders, Tribal–State Agreements, and procurement contracts;
 - h. modifies the governance of the Temporary State Commission on lobbying;
 - i. provides that opinions of the Commission shall be binding only on the person to whom such opinion is rendered;
 - j. increases the monetary threshold which triggers a lobbyist's obligations under the Lobbying Act from \$2,000 to \$5,000; and
 - k. establishes the Advisory Council on Procurement Lobbying.

Generally speaking, two related aspects of procurements were amended: (i) activities by the business and lobbying community seeking procurement contracts (through amendments to the Legislative Law) and (ii) activities involving governmental agencies establishing procurement contracts (through amendments to the State Finance Law).

Additionally, a new section 1-t was added to the Legislative Law establishing an Advisory Council on Procurement Lobbying (Advisory Council). This Advisory Council is authorized to establish the following model guidelines regarding the restrictions on contacts during the procurement process for use by governmental entities (see Legislative Law §1-t (e) and State Finance Law §139-j). In an effort to facilitate compliance by governmental entities, the Advisory Council has prepared model forms and language that can be used to meet the obligations imposed by State Finance Law §139-k, Disclosure of Contacts and Responsibility of Offerers. Sections 139-j and 139-k are collectively referred to as “new State Finance Law.”

It should be noted that while this Advisory Council is charged with the responsibility of providing advice to the New York Temporary State Commission on Lobbying (Lobbying Commission) regarding procurement lobbying, the Lobbying Commission retains full responsibility for the interpretation, administration and enforcement of the Lobbying Act established by Article 1-A of the Legislative Law (see Legislative Law §1-t (c) and §1-d). Accordingly, questions regarding the registration and operation of the Lobbying Act should be directed to the Lobbying Commission.

11. Accessibility of State Agency Web-based Intranet and Internet Information and

Applications

Any web-based intranet and internet information and applications development, or programming delivered pursuant to the contract or procurement will comply with NYS Office for Technology Policy P04-002, "Accessibility of New York State Web-based Intranet and Internet Information and Applications", and NYS Mandatory Technology Standard S04-001, as such policy or standard may be amended, modified or superseded, which requires that state agency web-based intranet and internet information and applications are accessible to persons with disabilities. Web content must conform to NYS Mandatory Technology Standard S04-00, as determined by quality assurance testing. Such quality assurance testing will be conducted by Department of Health, contractor or other, and the results of such testing must be satisfactory to the Department of Health before web content will be considered a qualified deliverable under the contract or procurement.

12. Information Security Breach and Notification Act

Section 208 of the State Technology Law (STL) and Section 899-aa of the General Business Law (GBL) require that State entities and persons or businesses conducting business in New York who own or license computerized data which includes private information including an individual's unencrypted personal information plus one or more of the following: social security number, driver's license number or non-driver ID, account number, credit or debit card number plus security code, access code or password which permits access to an individual's financial account, must disclose to a New York resident when their private information was, or is reasonably believed to have been, acquired by a person without valid authorization. Notification of breach of that private information to all individuals affected or potentially affected must occur in the most expedient time possible without unreasonable delay, after measures are taken to determine the scope of the breach and to restore integrity; provided, however, that notification may be delayed if law enforcement determines that expedient notification would impede a criminal investigation. When notification is necessary, the State entity or person or business conducting business in New York must also notify the following New York State agencies: the Attorney General, the Office of Cyber Security & Critical Infrastructure Coordination (CSCIC) and the Consumer Protection Board (CPB). Information relative to the law and the notification process is available at: <http://www.cscic.state.ny.us/security/securitybreach/>

13. New York State Tax Law Section 5-a

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded state contracts for commodities, services and technology valued at more than \$100,000 to certify to the Department of Tax and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to contracts where the total amount of such contractors' sales delivered into New York State are in excess of \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any affiliates and subcontractors whose

sales delivered into New York State exceeded \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

This law imposes upon certain contractors the obligation to certify whether or not the contractor, its affiliates, and its subcontractors are required to register to collect state sales and compensating use tax and contractors must certify to DTF that each affiliate and subcontractor exceeding such sales threshold is registered with DTF to collect New York State and local sales and compensating use taxes. The law prohibits the State Comptroller, or other approving agencies, from approving a contract awarded to an offerer meeting the registration requirements but who is not so registered in accordance with the law.

Contractor must complete and submit directly to the New York State Taxation and Finance, Contractor Certification Form ST-220-TD attached hereto. Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with DTF. If the information changes for the contractor, its affiliate(s), or its subcontractor(s), a new form (ST-220-TD) must be filed with DTF.

Contractor must complete and submit to the Department of Health the form ST-220-CA attached hereto, certifying that the contractor filed the ST-220-TD with DTF. Failure to make either of these filings may render an offerer non-responsive and non-responsible. Offerers shall take the necessary steps to provide properly certified forms within a timely manner to ensure compliance with the law.

G. APPENDICES

The following will be incorporated as appendices into any contract resulting from this Request for Proposal. This Request for Proposal will, itself, be referenced as an appendix of the contract.

- APPENDIX A - Standard Clauses for All New York State Contracts
- APPENDIX B - Request for Proposal
- APPENDIX C - Proposal
The bidder's proposal (if selected for award), including any Bid Forms and all proposal requirements.
- APPENDIX D - General Specifications
- APPENDIX E
Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or the Workers' Compensation Board, of coverage for:
- Workers' Compensation, for which one of the following is incorporated into this

contract as Appendix E-1:

- o WC/DB-100, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
- o C-105.2 – Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the U-26.3; OR
- o SI-12 – Certificate of Workers' Compensation Self-Insurance, OR GSI-105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance.
- Disability Benefits coverage, for which one of the following is incorporated into this contract as Appendix E-2:
 - o WC/DB-100, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
 - o DB-120.1 – Certificate of Disability Benefits Insurance
 - o DB-155 – Certificate of Disability Benefits Self-Insurance
- Appendix H - Health Insurance Portability and Accountability Act (HIPAA) (if applicable)

H. ATTACHMENTS

1. Bid Form
2. No Bid Form
3. Appendix A – Standard Clauses for All New York State Contracts
4. Appendix D – General Specifications
5. N.Y.S. Taxation and Finance Contractor Certification Form ST-220-TD
6. N.Y.S. Taxation and Finance Contractor Certification Form ST-220-CA
7. N.Y.S. Office of the State Comptroller Vendor Responsibility Questionnaire (for procurements greater than or equal to \$100,000)
8. State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term
9. State Consultant Services Form B, Contractor's Annual Employment Report
10. Vendor Responsibility Attestation
11. 2007 New York State Behavioral Risk Factor Surveillance System Questionnaire
12. CDC Asthma Call Back Survey Guidance
13. Asthma Call Back Survey Questionnaires
14. HRI Appendix A
15. HRI Consultant Agreement

Attachments 1 and 2

1. Bid Form
2. No-Bid Form

NEW YORK STATE
DEPARTMENT OF HEALTH

BID FORM

PROCUREMENT TITLE: _____ FAU # _____

Bidder Name:

Bidder Address:

Bidder Fed ID No:

A. _____ bids a total price of \$ _____
(Name of Offerer/Bidder)

B. Affirmations & Disclosures related to State Finance Law §§ 139-j & 139-k:

Offerer/Bidder affirms that it understands and agrees to comply with the procedures of the Department of Health relative to permissible contacts (provided below) as required by State Finance Law §139-j (3) and §139-j (6) (b).

Pursuant to State Finance Law §§139-j and 139-k, this *Invitation for Bid or Request for Proposal* includes and imposes certain restrictions on communications between the Department of Health (DOH) and an Offerer during the procurement process. An Offerer/bidder is restricted from making contacts from the earliest notice of intent to solicit *bids/proposals* through final award and approval of the Procurement Contract by the DOH and, if applicable, Office of the State Comptroller (“restricted period”) to other than designated staff unless it is a contact that is included among certain statutory exceptions set forth in State Finance Law §139-j(3)(a). Designated staff, as of the date hereof, is/are identified on the first page of this *Invitation for Bid, Request for Proposal, or other solicitation document*. DOH employees are also required to obtain certain information when contacted during the restricted period and make a determination of the responsibility of the Offerer/bidder pursuant to these two statutes. Certain findings of non-responsibility can result in rejection for contract award and in the event of two findings within a 4 year period, the Offerer/bidder is debarred from obtaining governmental Procurement Contracts. Further information about these requirements can be found on the Office of General Services Website at: <http://www.ogs.state.ny.us/aboutOgs/regulations/defaultAdvisoryCouncil.html>

1. Has any Governmental Entity made a finding of non-responsibility regarding the individual or entity seeking to enter into the Procurement Contract in the previous four years? (Please circle):

No Yes

If yes, please answer the next questions:

1a. Was the basis for the finding of non-responsibility due to a violation of State Finance Law §139-j (Please circle):

No Yes

1b. Was the basis for the finding of non-responsibility due to the intentional provision of false or incomplete information to a Governmental Entity? (Please circle):

No

Yes

1c. If you answered yes to any of the above questions, please provide details regarding the finding of non-responsibility below.

Governmental Entity: _____

Date of Finding of Non-responsibility: _____

Basis of Finding of Non-Responsibility:

(Add additional pages as necessary)

2a. Has any Governmental Entity or other governmental agency terminated or withheld a Procurement Contract with the above-named individual or entity due to the intentional provision of false or incomplete information? (Please circle):

No

Yes

2b. If yes, please provide details below.

Governmental Entity: _____

Date of Termination or Withholding of Contract: _____

Basis of Termination or Withholding:

(Add additional pages as necessary)

C. Offerer/Bidder certifies that all information provided to the Department of Health with respect to State Finance Law §139-k is complete, true and accurate.

D. Offerer/Bidder agrees to provide the following documentation either *with their submitted bid/proposal or upon award* as indicated below:

With Bid

Upon Award

1. A completed N.Y.S Taxation and Finance Contractor Certification Form ST-220-CA (for procurements greater than or equal to \$100,000)

2. A completed N.Y.S. Office of the State Comptroller Vendor Responsibility Questionnaire (for procurements greater than or equal to \$100,000)

3. A completed State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term

(Officer Signature)

(Date)

(Officer Title)

(Telephone)

(e-mail Address)

**NEW YORK STATE
DEPARTMENT OF HEALTH**

NO-BID FORM

PROCUREMENT TITLE: _____ FAU # _____

Bidders choosing not to bid are requested to complete the portion of the form below:

- We do not provide the requested services. Please remove our firm from your mailing list
- We are unable to bid at this time because:

- Please retain our firm on your mailing list.

(Firm Name)

(Officer Signature) _____
(Date)

(Officer Title) _____
(Telephone)

(e-mail Address)

FAILURE TO RESPOND TO BID INVITATIONS MAY RESULT IN YOUR FIRM BEING REMOVED FROM OUR MAILING LIST FOR THIS SERVICE.

Attachment 3

3. Appendix A – Standard Clauses for all New York State Contracts
(See Attached PDF File)

STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the previous consent, in writing, of the State and any attempts to assign the contract without the State's written consent are null and void. The Contractor may, however, assign its right to receive payment without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds \$50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds \$10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed \$85,000 (State Finance Law Section 163.6.a).

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, sexual orientation, age, disability, genetic predisposition or carrier status, or marital status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the

performance of work under this contract. Contractor is subject to fines of \$50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds \$5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor

within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION.

(a) FEDERAL EMPLOYER IDENTIFICATION NUMBER and/or FEDERAL SOCIAL SECURITY NUMBER. All invoices or New York State standard vouchers submitted for payment for the sale of goods or services or the lease of real or personal property to a New York State agency must include the payee's identification number, i.e., the seller's or lessor's identification number. The number is either the payee's Federal employer identification number or Federal social security number, or both such numbers when the payee has both such numbers. Failure to include this number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or New York State standard voucher, must give the reason or reasons why the payee does not have such number or numbers.

(b) PRIVACY NOTIFICATION. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law.

(2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in New York State's Central Accounting System by the Director of Accounting Operations, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN.

In accordance with Section 312 of the Executive Law, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of \$25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of \$100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of \$100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment,

employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over \$25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State; or (iii) banking services, insurance policies or the sale of securities. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Governor's Office of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of State Finance Law §165. (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
30 South Pearl St -- 7th Floor
Albany, New York 12245
Telephone: 518-292-5220
Fax: 518-292-5884
<http://www.empire.state.ny.us>

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
30 South Pearl St -- 2nd Floor
Albany, New York 12245
Telephone: 518-292-5250
Fax: 518-292-5803
<http://www.empire.state.ny.us>

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than \$1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. PURCHASES OF APPAREL. In accordance with State Finance Law 162 (4-a), the State shall not purchase any apparel from any vendor unable or unwilling to certify that: (i) such apparel was manufactured in compliance with all applicable labor and occupational safety laws, including, but not limited to, child labor laws, wage and hours laws and workplace safety laws, and (ii) vendor will supply, with its bid (or, if not a bid situation, prior to or at the time of signing a contract with the State), if known, the names and addresses of each subcontractor and a list of all manufacturing plants to be utilized by the bidder.

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Attachment 4

4. Appendix D – General Specifications
(See Attached PDF File)

APPENDIX D
GENERAL SPECIFICATIONS

- A. By signing the "Bid Form" each bidder attests to its express authority to sign on behalf of this company or other entity and acknowledges and accepts that:
- All specifications, general and specific appendices, including Appendix-A, the Standard Clauses for all New York State contracts, and all schedules and forms contained herein will become part of any contract entered, resulting from the Request for Proposal. Anything which is not expressly set forth in the specification, appendices and forms and resultant contract, but which is reasonable to be implied, shall be furnished and provided in the same manner as if specifically expressed.
- B. The work shall be commenced and shall be actually undertaken within such time as the Department of Health may direct by notice, whether by mail, telegram, or other writing, whereupon the undersigned will give continuous attention to the work as directed, to the end and with the intent that the work shall be completed within such reasonable time or times, as the case may be, as the Department may prescribe.
- C. The Department reserves the right to stop the work covered by this proposal and the contract at any time that the Department deems the successful bidder to be unable or incapable of performing the work to the satisfaction of the Department and in the event of such cessation of work, the Department shall have the right to arrange for the completion of the work in such manner as the Department may deem advisable and if the cost thereof exceeds the amount of the bid, the successful bidder and its surety be liable to the State of New York for any excess cost on account thereof.
- D. Each bidder is under an affirmative duty to be informed by personal examination of the specifications and location of the proposed work and by such other means as it may select, of character, quality, and extent of work to be performed and the conditions under which the contract is to be executed.
- E. The Department of Health will make no allowances or concession to a bidder for any alleged misunderstanding or deception because of quantity, quality, character, location or other conditions.
- F. The bid price is to cover the cost of furnishing all of the said services, materials, equipment, and labor to the satisfaction of the Department of Health and the performance of all work set forth in said specifications.
- G. The successful bidder will be required to complete the entire work, or any part thereof as the case may be, to the satisfaction of the Department of

Health in strict accordance with the specifications and pursuant to a contract therefore.

- H. Contractor will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

- I. **Non-Collusive Bidding**
By submission of this proposal, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of their knowledge and belief:
 - a. The prices of this bid have been arrived at independently without collusion, consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor;

 - b. Unless otherwise required by law, the prices which have been quoted in this bid have not been knowingly disclosed by the bidder and will not knowingly be disclosed by the bidder prior to opening, directly or indirectly to any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition;

 - c. No attempt has been made or will be made by the bidder to induce any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition.

NOTE: Chapter 675 of the Laws of New York for 1966 provides that every bid made to the state or any public department, agency or official thereof, where competitive bidding is required by statute, rule or regulation, for work or services performed or to be performed or goods sold or to be sold, shall contain the foregoing statement subscribed by the bidder and affirmed by such bidder as true under penalties of perjury.

A bid shall not be considered for award nor shall any award be made where (a), (b) and (c) above have not been complied with; provided however, that if in any case the bidder cannot make the foregoing certification, the bidder shall so state and shall furnish with the bid a signed statement which sets forth in detail the reasons therefore. Where (a), (b) and (c) above have not been complied with, the bid shall not be considered for award nor shall any award be made unless the head of the purchasing unit of the state, public department or agency to which the bid is made or its designee, determines that such disclosure was not made for the purpose of restricting competition.

The fact that a bidder has published price lists, rates, or tariffs covering items being procured, has informed prospective customers of proposed or pending publication of new or revised price lists for such items, or has sold the same items to other customers at the same price being bid, does not constitute, without more, a disclosure within the meaning of the above quoted certification.

Any bid made to the State or any public department, agency or official thereof by a corporate bidder for work or services performed or to be performed or goods, sold or to be sold, where competitive bidding is required by statute, rule or regulation and where such bid contains the certification set forth above shall be deemed to have been authorized by the board of directors of the bidder, and such authorization shall be deemed to include the signing and submission of the bid and the inclusion therein of the certificate as to non-collusion as the act and deed of the corporation.

- J. A bidder may be disqualified from receiving awards if such bidder or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its or its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.
- K. The Department reserves the right to make awards within ninety (90) days after the date of the bid opening, during which period bids shall not be withdrawn unless the bidder distinctly states in the bid that acceptance thereof must be made within a shorter specified time.
- L. **Work for Hire Contract**
Any contract entered into resultant from this request for proposal will be considered a "Work for Hire Contract." The Department will be the sole owner of all source code and any software which is developed or included in the application software provided to the Department as a part of this contract.
- M. **Technology Purchases Notification --** The following provisions apply if this Request for Proposal (RFP) seeks proposals for "Technology"
 - 1. For the purposes of this policy, "technology" applies to all services and commodities, voice/data/video and/or any related requirement, major software acquisitions, systems modifications or upgrades, etc., that result in a technical method of achieving a practical purpose or in improvements of productivity. The purchase can be as simple as an order for new or replacement personal computers, or for a consultant to design a new system, or as complex as a major systems improvement or innovation that changes how an agency conducts its business practices.

2. If this RFP results in procurement of software over \$20,000, or of other technology over \$50,000, or where the department determines that the potential exists for coordinating purchases among State agencies and/or the purchase may be of interest to one or more other State agencies, PRIOR TO AWARD SELECTION, this RFP and all responses thereto are subject to review by the New York State Office for Technology.
3. Any contract entered into pursuant to an award of this RFP shall contain a provision which extends the terms and conditions of such contract to any other State agency in New York. Incorporation of this RFP into the resulting contract also incorporates this provision in the contract.
4. The responses to this RFP must include a solution to effectively handle the turn of the century issues related to the change from the year 1999 to 2000.

N. YEAR 2000 WARRANTY

1. Definitions

For purposes of this warranty, the following definitions shall apply:

- a. Product shall include, without limitation: any piece or component of equipment, hardware, firmware, middleware, custom or commercial software, or internal components or subroutines therein which perform any date/time data recognition function, calculation, comparing or sequencing. Where services are being furnished, e.g. consulting, systems integration, code or data conversion or data entry, the term Product shall include resulting deliverables.
- b. Vendor's Product shall include all Product delivered under this Agreement by Vendor other than Third Party Product.
- c. Third Party Product shall include products manufactured or developed by a corporate entity independent from Vendor and provided by Vendor on a non-exclusive licensing or other distribution Agreement with the third party manufacturer. Third Party Product does not include product where Vendor is: a) corporate subsidiary or affiliate of the third party manufacturer/developer; and/or b) the exclusive re-seller or distributor of product manufactured or developed by said corporate entity.

2. Warranty Disclosure

At the time of bid, Product order or Product quote, Vendor is required to disclose the following information in writing to Authorized User:

- a. For Vendor Product and for Products (including, but not limited to, Vendor and/or Third Party Products and/or Authorized User's Installed Product) which have been specified to perform as a system: Compliance or non-compliance of the Products individually or as a system with the Warranty Statement set forth below; and
- b. For Third Party Product Not Specified as Part of a System: Third Party Manufacturer's statement of compliance or non-compliance of any Third Party Product being delivered with Third Party Manufacturer/Developer's Year 2000 warranty. If such Third Party Product is represented by Third Party Manufacturer/Developer as compliant with Third Party Manufacturer/Developer's Year 2000 Warranty, Vendor shall pass through said third party warranty from the third party manufacturer to the Authorized User but shall not be liable for the testing or verification of Third Party's compliance statement.

An absence or failure to furnish the required written warranty disclosure shall be deemed a statement of compliance of the product(s) or system(s) in question with the year 2000 warranty statement set forth below.

3. Warranty Statement

Year 2000 warranty compliance shall be defined in accordance with the following warranty statement:

Vendor warrants that Product(s) furnished pursuant to this Agreement shall, when used in accordance with the Product documentation, be able to accurately process date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000, including leap year calculations. Where a purchase requires that specific Products must perform as a package or system, this warranty shall apply to the Products as a system.

In the event of any breach of this warranty, Vendor shall restore the Product to the same level of performance as warranted herein, or repair or replace the Product with conforming Product so as to minimize interruption to Authorized User's ongoing business processes, time being of the essence, at Vendor's sole cost and

expense. This warranty does not extend to correction of Authorized User's errors in data entry or data conversion.

This warranty shall survive beyond termination or expiration of the Agreement.

Nothing in this warranty shall be construed to limit any rights or remedies otherwise available under this Agreement.

- O. No Subcontracting
Subcontracting by the contractor shall not be permitted except by prior written approval and knowledge of the Department of Health.
- P. Superintendence by Contractor
The Contractor shall have a representative to provide supervision of the work which Contractor employees are performing to ensure complete and satisfactory performance with the terms of the Contract. This representative shall also be authorized to receive and put into effect promptly all orders, directions and instructions from the Department of Health. A confirmation in writing of such orders or directions will be given by the Department when so requested from the Contractor.
- Q. Sufficiency of Personnel and Equipment
If the Department of Health is of the opinion that the services required by the specifications cannot satisfactorily be performed because of insufficiency of personnel, the Department shall have the authority to require the Contractor to use such additional personnel, to take such steps necessary to perform the services satisfactorily at no additional cost to the State.
- R. Experience Requirements
The Contractor shall submit evidence to the satisfaction of the Department that it possesses the necessary experience and qualifications to perform the type of services required under this contract and must show that it is currently performing similar services. The Contractor shall submit at least two references to substantiate these qualifications.
- S. Contract Amendments
This agreement may be amended by written agreement signed by the parties and subject to the laws and regulations of the State pertaining to contract amendments. This agreement may not be amended orally.

The contractor shall not make any changes in the scope of work as outlined herein at any time without prior authorization in writing from the Department of Health and without prior approval in writing of the amount of compensation for such changes.

T. Provisions Upon Default

1. In the event that the Contractor, through any cause, fails to perform any of the terms, covenants or promises of this agreement, the Department acting for and on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the Contractor
2. If, in the judgement of the Department of Health, the Contractor acts in such a way which is likely to or does impair or prejudice the interests of the State, the Department acting on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgement of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

U. Termination Provision

Upon termination of this agreement, the following shall occur:

1. Contractor shall make available to the State for examination all data, records and reports relating to this Contract; and
2. Except as otherwise provided in the Contract, the liability of the State for payments to the Contractor and the liability of the Contractor for services hereunder shall cease.

V. Conflicts

If, in the opinion of the Department of Health, (1) the specifications conflict, or (2) if the specifications are not clear as to (a) the method of performing any part of the work, or as to (b) the types of materials or equipment necessary, or as to (c) the work required to be done in every such situation, the Contractor shall be deemed to have based his bid upon performing the work and furnishing materials or equipment in the most inexpensive and efficient manner. If such conflicts and/or ambiguities arise, the Department of Health will furnish the Contractor supplementary information showing the manner in which the work is to be performed and the type or types of material or equipment that shall be used.

W. MINORITY AND WOMEN OWNED BUSINESS POLICY STATEMENT

The New York State Department of Health recognizes the need to take

affirmative action to ensure that Minority and Women Owned Business Enterprises are given the opportunity to participate in the performance of the Department of Health's contracting program. This opportunity for full participation in our free enterprise system by traditionally, socially and economically disadvantaged persons is essential to obtain social and economic equality and improve the functioning of the State economy.

It is the intention of the New York State Department of Health to fully execute the mandate of Executive Law, Article 15-A and provide Minority and Women Owned Business Enterprises with equal opportunity to bid on contracts awarded by this agency in accordance with the State Finance Law.

To implement this affirmative action policy statement, the contractor agrees to file with the Department of Health within 10 days of notice of award, a staffing plan of the anticipated work force to be utilized on this contract or, where required, information on the contractor's total work force, including apprentices, broken down by specified ethnic background, gender, and Federal occupational categories or other appropriate categories specified by the Department. The form of the staffing plan shall be supplied by the Department.

After an award of this contract, the contractor agrees to submit to the Department a work force utilization report, in a form and manner required by the Department, of the work force actually utilized on this contract, broken down by specified ethnic background, gender and Federal occupational categories or other appropriate categories specified by the Department.

X. Contract Insurance Requirements

1. The successful bidder must without expense to the State procure and maintain, until final acceptance by the Department of Health of the work covered by this proposal and the contract, insurance of the kinds and in the amounts hereinafter provided, in insurance companies authorized to do such business in the State of New York covering all operations under this proposal and the contract, whether performed by it or by subcontractors. Before commencing the work, the successful bidder shall furnish to the Department of Health a certificate or certificates, in a form satisfactory to the Department, showing that it has complied with the requirements of this section, which certificate or certificates shall state that the policies shall not be changed or canceled until thirty days written notice has been given to the Department. The kinds and amounts of required insurance are:

- a. A policy covering the obligations of the successful bidder in accordance with the provisions of Chapter 41, Laws of 1914, as amended, known as the Workers' Compensation Law, and the

contract shall be void and of no effect unless the successful bidder procures such policy and maintains it until acceptance of the work (reference Appendix E).

- b. Policies of Bodily Injury Liability and Property Damage Liability Insurance of the types hereinafter specified, each within limits of not less than \$500,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by one person in any one occurrence, and subject to that limit for that person, not less than \$1,000,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by two or more persons in any one occurrence, and not less than \$500,000 for damages arising out of damage to or destruction of property during any single occurrence and not less than \$1,000,000 aggregate for damages arising out of damage to or destruction of property during the policy period.
 - i. Contractor's Liability Insurance issued to and covering the liability of the successful bidder with respect to all work performed by it under this proposal and the contract.
 - ii. Protective Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.
 - iii. Automobile Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.

Y. Certification Regarding Debarment and Suspension

Regulations of the Department of Health and Human Services, located at Part 76 of Title 45 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in federal programs and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government-wide system for non-procurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the federal government. A person who is debarred or suspended by a federal agency is excluded from federal financial and non-financial assistance and

benefits under federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one federal agency has government-wide effect.

Pursuant to the above-cited regulations, the New York State Department of Health (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government-wide exclusion (including any exclusion from Medicare and State health care program participation on or after August 25, 1995), and the Department of Health must require its prospective contractors, as prospective lower tier participants, to provide the certification in Appendix B to Part 76 of Title 45 CFR, as set forth below:

1. APPENDIX B TO PART 76-CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

Instructions for Certification

- a. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
- b. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered and erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
- c. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
- d. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered Transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of

those regulations.

- e. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
- f. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions.
- g. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of parties Excluded from Federal Procurement and Non-procurement Programs.
- h. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
- i. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

2. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions
 - a. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily exclude from participation in this transaction by any Federal department agency.
 - b. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Z. Confidentiality Clauses

1. Any materials, articles, papers, etc., developed by the CONTRACTOR under or in the course of performing this AGREEMENT shall contain the following, or similar acknowledgment: "Funded by the New York State Department of Health". Any such materials must be reviewed and approved by the STATE for conformity with the policies and guidelines for the New York State Department of Health prior to dissemination and/or publication. It is agreed that such review will be conducted in an expeditious manner. Should the review result in any unresolved disagreements regarding content, the CONTRACTOR shall be free to publish in scholarly journals along with a disclaimer that the views within the Article or the policies reflected are not necessarily those of the New York State Department of Health. The Department reserves the right to disallow funding for any educational materials not approved through its review process.
2. Any publishable or otherwise reproducible material developed under or in the course of performing this AGREEMENT, dealing with any aspect of performance under this AGREEMENT, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the STATE, and shall not be published or otherwise disseminated by the CONTRACTOR to any other party unless prior written approval is secured from the STATE or under circumstances as indicated in paragraph 1 above. Any and all net proceeds obtained by the CONTRACTOR resulting from any such publication shall belong to and be paid over to the STATE. The STATE shall have a perpetual royalty-free, non-exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.

3. No report, document or other data produced in whole or in part with the funds provided under this AGREEMENT may be copyrighted by the CONTRACTOR or any of its employees, nor shall any notice of copyright be registered by the CONTRACTOR or any of its employees in connection with any report, document or other data developed pursuant to this AGREEMENT.
4. All reports, data sheets, documents, etc. generated under this contract shall be the sole and exclusive property of the Department of Health. Upon completion or termination of this AGREEMENT the CONTRACTOR shall deliver to the Department of Health upon its demand all copies of materials relating to or pertaining to this AGREEMENT. The CONTRACTOR shall have no right to disclose or use any of such material and documentation for any purpose whatsoever, without the prior written approval of the Department of Health or its authorized agents.
5. The CONTRACTOR , its officers, agents and employees and subcontractors shall treat all information, which is obtained by it through its performance under this AGREEMENT, as confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New York.
6. All subcontracts shall contain provisions specifying:
 - a. that the work performed by the subcontractor must be in accordance with the terms of this AGREEMENT, and
 - b. that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the AGREEMENT between the STATE and the CONTRACTOR.

AA. Provision Related to Consultant Disclosure Legislation

1. If this contract is for the provision of consulting services as defined in Subdivision 17 of Section 8 of the State Finance Law, the CONTRACTOR shall submit a "State Consultant Services Form B, Contractor's Annual Employment Report" no later than May 15th following the end of each state fiscal year included in this contract term. This report must be submitted to:
 - a. The NYS Department of Health, at the STATE's designated payment office address included in this AGREEMENT; and

- b. The NYS Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th Floor, Albany NY 12236 ATTN: Consultant Reporting - or via fax at (518) 474-8030 or (518) 473-8808; and
- c. The NYS Department of Civil Service, Alfred E. Smith Office Building, Albany NY 12239, ATTN: Consultant Reporting.

BB. Provisions Related to New York State Procurement Lobbying Law

- 1. The STATE reserves the right to terminate this AGREEMENT in the event it is found that the certification filed by the CONTRACTOR in accordance with New York State Finance Law §139-k was intentionally false or intentionally incomplete. Upon such finding, the STATE may exercise its termination right by providing written notification to the CONTRACTOR in accordance with the written notification terms of this AGREEMENT.

CC. Provisions Related to New York State Information Security Breach and Notification Act

- 1. CONTRACTOR shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). CONTRACTOR shall be liable for the costs associated with such breach if caused by CONTRACTOR'S negligent or willful acts or omissions, or the negligent or willful acts or omissions of CONTRACTOR'S agents, officers, employees or subcontractors.

Attachment 5

5. N.Y.S. Taxation and Finance Contractor Certification Form ST-220 -TD
(See Attached PDF File)



Contractor Certification

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

ST-220-TD

(6/06)

For information, consult Publication 223, Questions and Answers Concerning Tax Law Section 5-a (see Need help? below).

Contractor name				
Contractor's principal place of business		City	State	ZIP code
Contractor's mailing address (if different than above)				
Contractor's federal employer identification number (EIN)		Contractor's sales tax ID number (if different from contractor's EIN)		Contractor's telephone number ()
Covered agency name	Contract number or description		Estimated contract value over the full term of contract (but not including renewals) \$	
Covered agency address			Covered agency telephone number	

General information

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded certain state contracts valued at more than \$100,000 to certify to the Tax Department that they are registered to collect New York State and local sales and compensating use taxes, if they made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000, measured over a specified period. In addition, contractors must certify to the Tax Department that each affiliate and subcontractor exceeding such sales threshold during a specified period is registered to collect New York State and local sales and compensating use taxes. Contractors must also file a Form ST-220-CA, certifying to the procuring state entity that they filed Form ST-220-TD with the Tax Department and that the information contained on Form ST-220-TD is correct and complete as of the date they file Form ST-220-CA.

For more detailed information regarding this form and section 5-a of the Tax Law, see Publication 223, *Questions and Answers Concerning Tax Law Section 5-a, (as amended, effective April 26, 2006)*, available at www.nystax.gov. Information is also available by calling the Tax Department's Contractor Information Center at 1 800 698-2931.

Note: Form ST-220-TD must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 4 of this form must be completed before a notary public.

Mail completed form to:

**NYS TAX DEPARTMENT
DATA ENTRY SECTION
W A HARRIMAN CAMPUS
ALBANY NY 12227**

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227; telephone 1 800 225-5829. From areas outside the United States and outside Canada, call (518) 485-6800.

Need help?

 **Internet access:** www.nystax.gov
(for information, forms, and publications)

 **Fax-on-demand forms:** 1 800 748-3676

 **Telephone assistance** is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday.

To order forms and publications: 1 800 462-8100

Sales Tax Information Center: 1 800 698-2909

From areas outside the U.S. and outside Canada: (518) 485-6800

Hearing and speech impaired (telecommunications device for the deaf (TDD) callers only): 1 800 634-2110

 **Persons with disabilities:** In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, please call 1 800 972-1233.

I, _____, hereby affirm, under penalty of perjury, that I am _____
(name) *(title)*
of the above-named contractor, and that I am authorized to make this certification on behalf of such contractor.

Make only one entry in each section below.

Section 1 — Contractor registration status

- The contractor has made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made. The contractor is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law, and is listed on Schedule A of this certification.
- The contractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Section 2 — Affiliate registration status

- The contractor does not have any affiliates.
- To the best of the contractor's knowledge, the contractor has one or more affiliates having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made, and each affiliate exceeding the \$300,000 cumulative sales threshold during such quarters is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed each affiliate exceeding the \$300,000 cumulative sales threshold during such quarters on Schedule A of this certification.
- To the best of the contractor's knowledge, the contractor has one or more affiliates, and each affiliate has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Section 3 — Subcontractor registration status

- The contractor does not have any subcontractors.
- To the best of the contractor's knowledge, the contractor has one or more subcontractors having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made, and each subcontractor exceeding the \$300,000 cumulative sales threshold during such quarters is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed each subcontractor exceeding the \$300,000 cumulative sales threshold during such quarters on Schedule A of this certification.
- To the best of the contractor's knowledge, the contractor has one or more subcontractors, and each subcontractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Sworn to this ____ day of _____, 20 ____

(sign before a notary public)

(title)

Attachment 6

6. N.Y.S. Taxation and Finance Contractor Certification Form ST-220-CA
(See Attached PDF File)



Contractor Certification to Covered Agency

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

ST-220-CA

(6/06)

For information, consult Publication 223, *Questions and Answers Concerning Tax Law Section 5-a* (see *Need Help?* on back).

Contractor name		For covered agency use only Contract number or description	
Contractor's principal place of business	City	State	ZIP code
Contractor's mailing address (if different than above)		Estimated contract value over the full term of contract (but not including renewals)	
Contractor's federal employer identification number (EIN)	Contractor's sales tax ID number (if different from contractor's EIN)		\$
Contractor's telephone number	Covered agency name		
Covered agency address		Covered agency telephone number	

I, _____, hereby affirm, under penalty of perjury, that I am _____

(name)

(title)

of the above-named contractor, that I am authorized to make this certification on behalf of such contractor, and I further certify that:

(Mark an X in only one box)

The contractor has filed Form ST-220-TD with the Department of Taxation and Finance in connection with this contract and, to the best of contractor's knowledge, the information provided on the Form ST-220-TD, is correct and complete.

The contractor has previously filed Form ST-220-TD with the Tax Department in connection with _____
(insert contract number or description)

and, to the best of the contractor's knowledge, the information provided on that previously filed Form ST-220-TD, is correct and complete as of the current date, and thus the contractor is not required to file a new Form ST-220-TD at this time.

Sworn to this ____ day of _____, 20 ____

(sign before a notary public)

(title)

Instructions

General information

Tax Law section 5-a was amended, effective April 26, 2006. On or after that date, in all cases where a contract is subject to Tax Law section 5-a, a contractor must file (1) Form ST-220-CA, *Contractor Certification to Covered Agency*, with a covered agency, and (2) Form ST-220-TD with the Tax Department before a contract may take effect. The circumstances when a contract is subject to section 5-a are listed in Publication 223, Q&A 3. This publication is available on our Web site, by fax, or by mail. (See *Need help?* for more information on how to obtain this publication.) In addition, a contractor must file a new Form ST-220-CA with a covered agency before an existing contract with such agency may be renewed.

If you have questions, please call our information center at 1 800 698-2931.

Note: Form ST-220-CA must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 2 of this form must be completed before a notary public.

When to complete this form

As set forth in Publication 223, a contract is subject to section 5-a, and you must make the required certification(s), if:

- i. The procuring entity is a *covered agency* within the meaning of the statute (see Publication 223, Q&A 5);
- ii. The contractor is a *contractor* within the meaning of the statute (see Publication 223, Q&A 6); and
- iii. The contract is a *contract* within the meaning of the statute. This is the case when it (a) has a value in excess of \$100,000 and (b) is a contract for *commodities* or *services*, as such terms are defined for purposes of the statute (see Publication 223, Q&A 8 and 9).

Furthermore, the procuring entity must have begun the solicitation to purchase on or after January 1, 2005, and the resulting contract must have been awarded, amended, extended, renewed, or assigned *on or after April 26, 2006* (the effective date of the section 5-a amendments).

Individual, Corporation, Partnership, or LLC Acknowledgment

STATE OF }
: SS.:
COUNTY OF }

On the ___ day of _____ in the year 20___, before me personally appeared _____,
known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that
_he resides at _____,
Town of _____,
County of _____,
State of _____; and further that:

[Mark an X in the appropriate box and complete the accompanying statement.]

- (If an individual): _he executed the foregoing instrument in his/her name and on his/her own behalf.
(If a corporation): _he is the _____ of _____, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.
(If a partnership): _he is a _____ of _____, the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.
(If a limited liability company): _he is a duly authorized member of _____, LLC, the limited liability company described in said instrument; that _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

Notary Public

Registration No.

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).
This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.
Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.
Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.
This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227; telephone 1 800 225-5829. From areas outside the United States and outside Canada, call (518) 485-6800.

Need help?
Internet access: www.nystax.gov (for information, forms, and publications)
Fax-on-demand forms: 1 800 748-3676
Telephone assistance is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday. 1 800 698-2931
To order forms and publications: 1 800 462-8100
From areas outside the U.S. and outside Canada: (518) 485-6800
Hearing and speech impaired (telecommunications device for the deaf (TDD) callers only): 1 800 634-2110
Persons with disabilities: In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, please call 1 800 972-1233.

Attachment 7

7. N.Y.S. Office of the State Comptroller Vendor Responsibility Questionnaire

New York State

OFFICE OF THE STATE COMPTROLLER - BUREAU OF CONTRACTS

Vendor Responsibility Questionnaire

A contracting agency is required to conduct a review of a prospective contractor to provide reasonable assurances that the vendor is responsible. This questionnaire is designed to provide information to assist a contracting agency in assessing a vendor's responsibility prior to entering into a contract with the vendor. Vendor responsibility is determined by a review of each bidder or proposer's authorization to do business in New York, business integrity, financial and organizational capacity, and performance history.

Prospective contractors must answer every question contained in this questionnaire. Each "Yes" response requires additional information. The vendor must attach a written response that adequately details each affirmative response. The completed questionnaire and attached responses will become part of the procurement record.

It is imperative that the person completing the vendor responsibility questionnaire be knowledgeable about the proposing contractor's business and operations as the questionnaire information must be attested to by an owner or officer of the vendor. **Please read the certification requirement at the end of this questionnaire.**

State of New York
OFFICE OF THE STATE COMPTROLLER - BUREAU OF CONTRACTS
Vendor Responsibility Questionnaire

FEIN #

1. VENDOR IS: <input type="checkbox"/> PRIME CONTRACTOR <input type="checkbox"/> SUB-CONTRACTOR			
2. VENDOR'S LEGAL BUSINESS NAME		3. IDENTIFICATION NUMBERS a) FEIN # b) DUNS #	
4. D/B/A - Doing Business As (if applicable) & COUNTY FILED:		5. WEBSITE ADDRESS (if applicable)	
6. ADDRESS OF PRIMARY PLACE OF BUSINESS/EXECUTIVE OFFICE		7. TELEPHONE NUMBER	8. FAX NUMBER
9. ADDRESS OF PRIMARY PLACE OF BUSINESS/EXECUTIVE OFFICE IN NEW YORK STATE, if different from above		10. TELEPHONE NUMBER	11. FAX NUMBER
12. PRIMARY PLACE OF BUSINESS IN NEW YORK STATE IS: <input type="checkbox"/> Owned <input type="checkbox"/> Rented If rented, please provide landlord's name, address, and telephone number below:		13. AUTHORIZED CONTACT FOR THIS QUESTIONNAIRE Name Title Telephone Number Fax Number e-mail	
14. VENDOR'S BUSINESS ENTITY IS (please check appropriate box and provide additional information):			
a) <input type="checkbox"/> Business Corporation	Date of Incorporation	State of Incorporation*	
b) <input type="checkbox"/> Sole Proprietor	Date Established		
c) <input type="checkbox"/> General Partnership	Date Established		
d) <input type="checkbox"/> Not-for-Profit Corporation	Date of Incorporation	State of Incorporation* Charities Registration Number	
e) <input type="checkbox"/> Limited Liability Company (LLC)	Date Established		
f) <input type="checkbox"/> Limited Liability Partnership	Date Established		
g) <input type="checkbox"/> Other - Specify:	Date Established	Jurisdiction Filed (if applicable)	
* If not incorporated in New York State, please provide a copy of authorization to do business in New York.			
15. PRIMARY BUSINESS ACTIVITY - (Please identify the primary business categories, products or services provided by your business)			
16. NAME OF WORKERS' COMPENSATION INSURANCE CARRIER:			
17. LIST ALL OF THE VENDOR'S PRINCIPAL OWNERS AND THE THREE OFFICERS WHO DIRECT THE DAILY OPERATIONS OF THE VENDOR (Attach additional pages if necessary):			
a) NAME (print)	TITLE	b) NAME (print)	TITLE
c) NAME (print)	TITLE	d) NAME (print)	TITLE

State of New York
OFFICE OF THE STATE COMPTROLLER - BUREAU OF CONTRACTS
Vendor Responsibility Questionnaire

FEIN #

A DETAILED EXPLANATION IS REQUIRED FOR EACH QUESTION ANSWERED WITH A "YES," AND MUST BE PROVIDED AS AN ATTACHMENT TO THE COMPLETED QUESTIONNAIRE. YOU MUST PROVIDE ADEQUATE DETAILS OR DOCUMENTS TO AID THE CONTRACTING AGENCY IN MAKING A DETERMINATION OF VENDOR RESPONSIBILITY. PLEASE NUMBER EACH RESPONSE TO MATCH THE QUESTION NUMBER.

18.	Is the vendor certified in New York State as a (check please): <div style="display: flex; justify-content: flex-end; align-items: flex-start; margin-top: 5px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <ul style="list-style-type: none"> <input type="checkbox"/> Minority Business Enterprise (MBE) <input type="checkbox"/> Women's Business Enterprise (WBE) <input type="checkbox"/> Disadvantaged Business Enterprise (DBE)? Please provide a copy of any of the above certifications that apply.
19.	Does the vendor use, or has it used in the past ten (10) years, any other Business Name, FEIN, or D/B/A other than those listed in items 2-4 above? <div style="display: flex; justify-content: flex-end; align-items: flex-start; margin-top: 5px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <p>List all other business name(s), Federal Employer Identification Number(s) or any D/B/A names and the dates that these names or numbers were/are in use. Explain the relationship to the vendor.</p>
20.	Are there any individuals now serving in a managerial or consulting capacity to the vendor, including principal owners and officers, who now serve or in the past three (3) years have served as:
a)	An elected or appointed public official or officer? <div style="display: flex; justify-content: flex-end; align-items: flex-start; margin-top: 5px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <p>List each individual's name, business title, the name of the organization and position elected or appointed to, and dates of service.</p>
b)	A full or part-time employee in a New York State agency or as a consultant, in their individual capacity, to any New York State agency? <div style="display: flex; justify-content: flex-end; align-items: flex-start; margin-top: 5px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <p>List each individual's name, business title or consulting capacity and the New York State agency name, and employment position with applicable service dates.</p>
c)	If yes to item #20b, did this individual perform services related to the solicitation, negotiation, operation and/or administration of public contracts for the contracting agency? <div style="display: flex; justify-content: flex-end; align-items: flex-start; margin-top: 5px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <p>List each individual's name, business title or consulting capacity and the New York State agency name, and consulting/advisory position with applicable service dates. List each contract name and assigned NYS number.</p>
d)	An officer of any political party organization in New York State, whether paid or unpaid? <div style="display: flex; justify-content: flex-end; align-items: flex-start; margin-top: 5px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <p>List each individual's name, business title or consulting capacity and the official political party position held with applicable service dates.</p>

State of New York
OFFICE OF THE STATE COMPTROLLER - BUREAU OF CONTRACTS
Vendor Responsibility Questionnaire

FEIN #

<p>21. Within the past five (5) years, has the vendor, any individuals serving in managerial or consulting capacity, principal owners, officers, major stockholder(s) (10% or more of the voting shares for publicly traded companies, 25% or more of the shares for all other companies), affiliate¹ or any person involved in the bidding or contracting process:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>a)</p> <ol style="list-style-type: none"> 1. been suspended, debarred or terminated by a local, state or federal authority in connection with a contract or contracting process; 2. been disqualified for cause as a bidder on any permit, license, concession franchise or lease; 3. entered into an agreement to a voluntary exclusion from bidding/contracting; 4. had a bid rejected on a New York State contract for failure to comply with the MacBride Fair Employment Principles; 5. had a low bid rejected on a local, state or federal contract for failure to meet statutory affirmative action or M/WBE requirements on a previously held contract; 6. had status as a Women's Business Enterprise, Minority Business Enterprise or Disadvantaged Business Enterprise denied, de-certified, revoked or forfeited; 7. been subject to an administrative proceeding or civil action seeking specific performance or restitution in connection with any local, state or federal government contract; 8. been denied an award of a local, state or federal government contract, had a contract suspended or had a contract terminated for non-responsibility; or 9. had a local, state or federal government contract suspended or terminated for cause prior to the completion of the term of the contract? 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>b) been indicted, convicted, received a judgment against them or a grant of immunity for any business-related conduct constituting a crime under local, state or federal law including but not limited to, fraud, extortion, bribery, racketeering, price-fixing, bid collusion or any crime related to truthfulness and/or business conduct?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>c) been issued a citation, notice, violation order, or are pending an administrative hearing or proceeding or determination for violations of:</p> <ol style="list-style-type: none"> 1. federal, state or local health laws, rules or regulations, including but not limited to Occupational Safety & Health Administration (OSHA) or New York State labor law; 2. state or federal environmental laws; 3. unemployment insurance or workers' compensation coverage or claim requirements; 4. Employee Retirement Income Security Act (ERISA); 5. federal, state or local human rights laws; 6. civil rights laws; 7. federal or state security laws; 	<input type="checkbox"/> Yes <input type="checkbox"/> No

State of New York
OFFICE OF THE STATE COMPTROLLER - BUREAU OF CONTRACTS
Vendor Responsibility Questionnaire

FEIN #

	<p>8. federal Immigration and Naturalization Services (INS) and Alienage laws; 9. state or federal anti-trust laws; or 10. charity or consumer laws? For any of the above, detail the situation(s), the date(s), the name(s), title(s), address(es) of any individuals involved and, if applicable, any contracting agency, specific details related to the situation(s) and any corrective action(s) taken by the vendor.</p>	
22.	<p>In the past three (3) years, has the vendor or its affiliates¹ had any claims, judgments, injunctions, liens, fines or penalties secured by any governmental agency? Indicate if this is applicable to the submitting vendor or affiliate. State whether the situation(s) was a claim, judgment, injunction, lien or other with an explanation. Provide the name(s) and address(es) of the agency, the amount of the original obligation and outstanding balance. If any of these items are open, unsatisfied, indicate the status of each item as "open" or "unsatisfied."</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
23.	<p>Has the vendor (for profit and not-for profit corporations) or its affiliates¹, in the past three (3) years, had any governmental audits that revealed material weaknesses in its system of internal controls, compliance with contractual agreements and/or laws and regulations or any material disallowances? Indicate if this is applicable to the submitting vendor or affiliate. Detail the type of material weakness found or the situation(s) that gave rise to the disallowance, any corrective action taken by the vendor and the name of the auditing agency.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
24.	<p>Is the vendor exempt from income taxes under the Internal Revenue Code? Indicate the reason for the exemption and provide a copy of any supporting information.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
25.	<p>During the past three (3) years, has the vendor failed to:</p> <p>a) file returns or pay any applicable federal, state or city taxes? Identify the taxing jurisdiction, type of tax, liability year(s), and tax liability amount the vendor failed to file/pay and the current status of the liability.</p> <p>b) file returns or pay New York State unemployment insurance? Indicate the years the vendor failed to file/pay the insurance and the current status of the liability.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
26.	<p>Have any bankruptcy proceedings been initiated by or against the vendor or its affiliates¹ within the past seven (7) years (whether or not closed) or is any bankruptcy proceeding pending by or against the vendor or its affiliates regardless of the date of filing? Indicate if this is applicable to the submitting vendor or affiliate. If it is an affiliate, include the affiliate's name and FEIN. Provide the court name, address and docket number. Indicate if the proceedings have been initiated, remain pending or have been closed. If closed, provide the date closed.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

State of New York
OFFICE OF THE STATE COMPTROLLER - BUREAU OF CONTRACTS
Vendor Responsibility Questionnaire

FEIN #

27.	<p>Is the vendor currently insolvent, or does vendor currently have reason to believe that an involuntary bankruptcy proceeding may be brought against it?</p> <p>Provide financial information to support the vendor's current position, for example, Current Ratio, Debt Ratio, Age of Accounts Payable, Cash Flow and any documents that will provide the agency with an understanding of the vendor's situation.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
28.	<p>Has the vendor been a contractor or subcontractor on any contract with any New York State agency in the past five (5) years?</p> <p>List the agency name, address, and contract effective dates. Also provide state contract identification number, if known.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
29.	<p>In the past five (5) years, has the vendor or any affiliates¹:</p> <ul style="list-style-type: none">a) defaulted or been terminated on, or had its surety called upon to complete, any contract (public or private) awarded;b) received an overall unsatisfactory performance assessment from any government agency on any contract; orc) had any liens or claims over \$25,000 filed against the firm which remain undischarged or were unsatisfied for more than 90 days ? <p>Indicate if this is applicable to the submitting vendor or affiliate. Detail the situation(s) that gave rise to the negative action, any corrective action taken by the vendor and the name of the contracting agency.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

¹ "Affiliate" meaning: (a) any entity in which the vendor owns more than 50% of the voting stock; (b) any individual, entity or group of principal owners or officers who own more than 50% of the voting stock of the vendor; or (c) any entity whose voting stock is more than 50% owned by the same individual, entity or group described in clause (b).

In addition, if a vendor owns less than 50% of the voting stock of another entity, but directs or has the right to direct such entity's daily operations, that entity will be an "affiliate" for purposes of this questionnaire.

Attachments 8 and 9

8. State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term
9. State Consultant Services Form B, Contractor's Annual Employment Report

Instructions

State Consultant Services
Form A: Contractor's Planned Employment
And
Form B: Contractor's Annual Employment Report

Form A: This report must be completed before work begins on a contract. Typically it is completed as a part of the original bid proposal. The report is submitted only to the soliciting agency who will in turn submit the report to the NYS Office of the State Comptroller.

Form B: This report must be completed annually for the period April 1 through March 31. The report must be submitted by May 15th of each year to the following three addresses:

1. the designated payment office (DPO) outlined in the consulting contract.
2. NYS Office of the State Comptroller
Bureau of Contracts
110 State Street, 11th Floor
Albany, NY 12236
Attn: Consultant Reporting
or via fax to -
(518) 474-8030 or (518) 473-8808
3. NYS Department of Civil Service
Alfred E. Smith Office Building
Albany, NY 12239
Attn: Consultant Reporting

Completing the Reports:

Scope of Contract (Form B only): a general classification of the single category that best fits the predominate nature of the services provided under the contract.

Employment Category: the specific occupation(s), as listed in the O*NET occupational classification system, which best describe the employees providing services under the contract. Access the O*NET database, which is available through the US Department of Labor's Employment and Training Administration, on-line at online.onetcenter.org to find a list of occupations.)

Number of Employees: the total number of employees in the employment category employed to provide services under the contract during the Report Period, including part time employees and employees of subcontractors.

Number of hours (to be) worked: for Form A, the total number of hours to be worked, and for Form B, the total number of hours worked during the Report Period by the employees in the employment category.

Amount Payable under the Contract: the total amount paid or payable by the State to the State contractor under the contract, for work by the employees in the employment category, for services provided during the Report Period.

State Consultant Services
FORM B

OSC Use Only
Reporting Code:
Category Code:

Contractor's Annual Employment Report
Report Period: April 1, ____ to March 31, ____

New York State Department of Health	Agency Code 12000
Contract Number:	
Contract Start Date: / /	Contract End Date: / /
Contractor Name:	
Contractor Address:	
Description of Services Being Provided:	

Analysis	Evaluation	Research
Training	Data Processing	Computer Programming
Other IT Consulting	Engineering	Architect Services
Surveying	Environmental Services	Health Services
Mental Health Services	Accounting	Auditing
Paralegal	Legal	Other Consulting

Employment Category	Number of Employees	Number of Hours to be Worked	Amount Payable Under the Contract
Totals this page:	0	0	\$ 0.00
Grand Total:	0	0	\$ 0.00

Name of person who prepared this report:
Title:

Phone #:

Preparer's signature:
Date Prepared: / /

Page of
(use additional pages if necessary)

Attachment 10

10. Vendor Responsibility Attestation

Vender Responsibility Attestation

To comply with the Vendor Responsibility Requirements outlined in Section E, Administrative, 8. Vendor Responsibility Questionnaire, I hereby certify:

Choose one:

- An on-line Vendor Responsibility Questionnaire has been updated or created at OSC's website: <http://portal.osc.state.ny.us> within the last six months.
- A hard copy Vendor Responsibility Questionnaire is included with this proposal/bid and is dated within the last six months.
- A Vendor Responsibility Questionnaire is not required due to an exempt status. Exemptions include governmental entities, public authorities, public colleges and universities, public benefit corporations, and Indian Nations.

Signature of Organization Official: _____

Print/type Name: _____

Title: _____

Organization: _____

Date Signed: _____

Attachment 11

11. 2007 New York State Behavioral Risk Factor Surveillance System Questionnaire

(See Attached PDF File)



**2007
New York State
Behavioral Risk Factor Surveillance System
Questionnaire**

Updated

CDC: December 7, 2006

NY SA : January 23, 2007

Behavioral Risk Factor Surveillance System 2007 Questionnaire

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Interviewer's Script

HELLO, I am calling for the (health department) . My name is (name) . We are gathering information about the health of (state) residents. This project is conducted by the health department with assistance from the Centers for Disease Control and Prevention. Your telephone number has been chosen randomly, and I would like to ask some questions about health and health practices.

Is this (phone number) ?

If "no,"

Thank you very much, but I seem to have dialed the wrong number. It's possible that your number may be called at a later time. **STOP**

Is this a private residence?

If "no,"

Thank you very much, but we are only interviewing private residences. **STOP**

Is this a cellular telephone?

Read only if necessary: "By cellular telephone we mean a telephone that is mobile and usable outside of your neighborhood".

If "yes,"

Thank you very much, but we are only interviewing land line telephones and private residences. **STOP**

I need to randomly select one adult who lives in your household to be interviewed. How many members of your household, including yourself, are 18 years of age or older?

___ Number of adults

If "1,"

Are you the adult?

If "yes,"

Then you are the person I need to speak with. Enter 1 man or 1 woman below (Ask gender if necessary). **Go to page 5.**

If "no,"

Is the adult a man or a woman? Enter 1 man or 1 woman below. May I speak with **[fill in (him/her) from previous question]**? **Go to "correct respondent" on the next page.**

How many of these adults are men and how many are women?

___ Number of men

___ Number of women

The person in your household that I need to speak with is _____.

If "you," go to page 4



To the correct respondent:

HELLO, I am calling for the **(health department)** . My name is **(name)** . We are gathering information about the health of **(state)** residents. This project is conducted by the health department with assistance from the Centers for Disease Control and Prevention. Your telephone number has been chosen randomly, and I would like to ask some questions about health and health practices.

Core Sections

I will not ask for your last name, address, or other personal information that can identify you. You do not have to answer any question you do not want to, and you can end the interview at any time. Any information you give me will be confidential. If you have any questions, I will provide a telephone number for you to call to get more information.

Section 1: Health Status

1.1 Would you say that in general your health is— (73)

Please read:

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair

Or

- 5 Poor

Do not read:

- 7 Don't know / Not sure
- 9 Refused

Section 2: Healthy Days — Health-Related Quality of Life

2.1 Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? (74–75)

- 8 8 Number of days
- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

2.2 Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? (76–77)

- | | | | |
|---|---|-----------------------|---|
| – | – | Number of days | |
| 8 | 8 | None | [If Q2.1 and Q2.2 = 88 (None), go to next section] |
| 7 | 7 | Don't know / Not sure | |
| 9 | 9 | Refused | |

2.3 During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (78–79)

- | | | |
|---|---|-----------------------|
| – | – | Number of days |
| 8 | 8 | None |
| 7 | 7 | Don't know / Not sure |
| 9 | 9 | Refused |

Section 3: Health Care Access

3.1 Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare? (80)

- | | |
|---|-----------------------|
| 1 | Yes |
| 2 | No |
| 7 | Don't know / Not sure |
| 9 | Refused |

3.2 Do you have one person you think of as your personal doctor or health care provider?
If “No,” ask: “Is there more than one, or is there no person who you think of as your personal doctor or health care provider?” (81)

- | | |
|---|-----------------------|
| 1 | Yes, only one |
| 2 | More than one |
| 3 | No |
| 7 | Don't know / Not sure |
| 9 | Refused |

3.3 Was there a time in the past 12 months when you needed to see a doctor but could not because of cost? (82)

- | | |
|---|-----------------------|
| 1 | Yes |
| 2 | No |
| 7 | Don't know / Not sure |
| 9 | Refused |

- 3.4** About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. (83)
- 1 Within past year (anytime less than 12 months ago)
 - 2 Within past 2 years (1 year but less than 2 years ago)
 - 3 Within past 5 years (2 years but less than 5 years ago)
 - 4 5 or more years ago
 - 7 Don't know / Not sure
 - 8 Never
 - 9 Refused

Section 4: Exercise

- 4.1** During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise? (84)
- 1 Yes
 - 2 No
 - 7 Don't know / Not sure
 - 9 Refused

Section 5: Diabetes

- 5.1** Have you ever been told by a doctor that you have diabetes? (85)
- If "Yes" and respondent is female, ask: "Was this only when you were pregnant?"**
- If respondent says pre-diabetes or borderline diabetes, use response code 4.**
- 1 Yes
 - 2 Yes, but female told only during pregnancy
 - 3 No
 - 4 No, pre-diabetes or borderline diabetes
 - 7 Don't know / Not sure
 - 9 Refused

NY State-Added Module 11: Diabetes

To be asked following Core Q5.1; if response is "Yes" (code = 1)

NY11Q01. A test for "A one C" measures the average level of blood sugar over the past three months. About how many times in the past 12 months has a doctor, nurse, or other health professional checked you for "A one C"?

- Number of times [76 = 76 or more]
- 8 8 None
 - 9 8 Never heard of "A one C" test
 - 7 7 Don't know / Not sure
 - 9 9 Refused

NY11Q02. About how many times in the past 12 months has a health professional checked your feet for any sores or irritations?

- Number of times [76 = 76 or more]
- 8 8 None
 - 9 8 No feet
 - 7 7 Don't know / Not sure
 - 9 9 Refused

NY11Q03. When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light.

Read only if necessary:

- 1 Within the past month (anytime less than 1 month ago)
- 2 Within the past year (1 month but less than 12 months ago)
- 3 Within the past 2 years (1 year but less than 2 years ago)
- 4 2 or more years ago

Do not read:

- 7 Don't know / Not sure
- 8 Never
- 9 Refused

Section 6: Hypertension Awareness

- 6.1** Have you EVER been told by a doctor, nurse, or other health professional that you have high blood pressure? (86)

If “Yes” and respondent is female, ask: “Was this only when you were pregnant?”

- | | | |
|---|--|----------------------|
| 1 | Yes | |
| 2 | Yes, but female told only during pregnancy | [Go to next section] |
| 3 | No | [Go to next section] |
| 4 | Told borderline high or pre-hypertensive | [Go to next section] |
| 7 | Don't know / Not sure | [Go to next section] |
| 9 | Refused | [Go to next section] |

- 6.2** Are you currently taking medicine for your high blood pressure? (87)

- | | |
|---|-----------------------|
| 1 | Yes |
| 2 | No |
| 7 | Don't know / Not sure |
| 9 | Refused |

Section 7: Cholesterol Awareness

- 7.1** Blood cholesterol is a fatty substance found in the blood. Have you EVER had your blood cholesterol checked? (88)

- | | | |
|---|-----------------------|----------------------|
| 1 | Yes | |
| 2 | No | [Go to next section] |
| 7 | Don't know / Not sure | [Go to next section] |
| 9 | Refused | [Go to next section] |

- 7.2** About how long has it been since you last had your blood cholesterol checked? (89)

Read only if necessary:

- | | |
|---|---|
| 1 | Within the past year (anytime less than 12 months ago) |
| 2 | Within the past 2 years (1 year but less than 2 years ago) |
| 3 | Within the past 5 years (2 years but less than 5 years ago) |
| 4 | 5 or more years ago |

Do not read:

- | | |
|---|-----------------------|
| 7 | Don't know / Not sure |
| 9 | Refused |

7.3 Have you EVER been told by a doctor, nurse or other health professional that your blood cholesterol is high? (90)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Section 8: Cardiovascular Disease Prevalence

Now I would like to ask you some questions about cardiovascular disease.

Has a doctor, nurse, or other health professional EVER told you that you had any of the following? For each, tell me "Yes", "No", or you're "Not sure."

8.1 (Ever told) you had a heart attack, also called a myocardial infarction? (91)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

8.2 (Ever told) you had angina or coronary heart disease? (92)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

8.3 (Ever told) you had a stroke? (93)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Section 9: Asthma

9.1 Have you ever been told by a doctor, nurse, or other health professional that you had asthma? (94)

- 1 Yes
- 2 No [Go to next section]
- 7 Don't know / Not sure [Go to next section]
- 9 Refused [Go to next section]

9.2 Do you still have asthma? (95)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Section 10: Immunization

10.1 A flu shot is an influenza vaccine injected into your arm. During the past 12 months, have you had a flu shot? (96)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

10.2 During the past 12 months, have you had a flu vaccine that was sprayed in your nose? The flu vaccine sprayed in the nose is also called FluMist™. (97)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

10.3 A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot? (98)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

NY State-Added Module 2: Immunization

IF C10Q01=1 or C10Q02 = 1 (yes flu shot or yes flu mist) continue else go to NY02Q02

NY02Q01. Where did you go to get your most recent flu vaccine?

INTERVIEWER NOTE: IF NECESSARY READ, “Your flu vaccine could have either been administered as a shot or as a spray in the nose.”

PROBE: “How would you describe the place where you went to get your most recent flu vaccine?”

Read only if necessary:

01= A doctor’s office or health maintenance organization (HMO)

02= A health department

03=Another type of clinic or health center

[*Example: a community health center*]

04= A senior, recreation, or community center

05 =A store [*Examples: supermarket, drug store*]

06= A hospital [*Example: in-patient*]

07= An emergency room

08 =Workplace

or

09 =Some other kind of place

10 =Received vaccination in Canada/Mexico (Volunteered- Do not read)

Do not read:

77 =Don’t know/Not sure

99= Refused

IF C10Q01 <>1 AND C10Q02 <> 1 (no flu shot AND no flu mist) continue else go to NY02Q03

[IF DATE ≤ MARCH 2007 SHOW]: What is the main reason you have not received a flu vaccination for this current flu season?

[IF DATE ≤ MARCH 2007 SHOW]: INTERVIEWER NOTE: THE CURRENT FLU SEASON IS SEPTEMBER 2006 THROUGH MARCH 2007

[IF DATE > MARCH 2007 AND DATE < SEPTEMBER 2007 SHOW]: What is the main reason you did not receive a flu vaccination during the previous flu season?

[IF DATE > MARCH 2007 AND DATE < SEPTEMBER 2007 SHOW]: INTERVIEWER NOTE: THE PREVIOUS FLU SEASON WAS SEPTEMBER 2006 THROUGH MARCH 2007.

[IF DATE ≥ SEPTEMBER 2007 SHOW]: What is the main reason you have not received a flu vaccination for this current flu season?

[IF DATE ≥ SEPTEMBER 2007 SHOW]: INTERVIEWER NOTE: THE CURRENT FLU SEASON IS SEPTEMBER 2007 THROUGH MARCH 2008

NY02Q02. What is the **MAIN** reason you have **NOT** received a flu vaccination for this current flu season?

[Interviewer note: The current flu season = Sept. '06 – Mar. '07, = Sept. '07 – Mar. '08]

Do not read answer choices below. Select category that best matches response.

- 01 Need: Do not need it
- 02 Need: Doctor did not recommend it
- 03 Need: Did not know that I should be vaccinated
- 04 Need: Flu is not that serious
- 05 Need: Had the flu already this flu season
- 06 Concern about vaccine: side effects/can cause flu
- 07 Concern about vaccine: does not work
- 08 Access: Plan to get vaccinated later this flu season
- 09 Access: Flu vaccination costs too much
- 10 Access: Inconvenient to get vaccinated
- 11 Vaccine shortage: saving vaccine for people who need it more
- 12 Vaccine shortage: tried to find vaccine, but could not get it
- 13 Vaccine shortage: not eligible to receive vaccine
- 14 Some other reason
- 77 Don't know/Not sure (Probe: "What was the main reason?")
- 99 Refused

NY02Q03 **Has a doctor, nurse, or other health professional ever said that you have any of the following health problems or conditions?**

[READ IF NECESSARY]: By "other health professional" we mean a nurse practitioner, a physician's assistant, or some other licensed professional.

Read all items listed below before waiting for an answer:

Lung problems or conditions, other than asthma;

Kidney problems or conditions;

Sickle cell anemia or other anemia;

-or-

A weakened immune system caused by a chronic illness or by medicines taken for a chronic illness?

Do not read:

1= Yes

2= No

7= Don't know / Not sure

9= Refused

INTERVIEWER NOTE: READ IF NECESSARY, "Illnesses such as cancer or HIV/AIDS can cause a person to have a weakened immune system. Medicines such as steroids or transplant medications can cause a person to have a weakened immune system. Do you need me to repeat this question?"

10.4 Have you EVER received the hepatitis B vaccine? The hepatitis B vaccine is completed after the third shot is given.

(99)

INTERVIEWER NOTE: Response is “Yes” only if respondent has received the entire series of three shots.

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

The next question is about behaviors related to Hepatitis B.

10.5 Please tell me if ANY of these statements is true for YOU. Do NOT tell me WHICH statement or statements are true for you, just if ANY of them are:

- You have hemophilia and have received clotting factor concentrate
- You have had sex with a man who has had sex with other men, even just one time
- You have taken street drugs by needle, even just one time
- You traded sex for money or drugs, even just one time
- You have tested positive for HIV
- You have had sex (even just one time) with someone who would answer "yes" to any of these statements
- You had more than two sex partners in the past year

Are any of these statements true for you?

(100)

- 1 Yes, at least one statement is true
- 2 No, none of these statements is true
- 7 Don't know / Not sure
- 9 Refused

Section 11: Tobacco Use

11.1 Have you smoked at least 100 cigarettes in your entire life?

(101)

NOTE: 5 packs = 100 cigarettes

- 1 Yes
- 2 No **[Go to next section]**
- 7 Don't know / Not sure **[Go to next section]**
- 9 Refused **[Go to next section]**

11.2 Do you now smoke cigarettes every day, some days, or not at all?

(102)

- 1 Every day
- 2 Some days
- 3 Not at all **[Go to next section]**
- 7 Don't know/Not sure **[Go to next section]**
- 9 Refused **[Go to next section]**

- 11.3** During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking? (103)
- 1 Yes
 - 2 No
 - 7 Don't know / Not sure
 - 9 Refused

Section 12: Demographics

- 12.1** What is your age? (104-105)

Code age in years
0 7 Don't know / Not sure
0 9 Refused

- 12.2** Are you Hispanic or Latino? (106)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

- 12.3** Which one or more of the following would you say is your race? (107-112)

(Check all that apply)

Please read:

- 1 White
- 2 Black or African American
- 3 Asian
- 4 Native Hawaiian or Other Pacific Islander
- 5 American Indian or Alaska Native

Or

6 Other [specify]_____

Do not read:

- 8 No additional choices
- 7 Don't know / Not sure
- 9 Refused

CATI note: If more than one response to Q12.3; continue. Otherwise, go to Q12.5.

12.4 Which one of these groups would you say best represents your race? (113)

- 1 White
- 2 Black or African American
- 3 Asian
- 4 Native Hawaiian or Other Pacific Islander
- 5 American Indian or Alaska Native
- 6 Other [specify] _____

Do not read:

- 7 Don't know / Not sure
- 9 Refused

12.5 Have you ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit? *Active duty does not include training for the Reserves or National Guard, but DOES include activation, for example, for the Persian Gulf War.* (114)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

12.6 Are you...? (115)

Please read:

- 1 Married
- 2 Divorced
- 3 Widowed
- 4 Separated
- 5 Never married

Or

- 6 A member of an unmarried couple

Do not read:

- 9 Refused

12.7 How many children less than 18 years of age live in your household? (116-117)

- — Number of children
- 8 8 None
- 9 9 Refused

12.8 What is the highest grade or year of school you completed? (118)

Read only if necessary:

- 1 Never attended school or only attended kindergarten
- 2 Grades 1 through 8 (Elementary)
- 3 Grades 9 through 11 (Some high school)
- 4 Grade 12 or GED (High school graduate)
- 5 College 1 year to 3 years (Some college or technical school)
- 6 College 4 years or more (College graduate)

Do not read:

- 9 Refused

12.9 Are you currently...? (119)

Please read:

- 1 Employed for wages
- 2 Self-employed
- 3 Out of work for more than 1 year
- 4 Out of work for less than 1 year
- 5 A Homemaker
- 6 A Student
- 7 Retired

Or

- 8 Unable to work

Do not read:

- 9 Refused

12.10 Is your annual household income from all sources— (120-121)

If respondent refuses at ANY income level, code '99' (Refused)

Read only if necessary:

- 0 4 Less than \$25,000 **If "no," ask 05; if "yes," ask 03**
(\$20,000 to less than \$25,000)

- 0 3 Less than \$20,000 If “no,” code 04; if “yes,” ask 02
(\$15,000 to less than \$20,000)
- 0 2 Less than \$15,000 If “no,” code 03; if “yes,” ask 01
(\$10,000 to less than \$15,000)
- 0 1 Less than \$10,000 If “no,” code 02
- 0 5 Less than \$35,000 If “no,” ask 06
(\$25,000 to less than \$35,000)
- 0 6 Less than \$50,000 If “no,” ask 07
(\$35,000 to less than \$50,000)
- 0 7 Less than \$75,000 If “no,” code 08
(\$50,000 to less than \$75,000)
- 0 8 \$75,000 or more

Do not read:

- 7 7 Don't know / Not sure
- 9 9 Refused

12.11 About how much do you weigh without shoes? (122-125)

Note: If respondent answers in metrics, put “9” in column 122.

Round fractions up

- Weight
- — — — (pounds/kilograms)
- 7 7 7 7 Don't know / Not sure
- 9 9 9 9 Refused

12.12 About how tall are you without shoes? (126-129)

Note: If respondent answers in metrics, put “9” in column 126.

Round fractions down

- Height
- — / — — (ft / inches/meters/centimeters)
- 7 7 7 7 Don't know / Not sure
- 9 9 9 9 Refused

12.13 **ASK IF C12Q11 <> 7777 OR 9999**

How much did you weigh a year ago? [Female respondent: If you were pregnant a year ago, how much did you weigh before your pregnancy?] (130-133)

Note: If respondent answers in metrics, put “9” in column 130.

Round fractions up

— — — —	Weight
(pounds/kilograms)	
7 7 7 7	Don't know / Not sure
9 9 9 9	Refused

CATI note: Subtract weight one year ago from current weight. If weight is same, skip Q12.14.

12.14 ASK IF ((C12Q11 & C12Q13) <> (7777 OR 9999)) AND (C12Q13 <> C12Q11)

Has the change between your current weight and your weight a year ago intentional? (134)

1	Yes
2	No
7	Don't know / Not sure
9	Refused

12.15 What county do you live in? (135-137)

— — —	FIPS county code
7 7 7	Don't know / Not sure
9 9 9	Refused

12.16 What is your ZIP Code where you live? (138-142)

— — — —	ZIP Code
7 7 7 7	Don't know / Not sure
9 9 9 9	Refused

12.17 Do you have more than one telephone number in your household? Do not include cell phones or numbers that are only used by a computer or fax machine. (143)

1	Yes	
2	No	[Go to Q12.19]
7	Don't know / Not sure	[Go to Q12.19]
9	Refused	[Go to Q12.19]

12.18 How many of these telephone numbers are residential numbers? (144)

—	Residential telephone numbers [6 = 6 or more]
7	Don't know / Not sure
9	Refused

12.19 During the past 12 months, has your household been without telephone service for 1 week or more? Do not include interruptions of telephone service because of weather or natural disasters. (145)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

12.20 Indicate sex of respondent. **Ask only if necessary.** (146)

- 1 Male **[Go to next section]**
- 2 Female **[If respondent is 45 years old or older, go to next section]**

12.21 To your knowledge, are you now pregnant? (147)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Section 13: Alcohol Consumption

13.1 During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor? (148)

- 1 Yes
- 2 No **[Go to next section]**
- 7 Don't know / Not sure **[Go to next section]**
- 9 Refused **[Go to next section]**

13.2 During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage? (149-151)

- 1_ _ _ Days per week
- 2_ _ _ Days in past 30 days
- 8 8 8 No drinks in past 30 days **[Go to next section]**
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

13.3 One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average? (152-153)

— — Number of drinks
 7 7 Don't know / Not sure
 9 9 Refused

13.4 Considering all types of alcoholic beverages, how many times during the past 30 days did you have **X [CATI X = 5 for men, X = 4 for women]** or more drinks on an occasion? (154-155)

— — Number of times
 8 8 None
 7 7 Don't know / Not sure
 9 9 Refused

13.5 During the past 30 days, what is the largest number of drinks you had on any occasion? (156-157)

— — Number of drinks
 7 7 Don't know / Not sure
 9 9 Refused

Section 14: Disability

The following questions are about health problems or impairments you may have.

14.1 Are you limited in any way in any activities because of physical, mental, or emotional problems? (158)

1 Yes
 2 No
 7 Don't know / Not Sure
 9 Refused

14.2 Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone? (159)

Include occasional use or use in certain circumstances.

- 1 Yes
- 2 No
- 7 Don't know / Not Sure
- 9 Refused

Section 15: Arthritis Burden

The next questions refer to the joints in your body. Please do **NOT** include the back or neck.

15.1 During the past 30 days, have you had symptoms of pain, aching, or stiffness in or around a joint? (160)

- 1 Yes
- 2 No [Go to Q15.4]
- 7 Don't know / Not sure [Go to Q15.4]
- 9 Refused [Go to Q15.4]

15.2 Did your joint symptoms first begin more than 3 months ago? (161)

- 1 Yes
- 2 No [Go to Q15.4]
- 7 Don't know / Not sure [Go to Q15.4]
- 9 Refused [Go to Q15.4]

15.3 Have you ever seen a doctor or other health professional for these joint symptoms? (162)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

15.4 Have you ever been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia? (163)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

INTERVIEWER NOTE: Arthritis diagnoses include:

- rheumatism, polymyalgia rheumatica
- osteoarthritis (not osteoporosis)

- tendonitis, bursitis, bunion, tennis elbow
- carpal tunnel syndrome, tarsal tunnel syndrome
- joint infection, Reiter’s syndrome
- ankylosing spondylitis; spondylosis
- rotator cuff syndrome
- connective tissue disease, scleroderma, polymyositis, Raynaud’s syndrome
- vasculitis (giant cell arteritis, Henoch-Schonlein purpura, Wegener’s granulomatosis, polyarteritis nodosa)

CATI Note: If either Q15.2 = 1 (Yes) or Q.15.4 = 1 (Yes); continue. Otherwise, go to next section.

- 15.5** Are you now limited in any way in any of your usual activities because of arthritis or joint symptoms? (164)
- 1 Yes
 - 2 No
 - 7 Don’t know / Not sure
 - 9 Refused

INTERVIEWER NOTE: If a respondent question arises about medication, then the interviewer should reply: “Please answer the question based on how you are when you are taking any of the medications or treatments you might use.”

Section 16: Fruits and Vegetables

These next questions are about the foods you usually eat or drink. Please tell me how often you eat or drink each one, for example, twice a week, three times a month, and so forth. Remember, I am only interested in the foods **you** eat. Include all foods *you* eat, both at home and away from home.

- 16.1** How often do you drink fruit juices such as orange, grapefruit, or tomato? (165-167)
- 1 __ Per day
 - 2 __ Per week
 - 3 __ Per month
 - 4 __ Per year
 - 5 5 5 Never
 - 7 7 7 Don’t know / Not sure
 - 9 9 9 Refused

- 16.2** Not counting juice, how often do you eat fruit? (168-170)
- 1 __ Per day
 - 2 __ Per week
 - 3 __ Per month
 - 4 __ Per year
 - 5 5 5 Never
 - 7 7 7 Don’t know / Not sure
 - 9 9 9 Refused

- 16.3** How often do you eat green salad? (171-173)
- 1 __ Per day

- 2 __ Per week
- 3 __ Per month
- 4 __ Per year
- 5 5 5 Never
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

16.4 How often do you eat potatoes not including French fries, fried potatoes, or potato chips?
(174-176)

- 1 __ Per day
- 2 __ Per week
- 3 __ Per month
- 4 __ Per year
- 5 5 5 Never
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

16.5 How often do you eat carrots?
(177-179)

- 1 __ Per day
- 2 __ Per week
- 3 __ Per month
- 4 __ Per year
- 5 5 5 Never
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

16.6 Not counting carrots, potatoes, or salad, how many servings of vegetables do you usually eat? (Example: A serving of vegetables at both lunch and dinner would be two servings.)
(180-182)

- 1 __ Per day
- 2 __ Per week
- 3 __ Per month
- 4 __ Per year
- 5 5 5 Never
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

Section 17: Physical Activity

CATI note: If Core Q12.9 = 1 (employed for wages) or 2 (self-employed) then continue. Otherwise, Go to Q17.2.

17.1 When you are at work, which of the following best describes what you do? Would you say— (183)

If respondent has multiple jobs, include all jobs.

Please read:

- 1 Mostly sitting or standing
- 2 Mostly walking
- 3 Mostly heavy labor or physically demanding work

Do not read:

- 7 Don't know / Not sure
- 9 Refused

Please read:

We are interested in two types of physical activity - vigorous and moderate. Vigorous activities cause large increases in breathing or heart rate while moderate activities cause small increases in breathing or heart rate.

17.2 Now, thinking about the moderate activities you do **[fill in “when you are not working” if “employed” or self-employed”]** in a usual week, do you do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, vacuuming, gardening, or anything else that causes some increase in breathing or heart rate? (184)

- 1 Yes
- 2 No **[Go to Q17.5]**
- 7 Don't know / Not sure **[Go to Q17.5]**
- 9 Refused **[Go to Q17.5]**

17.3 How many days per week do you do these moderate activities for at least 10 minutes at a time? (185-186)

- — Days per week
- 8 8 Do not do any moderate physical activity for at least 10 minutes at a time? **[Go to Q17.5]**
- 7 7 Don't know / Not sure **[Go to Q17.5]**
- 9 9 Refused **[Go to Q17.5]**

17.4 On days when you do moderate activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities? (187-189)

- : — Hours and minutes per day
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

17.5 Now, thinking about the vigorous activities you do [fill in “when you are not working” if “employed” or “self-employed”] in a usual week, do you do vigorous activities for at least 10 minutes at a time, such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate? (190)

- 1 Yes
- 2 No [Go to next section]
- 7 Don't know / Not sure [Go to next section]
- 9 Refused [Go to next section]

17.6 How many days per week do you do these vigorous activities for at least 10 minutes at a time? (191-192)

- __ __ Days per week
- 8 8 Do not do any vigorous physical activity for at least 10 minutes at a time [Go to next section]
- 7 7 Don't know / Not sure [Go to next section]
- 9 9 Refused [Go to next section]

17.7 On days when you do vigorous activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities? (193-195)

- : __ __ Hours and minutes per day
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

Section 18: HIV/AIDS

CATI note: If respondent is 65 years old or older, go to next section.

The next few questions are about the national health problem of HIV, the virus that causes AIDS. Please remember that your answers are strictly confidential and that you don't have to answer every question if you do not want to. Although we will ask you about testing, we will not ask you about the results of any test you may have had.

18.1 Have you ever been tested for HIV? Do not count tests you may have had as part of a blood donation. Include testing fluid from your mouth. (196)

- 1 Yes
- 2 No [Go to next section]
- 7 Don't know / Not Sure [Go to next section]
- 9 Refused [Go to next section]

18.2 Not including blood donations, in what month and year was your last HIV test? (197-202)

NOTE: If response is before January 1985, code “Don’t know.”

CATI INSTRUCTION: If the respondent remembers the year but cannot remember the month, code the first two digits 77 and the last four digits for the year.

— / — — — —	Code month and year
7 7 / 7 7 7 7	Don't know / Not sure
9 9 / 9 9 9 9	Refused

18.3 Where did you have your last HIV test — at a private doctor or HMO office, at a counseling and testing site, at a hospital, at a clinic, in a jail or prison, at a drug treatment facility, at home, or somewhere else? (203-204)

0 1	Private doctor or HMO office
0 2	Counseling and testing site
0 3	Hospital
0 4	Clinic
0 5	Jail or prison (or other correctional facility)
0 6	Drug treatment facility
0 7	At home
0 8	Somewhere else
7 7	Don't know/Not sure
9 9	Refused

CATI note: Ask Q.18.4; if Q.18.2 = within last 12 months. Otherwise, go to next section.

18.4 Was it a rapid test where you could get your results within a couple of hours? (205)

1	Yes
2	No
7	Don't know / Not sure
9	Refused

Section 19: Emotional Support and Life Satisfaction

The next two questions are about emotional support and your satisfaction with life.

19.1 How often do you get the social and emotional support you need?

INTERVIEWER NOTE: If asked, say “please include support from any source”. (206)

Please read:

1	Always
2	Usually
3	Sometimes
4	Rarely
5	Never

Do not read:

7	Don't know / Not sure
9	Refused

19.2 In general, how satisfied are you with your life?

(207)

Please read:

- 1 Very satisfied
- 2 Satisfied
- 3 Dissatisfied
- 4 Very dissatisfied

Do not read:

- 7 Don't know / Not sure
- 9 Refused

Section 20: Gastrointestinal Disease

Now I would like to ask you some questions about diarrhea that you may have experienced and about medical care you sought for your diarrheal illness.

20.1 In the past 30 days, did you have diarrhea that began within the 30 day period? *Diarrhea is defined as 3 or more loose stools in a 24-hour period.*

(208)

- 1 Yes
- 2 No **[Go to Optional Module 1]**
- 7 Don't know / Not sure **[Go to Optional Module 1]**
- 9 Refused **[Go to Optional Module 1]**

20.2 Did you visit a doctor, nurse or other health professional for this diarrheal illness?

Note: Do not answer "Yes" if you just had telephone contact with a health professional.

(209)

- 1 Yes
- 2 No **[Go to Optional Module 1]**
- 7 Don't know / Not sure **[Go to Optional Module 1]**
- 9 Refused **[Go to Optional Module 1]**

20.3 When you visited your health care professional, did you provide a stool sample for testing?

(210)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Transition to modules and/or state-added questions

Please read:

Finally, I have just a few questions left about some other health topics.

Optional Modules

Module 1: Random Child Selection

CATI note: If Core Q12.7 = 88, or 99 (no children under age 18 in the household, or refused), go to next module.

If Core Q12.7 = 1, Interviewer please read: “Previously, you indicated there was one child age 17 or younger in your household. I would like to ask you some questions about that child.” **[Go to Q1]**

If Core Q12.7 is >1 and Core Q12.7 does not equal 88 or 99, Interviewer please read: “Previously, you indicated there were **[number]** children age 17 or younger in your household. Think about those **[number]** children in order of their birth, from oldest to youngest. The oldest child is the first child and the youngest child is the last.” Please include children with the same birth date, including twins, in the order of their birth.

CATI INSTRUCTION: RANDOMLY SELECT ONE OF THE CHILDREN. This is the “Xth” child. Please substitute “Xth” child’s number in all questions below.

INTERVIEWER PLEASE READ:

I have some additional questions about one specific child. The child I will be referring to is the “Xth” **[CATI: please fill in correct number]** child in your household. All following questions about children will be about the “Xth” **[CATI: please fill in]** child.”

1. What is the birth month and year of the “Xth” child? (226-231)

$\bar{\bar{7}} \bar{\bar{7}} / \bar{\bar{7}} \bar{\bar{7}} \bar{\bar{7}} \bar{\bar{7}}$	Code month and year
$9 \ 9 / 9 \ 9 \ 9 \ 9$	Don't know / Not sure
	Refused

CATI INSTRUCTION: Calculate the child’s age in months (CHLDAGE1=0 to 216) and also in years (CHLDAGE2=0 to 17) based on the interview date and the birth month and year using a value of 15 for the birth day. If the selected child is < 12 months old enter the calculated months in CHLDAGE1 and 0 in CHLDAGE2. If the child is ≥ 12 months enter the calculated months in CHLDAGE1 and set CHLDAGE2=Truncate (CHLDAGE1/12).

2. Is the child a boy or a girl? (232)

1	Boy
2	Girl
9	Refused

3. Is the child Hispanic or Latino? (233)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

4. Which one or more of the following would you say is the race of the child? (234-239)

[Check all that apply]

Please read:

- 1 White
- 2 Black or African American
- 3 Asian
- 4 Native Hawaiian or Other Pacific Islander
- 5 American Indian, Alaska Native

Or

- 6 Other [specify] _____

Do not read:

- 8 No additional choices
- 7 Don't know / Not sure
- 9 Refused

CATI note: If more than one response to Q4, continue. Otherwise, go to Q6.

5. Which one of these groups would you say best represents the child's race? (240)

- 1 White
- 2 Black or African American
- 3 Asian
- 4 Native Hawaiian or Other Pacific Islander
- 5 American Indian, Alaska Native
- 6 Other
- 7 Don't know / Not sure
- 9 Refused

6. How are you related to the child? (241)

Please read:

- 1 Parent (include biologic, step, or adoptive parent)
- 2 Grandparent
- 3 Foster parent or guardian
- 4 Sibling (include biologic, step, and adoptive sibling)
- 5 Other relative
- 6 Not related in any way

Do not read:

- 7 Don't know / Not sure
- 9 Refused

Module 2: Childhood Asthma Prevalence

CATI note: If response to Core Q12.7 = 88 (None) or 99 (Refused), go to next module.

1. Has a doctor, nurse or other health professional EVER said that the child has asthma? (242)

- 1 Yes
- 2 No [Go to next module]
- 7 Don't know / Not sure [Go to next module]
- 9 Refused [Go to next module]

2. Does the child still have asthma? (243)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

NY State-Added Module 1: Asthma Call-Back (asked in Optional)

If C09.1 =1 (Adult lifetime =yes) or M02Q01=1 (childhood lifetime=yes)

“We would like to call to you again within the next 2 weeks to talk in more detail about (your/your child’s) experiences with asthma. The information will be used to help develop and improve the asthma programs in New York. The information you gave us today and any you give us in the future will be kept confidential. If you agree to this, we will keep your first name or initials and phone number on file, separate from the answers collected today. Even if you agree now, you may refuse to participate in the future. Would it be okay if we called you back to ask additional asthma-related questions at a later time?”

- 1 Yes
- 2 No Go to next Module

If NY01Q01 = 1:

Can I please have either your first name or initials so we will know who to ask for when we call back?

_____ Enter first name or initials (Cati only)

If NY01Q01 = 1 and child selected:

Can I please have either the child’s first name or initials so we will know which child to ask about when we call back?

_____ Enter first name or initials (Cati)

Module 4: Visual Impairment and Access to Eye Care

CATI note: If respondent is less than 40 years of age, go to next module.

I would like to ask you questions about how much difficulty, if any, you have doing certain activities. If you usually wear glasses or contact lenses, please rate your ability to do them while wearing glasses or contact lenses.

1. How much difficulty, if any, do you have in recognizing a friend across the street? Would you say— (264)

Please read:

- 1 No difficulty
- 2 A little difficulty
- 3 Moderate difficulty
- 4 Extreme difficulty
- 5 Unable to do because of eyesight
- 6 Unable to do for other reasons

Do not read:

- 7 Don’t know / Not sure
- 8 Not applicable (Blind) **[Go to next module]**

9 Refused

2. How much difficulty, if any, do you have reading print in newspaper, magazine, recipe, menu, or numbers on the telephone? Would you say—

(265)

Please read:

- 1 No difficulty
- 2 A little difficulty
- 3 Moderate difficulty
- 4 Extreme difficulty
- 5 Unable to do because of eyesight
- 6 Unable to do for other reasons

Do not read:

- 7 Don't know / Not sure
- 8 Not applicable (Blind) **[Go to next module]**
- 9 Refused

3. When was the last time you had your eyes examined by any doctor or eye care provider? (266)

Read only if necessary:

- 1 Within the past month (anytime less than 1 month ago) **[Go to Q5]**
- 2 Within the past year (1 month but less than 12 months ago) **[Go to Q5]**
- 3 Within the past 2 years (1 year but less than 2 years ago)
- 4 2 or more years ago
- 5 Never

Do not read:

- 7 Don't know / Not sure
- 8 Not applicable (Blind) **[Go to next module]**
- 9 Refused

4. What is the main reason you have not visited an eye care professional in the past 12 months?

(267-268)

Read only if necessary:

- 0 1 Cost/insurance
- 0 2 Do not have/know an eye doctor
- 0 3 Cannot get to the office/clinic (too far away, no transportation)
- 0 4 Could not get an appointment
- 0 5 No reason to go (no problem)
- 0 6 Have not thought of it
- 0 7 Other

Do not read:

- 7 7 Don't know / Not sure
- 0 8 Not Applicable (Blind) **[Go to next module]**
- 9 9 Refused

CATI note: If NY11Q03 = 1 thru 4, 7, 8, 9 then go to Q6 (M04Q06).

5. When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light. (269)

Read only if necessary:

- 1 Within the past month (anytime less than 1 month ago)
- 2 Within the past year (1 month but less than 12 months ago)
- 3 Within the past 2 years (1 year but less than 2 years ago)
- 4 2 or more years ago
- 5 Never

Do not read:

- 7 Don't know / Not sure
- 8 Not applicable (Blind) **[Go to next module]**
- 9 Refused

6. Do you have any kind of health insurance coverage for eye care? (270)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 8 Not applicable (Blind) **[Go to next module]**
- 9 Refused

7. Have you been told by an eye doctor or other health care professional that you NOW have cataracts? (271)

- 1 Yes
- 2 Yes, but had them removed
- 3 No
- 7 Don't know / Not sure
- 8 Not applicable (Blind) **[Go to next module]**
- 9 Refused

8. Have you EVER been told by an eye doctor or other health care professional that you had glaucoma? (272)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 8 Not applicable (Blind) **[Go to next module]**

9 Refused

Please read:

Age-related Macular Degeneration (AMD) is a disease that blurs the sharp, central vision you need for “straight-ahead” activities such as reading, sewing, and driving. AMD affects the macula, the part of the eye that allows you to see fine detail.

9. Have you EVER been told by an eye doctor or other health care professional that you had age-related macular degeneration? (273)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 8 Not applicable (Blind) **[Go to next module]**
- 9 Refused

10. Have you EVER had an eye injury that occurred at your workplace while you were doing your work? (274)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Module 5: Healthy Days (Symptoms)

The next few questions are about health-related problems or symptoms.

1. During the past 30 days, for about how many days did pain make it hard for you to do your usual activities, such as self-care, work, or recreation? (275-276)

- Number of days
- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

2. During the past 30 days, for about how many days have you felt sad, blue, or depressed? (277-278)

- Number of days
- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

3. During the past 30 days, for about how many days have you felt worried, tense, or anxious? (279-280)

- — Number of days
- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

4. During the past 30 days, for about how many days have you felt you did not get enough rest or sleep? (281-282)

- — Number of days
- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

5. During the past 30 days, for about how many days have you felt very healthy and full of energy? (283-284)

- — Number of days
- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

Module 6: Cardiovascular Health

I would like to ask you a few more questions about your cardiovascular or heart health.

CATI note: If Core Q8.1 = 1 (Yes), ask Q1. If Core Q8.1 = 2, 7, or 9, skip Q1.

1. After you left the hospital following your heart attack did you go to any kind of outpatient rehabilitation? This is sometimes called "rehab." (285)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

CATI note: If Core Q8.3 = 1 (Yes), ask Q2. If Core Q8.3 = 2, 7, or 9 (No, Don't know, or Refused), skip Q2.

2. After you left the hospital following your stroke did you go to any kind of outpatient rehabilitation? This is sometimes called "rehab." (286)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

[Question 3 is asked of all respondents.]

3. Do you take aspirin daily or every other day? (287)

- 1 Yes **[Go to next module]**
- 2 No
- 7 Don't know / Not sure
- 9 Refused

4. Do you have a health problem or condition that makes taking aspirin unsafe for you? (288)

If "Yes," ask "*Is this a stomach condition?*" Code upset stomach as stomach problems.

- 1 Yes, not stomach related
- 2 Yes, stomach problems
- 3 No
- 7 Don't know / Not sure
- 9 Refused

Module 7: Actions to Control High Blood Pressure

CATI note: If Core Q6.1 = 1 (Yes); continue. Otherwise, go to next module.

Are you now doing any of the following to help lower or control your high blood pressure?

1. (Are you) changing your eating habits (to help lower or control your high blood pressure)? (289)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

2. (Are you) cutting down on salt (to help lower or control your high blood pressure)? (290)

- 1 Yes
- 2 No
- 3 Do not use salt
- 7 Don't know / Not sure
- 9 Refused

3. (Are you) reducing alcohol use (to help lower or control your high blood pressure)? (291)

- 1 Yes
- 2 No
- 3 Do not drink
- 7 Don't know / Not sure
- 9 Refused

4. (Are you) exercising (to help lower or control your high blood pressure)? (292)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Has a doctor or other health professional ever advised you to do any of the following to help lower or control your high blood pressure?

5. (Ever advised you to) change your eating habits (to help lower or control your high blood pressure)? (293)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

6. (Ever advised you to) cut down on salt (to help lower or control your high blood pressure)? (294)

- 1 Yes
- 2 No
- 3 Do not use salt
- 7 Don't know / Not sure
- 9 Refused

7. (Ever advised you to) reduce alcohol use (to help lower or control your high blood pressure)? (295)

- 1 Yes
- 2 No
- 3 Do not drink
- 7 Don't know / Not sure
- 9 Refused

8. (Ever advised you to) exercise (to help lower or control your high blood pressure)? (296)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

9. (Ever advised you to) take medication (to help lower or control your high blood pressure)? (297)

1 Yes
2 No
7 Don't know / Not sure
9 Refused

10. Were you told on **two or more different visits** to a doctor or other health professional that you had high blood pressure? (298)

If “Yes” and respondent is *female*, ask: “Was this only when you were pregnant?”

1 Yes
2 Yes, but female told only during pregnancy
3 No
4 Told borderline or pre-hypertensive
7 Don't know / Not sure
9 Refused

Module 13: Arthritis Management

CATI note: If Core Q15.2 or Q15.4 = 1 (Yes), continue. Otherwise, go to next module.

1. Earlier you indicated that you had arthritis or joint symptoms. Thinking about your arthritis or joint symptoms, which of the following best describes you **today**? (345)

Please read:

1 I can do everything I would like to do
2 I can do most things I would like to do
3 I can do some things I would like to do
4 I can hardly do anything I would like to do

Do not read:

7 Don't know / Not sure
9 Refused

2. Has a doctor or other health professional EVER suggested losing weight to help your arthritis or joint symptoms? (346)

1 Yes

- 2 No
- 7 Don't know / Not Sure
- 9 Refused

3. Has a doctor or other health professional ever suggested physical activity or exercise to help your arthritis or joint symptoms? (347)

Note: If the respondent is unclear about whether this means an increase or decrease in physical activity, this means increase.

- 1 Yes
- 2 No
- 7 Don't know / Not Sure
- 9 Refused

4. Have you EVER taken an educational course or class to teach you how to manage problems related to your arthritis or joint symptoms? (348)

- 1 Yes
- 2 No
- 7 Don't know / Not Sure
- 9 Refused

NY State-Added Module 3: Disability Limitations

CATI Note: if Core 14.1 = 1 (yes-limitations) or Core 14.2 = 1 (yes-special equipment) (Section 14: Disability) continue. Otherwise go to next module.

NY03Q01. Because of any impairment or health problem, do you need the help of other persons with your PERSONAL CARE needs, such as eating, bathing, dressing, or getting around the house?

- 1 Yes
- 2 No
- 7 Don't know/Not sure
- 9 Refused

NY03Q02. Because of any impairment or health problem, do you need the help of other persons in handling your ROUTINE needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

- 1 Yes
- 2 No
- 7 Don't know/Not sure
- 9 Refused

NY State-Added Module 4: Epilepsy

NY04Q01. Have you ever been told by a doctor that you have a seizure disorder or epilepsy?

- 1 Yes
- 2 No **Go to next module**
- 7 Don't know/not sure **Go to next module**
- 9 Refused **Go to next module**

NY04Q02. Are you currently taking any medicine to control your seizure disorder or epilepsy?

- 1 Yes
- 2 No
- 7 Don't know/not sure
- 9 Refused

NY04Q03. How many seizures of any type have you had in the last 3 months?

- 1 none
- 2 one
- 3 two or more
- 4 no longer have epilepsy/seizure disorder
- 7 Don't know/not sure
- 9 Refused

NY04Q04. During the past month, to what extent has epilepsy or its treatment interfered with your normal activities like working, school, or socializing with family or friends?

Would you say:

- 1 Not at all
- 2 Slightly
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

-- Do not read --

- 7 Don't know/not sure
- 9 Refused

NY04Q05. In the past year have you seen a neurologist or epilepsy specialist for your epilepsy or seizure disorder?

- 1 yes
- 2 no
- 7 Don't know/not sure
- 9 refused

NY State-Added Module 5: Walking

NY05Q01. In a usual week, do you walk for at least 10 minutes at a time for any reason?

- 1 Yes
- 2 No **Go to next module**
- 7 Don't know/Not sure **Go to next module**
- 9 Refused **Go to next module**

NY05Q02. How many days per week do you walk for at least 10 minutes at a time?

- Days per week _____ [1-7]
 77 Don't know/Not sure
 99 Refused

NY05Q03. On days when you walk for at least 10 minutes at a time, how much total time per day do you spend walking?

- Hours and minutes per day** _____: _____ **[greater than 10 minutes]**
 (Example: 30 minutes is coded as 30
 60 minutes is coded as 100
 2 hours and 30 minutes is coded as 230)
- 777 Don't know/Not sure
 - 999 Refused

NY State-Added Module 6: Milk Consumption

NY06Q01. What TYPE of milk do you usually drink or put on your cereal?

Interviewer Note: If respondent is uncertain how to answer read the following: “Different types of milk include whole, 2%, 1% and skim milk. “

Interviewer Note: If respondent is still uncertain, read the following: “Sometimes different types of milk are called regular, reduced fat, low fat or fat free.”

Interviewer Note: If respondent indicates they drink Lactose free milk, probe for which type – whole, 2%, 1% or skim.

- 1 whole (regular)
- 2 2% milk (reduced fat)
- 3 1% milk (low fat)
- 4 skim milk (fat free)
- 5 Don't usually drink milk
- 7 Don't Know
- 9 Refused

NY State-Added Module 7: Sexual Behavior

If C12Q01, age is 18-64 continue, otherwise go to NY State-Added Module 8.

The next questions are about your sexual behavior and about sexually transmitted disease.

NY07Q01. When you go to a doctor's office or clinic for a regular check-up or physical exam, how often does the doctor take a sexual history? By sexual history we mean asking you about sexual partners and sexual practices.

- 1 Every time
- 2 Almost every time
- 3 Sometimes
- 4 Rarely (Hardly Ever) **Interviewer Note:** Read () if needed
- 8 Never

Do not read

- 5 N/A Haven't had a regular check-up
- 7 Don't know / Not sure
- 9 Refused

NY07Q02. During the past 12 months, with how many people have you had sex? By sex we mean oral, vaginal, or anal sex, but NOT masturbation.

- __ Number of partners
- 88 None **GoTo NY07Q07**
- 77 Dk/Not sure **GoTo NY07Q07**

NY07Q03. During the past 12 months, have you had sex with only males, only females, or with both males and females?

- 1 Only with male(s)
- 2 Only with female(s)
- 3 Both male and female
- 7 Don't know / Not sure
- 9 Refused

NY07Q04. When you have sex with your main partner, how often do the two of you use condoms, would you say

- 1 Every time
- 2 Almost every time
- 3 Sometimes
- 4 Almost never
- 8 Never

---Do not read ---

- 6 Don't have a main sexual partner
- 7 Don't know / Not sure
- 9 Refused

NY07Q05. Do you have sex with someone that you would "not" call your main partner?

- 1 Yes
- 2 No **GoTo NY07Q07**
- 7 Don't know/Not sure **GoTo NY07Q07**
- 9 Refused **GoTo NY07Q07**

NY07Q06. When you have sex with someone you do "not" think of as a main partner, how often do the two of you use condoms, would you say...

- 1 Every time
- 2 Almost every time
- 3 Sometimes
- 4 Almost never
- 8 Never

---Do not read ---

- 7 Don't know / Not sure
- 9 Refused

NY07Q07. How many people in your community who are your age do you think have had an STD? By STD we mean any sexually transmitted disease such as gonorrhea, chlamydia, or syphilis. Would you say

Note if necessary Read: just your best estimate.
Interviewer Note: Do not read () unless needed

- 1 Hardly any (0-1 out of 10)
- 2 A few (2-3 out of 10)
- 3 About half (4-6 out of 10)
- 4 All or almost all (9-10 out of 10)

---Do not read ---

- 7 Don't know / Not sure
- 9 Refused

NY07Q08. Please tell me whether the following statement is true or false.

Having another STD increases your chances of being infected with HIV.

- 1 True
- 2 False
- 7 Don't Know/Not Sure
- 9 Refused

NY State-Added Module 8: Arthropod-Borne Disease

The next questions are about Lyme disease, a bacterial infection transmitted by the deer tick.

NY08Q01. Do you believe that Lyme disease in your county is extremely common, fairly common or rare?

- 1 Extremely common
- 2 Fairly common
- or-
- 3 Rare
- 7 Don't know/not sure
- 9 Refused

NY08Q02. Have you ever heard or received information about Lyme disease?

- 1 Yes
- 2 No **go to NY08Q04**
- 7 Don't know/not sure **go to NY08Q04**
- 9 Refused **go to NY08Q04**

NY08Q03. I'm going to read you a list of sources where you may have gotten this Lyme disease information. From the following, please select the major source of this information.

Interviewer note: Read list 1-5.

- 1 Doctor, nurse or health care practitioner
- 2 Television or radio ad
- 3 Newspaper, magazine or brochure
- 4 Family, friend or at work
- 5 Internet

-----Do not read-----

-or-

- 6 Other
- 7 Don't know/not sure
- 9 Refused

NY08Q04. Which of the following best describes the proper way to remove an attached tick?

- 1 Apply a lit match or cigarette to the tick
- 2 Petroleum jelly / Vaseline
- 3 Tweezers
- 4 Other

-----Do not read-----

- 7 Don't know/-not sure
- 9 Refused

NY08Q05. In the past year, have you taken the following steps to prevent yourself from getting tick, mosquito, or other insect bites.

A. Used insect repellent on your skin or clothes?

- 1 Yes
- 2 No
- 7 Don't know/Not sure
- 9 Refused

B. Avoided wooded or grassy areas?

- 1 Yes
- 2 No
- 7 Don't know/Not sure
- 9 Refused

C. Avoided going outdoors when mosquitoes are most active?

- 1 Yes
- 2 No

- 7 Don't know/Not sure
- 9 Refused

D. Changed the way you dressed, such as wearing long sleeves and long pants, wearing light colored clothes, or tucking your pants into your socks?

- 1 Yes
- 2 No
- 7 Don't know/Not sure
- 9 Refused

E. Removed standing water around your home?

- 1 Yes
- 2 No
- 3 No standing water around home
- 7 Don't know/Not sure
- 9 Refused

F. Looked for ticks on yourself or others in your family after being outdoors?

- 1 Yes
- 2 No
- 7 Don't know/Not sure
- 9 Refused

NY State-Added Module 9: Rabies

Only asked if county of residence not equal to NYC boroughs and/or zipcode outside of boroughs.

NY09Q01. Have you owned at least one dog, cat or ferret in the last five years?

- | | | |
|---|---------------------|--------------------------|
| 1 | yes | |
| 2 | no | Go to next module |
| 7 | Don't know/not sure | Go to next module |
| 9 | refused | Go to next module |

NY09Q02. Are you aware of the free rabies vaccination clinics for dogs, cats and ferrets sponsored by your county health department?

- | | | |
|---|---------------------|----------------------|
| 1 | yes | |
| 2 | no | Go to NY09Q04 |
| 7 | Don't know/not sure | Go to NY09Q04 |
| 9 | refused | Go to NY09Q04 |

NY09Q03. During the past 5 years did you get any of your dogs, cats, or ferrets vaccinated against rabies at any county sponsored free rabies vaccination?

- | | | |
|---|--------------------------|--------------------------|
| 1 | yes | Go to next module |
| 2 | no | |
| 3 | no, use own veterinarian | |

7 Don't know/not sure
9 refused

NY09Q04. “All counties outside of New York City conduct or sponsor free rabies vaccination clinics for dogs, cats and ferrets. Clinics are generally offered every 4 months, and you can find out when and where they are by contacting your county health department.”

Would you be likely to use the county-sponsored rabies vaccination clinics for your pets?

1 yes
2 no
7 Don't know/not sure
9 refused

NY State-Added Module 10: Worker's Compensation Coverage

If the answer to Core Q12.9 (employment) is (3) Out of work for more than a year or (9) Refused, then Go to closing.

If the answer to Core Q 12.9 (employment) is (1)Employed for wages, (2) Self-employed, or (4) Out of work less than a year then Go to NY10Q2.

Otherwise if Core Q12.9 =5,6,7 or 8 then continue.

NY10Q01.. During the past twelve months, have you been employed for any period of time, either part time, full time or self-employed?

1 Yes, employed full time or part time.
2 Yes, self-employed.
3 No. **Go to closing**
7 Don't know/Not Sure. **Go to closing**
9 Refused. **Go to closing**

The next question is about whether you have had a work-related injury. As a reminder, your responses are strictly confidential.

NY10Q02. During the past 12 months, that is since {one year before today date} were you injured seriously enough while performing your job that you got medical advice or treatment?

1 Yes
2 No **Go to closing**
7 Don't know/Not Sure **Go to closing**
9 Refused **Go to closing**

NY10Q03. How many days in a row did you miss work because of your most recent work-related injury (include weekends and scheduled days off or vacation)?

1 None
2 One or two
3 Three or four

- 4 Five
- 5 Six
- 6 Seven or more
- 7 Don't know/Not sure
- 9 Refused

NY10Q04. For your most recent work-related injury, who paid for your treatment?

Please read:

- 01 Workers' compensation or the State Insurance Fund. **Go to closing**
- 02 Private Insurance.
- 03 Medicare, Medicaid.
- 04 Indian Health Service/Alaska Native Health Service.
- 05 The military, Veterans Administration or Champus **Go to closing**
- 06 Federal government (OWCP program) **Go to closing**
- 07 You or your family; out of pocket.
- 08 Your employer through a workers' compensation claim **Go to closing**
- 09 Your employer without a workers' compensation claim
- 10 Your employer without a workers' compensation claim and through on-site medical treatment.
- 11 The union.
- 12 Other source. [**Specify:** _____]
- 13 Workers' compensation claim filed, still in process or not resolved. **Go to closing**

Do not read these responses

- 88 No one paid; no treatment **Go to closing**
- 77 Don't know/not sure **Go to closing**
- 99 Refused **Go to closing**

NY10Q05. For your most recent work-related injury, why was the treatment not paid for by workers' compensation?

Please read:

- 01 You did not know you could file a claim.
- 02 Your doctor did not want to file a claim
- 03 You did not want to file a claim because you were worried about retaliation
- 04 Your Workers' Compensation claim was rejected
- 05 Your employer paid for treatment
- 06 You are not covered, so no claim was filed
- 07 Some other reason (SPECIFY) _____

Do not read these responses

- 88 No reason given
- 77 Don't Know/Not Sure
- 99 Refused

Please read closing statement:

That is my last question. Everyone's answers will be combined to give us information about the health practices of people in this state. Thank you very much for your time and cooperation.

Attachment 12

12. CDC Asthma Call Back Survey Guidance

(See Attached PDF File)

2008 BRFSS Asthma Call-back Guidelines

1. All standard BRFSS data collection protocols (such as call attempts, assigning dispositions to cases, etc.) should be followed. Data collection for the follow-up must meet guidelines and data quality criteria established for the annual state-wide survey.
2. The BRFSS core and (where applicable) child selection modules will be required to select a respondent for the follow-up. The respondent will be either an adult (BRFSS respondent) or child (chosen using child selection module) who has ever had asthma. All cases meeting the qualification criteria in BRFSS will be included in the follow-up sample. Only one call-back interview per household will be conducted. If a household contains both an eligible adult and child, then one will be selected for the call-back using a random selection process built into the BRFSS interview. The program should select the child 50% of the time and the adult 50% of the time. If a child is the selected sample member for the call back, the interview will be conducted with the most knowledgeable parent or guardian in the household; persons under age 18 years will not be interviewed directly. The BRFSS respondent at the core must be the parent/guardian of the child selected. If the BRFSS respondent is not the parent/guardian of the selected child, a call-back survey for the child with asthma is not conducted (e.g. a core BRFSS respondent who is a sibling of the selected child, who is over 18, but is not the guardian of the selected child could not transfer the child call-back over to the parent/guardian of the child). The reason for this is that the core BRFSS data must also be for the parent/guardian of the selected child.
3. All states should make the BRFSS respondent aware that a callback will take place. A template with recommended wording for the question requesting permission to call the respondent back sometime in the next two weeks is provided in Appendix A. Because IRBs in different states may require slight changes in the wording of this question, you have the latitude to modify this template as necessary. We request only that you forward a copy of your final wording to Wil Murphy (BSB) for documentation purposes.
4. This call-back survey is an extension of the regular surveillance efforts conducted as a part of BRFSS and as such has exemption from full review by the CDC IRB. A copy of the BRFSS exemption email for the 2006 BRFSS is provided in Appendix B. BSB will forward a copy of the 2008 exemption once it is received (which should be sometime in October, 2007).
5. Because both the adult and child questionnaires were pretested and administered in three states during 2005, administered to 25 states in 2006, and 35 states in 2007, we will not be requiring a pretest of the 2007 questionnaire. CA provides a Spanish translation of each instrument. States can do a pretest, it's just not required. New states should test their CATI somehow if they are not using one of the contractors currently conducting the Asthma call-back.
6. Data collection for the call-back survey should begin by February 1, 2008. Interviews should be conducted within two weeks of the BRFSS interview completion date. Conducting the Asthma interview earlier than 2-weeks limit is preferred.

7. Data will be submitted via email to the BSB data mailbox (nccdachbrfss@cdc.gov) on the following schedule: (earlier submissions are fine if data collection is completed earlier)

- March 1, 2008
- April 1, 2008
- July 1, 2008
- October 1, 2008
- February 1, 2009

8. Standard BRFSS case disposition codes and code assignment rules are required. Four additional codes have been added for the call-back survey only:

Revised Disposition list is enclosed

9. A case should be considered as a partial complete (disposition code 120) if either:

- a. the respondent completed section 8 (medications) before terminating the interview; OR
- b. the respondent completed section 7 (modifications to environment) but didn't complete section 8 (medications) before terminating the interview but would have skipped section 8 due to a legitimate skip because he or she had responded "Never" to LAST_MED (3.4) "How long has it been since you last took asthma medication?".

A case would be considered as a termination within questionnaire (disposition code 210) if the respondent should have answered the questions about medications in section 8 and didn't, or if they would have skipped section 8 but terminated the questionnaire before reaching the end of section 7 (modifications to environment).

10. BSB is working on a PC Edits program. This is expected to be available before the first quarter of the '08 processing year.

11. BSB will weight the data and produce a final data set that includes the state-wide BRFSS data and the call-back survey data. Midyear files will be made available to the states for quality control checks.

Attachment 13

13. Asthma Call Back Survey Questionnaires

(See Attached PDF File)

Asthma Call Back Survey Questionnaires

1. Asthma Call back Survey – Child
2. Asthma Call back Survey – Adult

**BRFSS/ASTHMA SURVEY
CHILD QUESTIONNAIRE - 2007
CATI SPECIFICATIONS**

Section	Subject	Page
Section 1	Introduction.....	02
Section 2	Informed Consent.....	04
Section 3	Recent History.....	06
Section 4	History of Asthma (Symptoms & Episodes).....	08
Section 5	Health Care Utilization.....	11
Section 6	Knowledge of Asthma/Management Plan.....	15
Section 7	Modifications to Environment.....	17
Section 8	Medications.....	21
Section 9	Cost of Care.....	31
Section 10	School Related Asthma	32
Section 11	Complimentary and Alternative Therapy	36
Section 12	Additional Child Demographics	38

[CATI: IF INTERVIEW BREAKS OFF AT ANY POINT LEAVE REMAINING FIELDS BLANK. DO NOT FILL WITH ANY VALUE.]

Section 1. Introduction

INTRODUCTION TO THE BRFSS Asthma call back for Adult parent/guardian of child with asthma:

Hello, my name is _____. I'm calling on behalf of the {Minnesota/Michigan/Oregon} health department and the Centers for Disease Control and Prevention about an asthma study we are doing in your state. During a recent phone interview {sample person's first name or initials} indicated {he/she} would be willing to participate in this study about {sample child's} asthma.

ALTERNATE (no reference to asthma):

Hello, my name is _____. I'm calling on behalf of the {Minnesota/Michigan/Oregon} health department and the Centers for Disease Control and Prevention about a health study we are doing in your state. During a recent phone interview {sample person's first name or initials} indicated {he/she} would be willing to participate in this study about {sample child}.

1.1 Are you {sample person's first name or initials}?

1. Yes (go to informed consent)
2. No

1.2 May I speak with {sample person first name or initials}?

1. Yes (go to 1.3 when person comes to phone)
2. No

If not available set time for return call

1.3 Hello, my name is _____. I'm calling on behalf of the {Minnesota/Michigan/Oregon} state health department and the Centers for Disease Control and Prevention about an asthma study we are doing in your state. During a recent phone interview you indicated that {sample child's name} had asthma and that you would be able to complete the follow-up interview on {sample child's name} asthma

at this time.

ALTERNATE (no reference to asthma):

Hello, my name is _____. I'm calling on behalf of the {Minnesota/Michigan/Oregon} state health department and the Centers for Disease Control and Prevention about a health study we are doing in your state. During a recent phone interview you indicated that you would be able to complete a follow-up interview on {sample child's name} at this time.

If respondent requests transfer to another person (parent/guardian) who is more knowledgeable about the child's asthma use code 2 below:

- 1. BRFSS respondent will continue**
- 2. Alternate respondent will continue**

ADDED 12/15/05

Section 2. Informed Consent

INFORMED CONSENT

Before we continue, I'd like you to know that this survey is authorized by the U.S. Public Health Service Act

{Child's name} was selected to participate in this study about asthma because of your responses to questions about his or her asthma in a prior survey.

[If responses for sample child were "yes" to lifetime and no to "still" in core BRFSS interview read:]

The answers to asthma questions during the earlier survey indicated that a doctor or other health professional said that {child's name} had asthma sometime in {his/her} life, but does not have it now. Is that correct?

[IF YES, READ:] (IF NO, Go to REPEAT (2.0))

Since {child's name} no longer has asthma, your interview will be very brief (about 5 minutes). You may choose not to answer any question you don't want to answer or stop at any time. In order to evaluate my performance, my supervisor may listen as I ask the questions. I'd like to continue now unless you have any questions. [Go to section 3]

[If responses for sample child were "yes" to lifetime and yes to "still" in core BRFSS survey, read:]

Answers to the asthma questions in the earlier survey indicated that that a doctor or other health professional said that {child's name} had asthma sometime in his or her life, and that {child's name} still has asthma. Is that correct?

(IF YES, READ:) (IF NO, Go to REPEAT (2.0))

Since {child's name} has asthma now, your interview will last about 15 minutes. You may choose not to answer any question you don't want to answer or stop at any time. In order to evaluate my performance, my supervisor may listen as I ask the questions. I'd like to continue now unless you have any questions. [Go to section 3]

REPEAT (2.0)

If BRFSS core respondent: Check if correct person from core survey is on phone. Ask "is this {sample person's name} and are you {sample person's age} years old. If yes, continue. If not the correct respondent, ask to speak to that person, and start over at section 1. **Keep a disposition code for this.**

If alternate adult (from 1.3) or correct BRFSS respondent read:
I would like to repeat the questions from the previous survey now to make sure {sample child's name} qualifies for this study.

EVER_ASTH (2.1) Have you ever been told by a doctor or other health professional that {child's name} had asthma?

- (1) YES
- (2) NO [Go to TERMINATE]
- (7) DON'T KNOW [Go to TERMINATE]
- (9) REFUSED [Go to TERMINATE]

CUR_ASTH (2.2) Does {he/she} still have asthma?

7/06

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

RELATION (2.3) What is your relationship to {child's name}?

- (1) MOTHER (BIRTH/ADOPTIVE/STEP) [go to READ]
- (2) FATHER (BIRTH/ADOPTIVE/STEP) [go to READ]
- (3) BROTHER/SISTER (STEP/FOSTER/HALF/ADOPTIVE)
- (4) GRANDPARENT (FATHER/MOTHER)
- (5) OTHER RELATIVE
- (6) UNRELATED

- (7) DON'T KNOW
- (9) REFUSED

GUARDIAN (2.4) Are you the legal guardian for {child's name}?

- (1) YES
- (2) NO [go to TERMINATE ~~if BRFSS respondent; continue if alternate from 1.3~~]

- (7) DON'T KNOW [go to TERMINATE ~~if BRFSS respondent; continue if alternate from 1.3~~]
- (9) REFUSED [go to TERMINATE ~~if BRFSS respondent; continue if alternate from 1.3~~]

RE: above strike through - 2/6/06 Michael wants to terminate all non parent/guardian at this point.

READ: {child's name} does qualify for this study, I'd like to continue unless you have any questions. You may choose not to answer any question you don't want to answer or stop at any time. In order to evaluate my performance, my supervisor may listen as I ask the questions

[If YES to 2.2 read:]

Since {child's name} does have asthma now, your interview will last **about 15 minutes**. [Go to section 3]

[If NO to 2.2 read:]

Since {child's name} does not have asthma now, your interview will last **about 5 minutes**. **[Go to section 3]**

[If Don't know or refused to 2.2 read:]

Since you are not sure if {child's name} has asthma now, your interview will probably last **about 10 minutes**. **[Go to section 3]**

Some states may require the following section:

READ: Some of the information that you shared with us when we called you before could be useful in this study.

PERMISS (2.5) May we combine your answers to this survey with your answers from the survey you did a few weeks ago?

- (1) YES (Skip to Section 3)
- (2) NO (GO TO TERMINATE)

- (7) DON'T KNOW (GO TO TERMINATE)
- (9) REFUSED (GO TO TERMINATE)

[CATI: keep a disposition code for PERMISS (2.5)]

TERMINATE:

Upon survey termination, READ:

Those are all the questions I have. I'd like to thank you on behalf of the {Minnesota/Michigan/Oregon} Health Department and the Centers for Disease Control and Prevention for answering these questions. If you have any questions about this survey, you may call my supervisor toll-free at 1 – xxx-xxx-xxxx. If you have questions about your rights as a survey participant, you may call the chairman of the Institutional Review Board at 1-800-xxx-xxxx. Thanks again. Goodbye

LAST_MED (3.4) How long has it been since { he/she } last took asthma medication?7/06
[INTERVIEWER: READ RESPONSE OPTIONS IF NECESSARY]

- (88) NEVER
 - (01) LESS THAN ONE DAY AGO
 - (02) 1-6 DAYS AGO
 - (03) 1 WEEK TO LESS THAN 3 MONTHS AGO
 - (04) 3 MONTHS TO LESS THAN 1 YEAR AGO
 - (05) 1 YEAR TO LESS THAN 3 YEARS AGO
 - (06) 3 YEARS TO 5 YEARS AGO
 - (07) MORE THAN 5 YEARS AGO
-
- (77) DON'T KNOW
 - (99) REFUSED

INTRODUCTION FOR LASTSYMP:

READ: Symptoms of asthma include coughing, wheezing, shortness of breath, chest tightness or phlegm production when {child's name} **did not** have a cold or respiratory infection.

LASTSYMP (3.5) How long has
it been since { he/she } last had any symptoms of asthma?
[INTERVIEWER: READ RESPONSE OPTIONS IF NECESSARY]

- (88) NEVER
 - (01) LESS THAN ONE DAY AGO
 - (02) 1-6 DAYS AGO
 - (03) 1 WEEK TO LESS THAN 3 MONTHS AGO
 - (04) 3 MONTHS TO LESS THAN 1 YEAR AGO
 - (05) 1 YEAR TO LESS THAN 3 YEARS AGO
 - (06) 3 YEARS TO 5 YEARS AGO
 - (07) MORE THAN 5 YEARS AGO
-
- (77) DON'T KNOW
 - (99) REFUSED

IF CHILD DOES NOT CURRENTLY HAVE ASTHMA AND THEY ANSWERED “NEVER “ OR “MORE THAN ONE YEAR AGO” TO EACH OF 1) SEEING A DOCTOR ABOUT ASTHMA, 2) TAKING ASTHMA MEDICATION, AND 3) SHOWING SYMPTOMS OF ASTHMA THEN SKIP SECTION 4.

IF question #2 from BRFSS module 11 is no (2) or CUR_ASTH (2.2) = 2 AND LAST_MD (3.3) = 88, 05, 06, 07 AND LAST_MED (3.4) = 88, 05, 06, 07, AND LASTSYMP (3.5) = 88, 05, 06, 07, THEN SKIP TO INS1 (Section 5).

Yes to still, do section 4

No to still and nothing within a year, skip all of section 4 because all questions reference 2 weeks to 1 year

No to still, and something within a year, do parts of Section 4

DK/REFUSED to still, do Section 4

Section 4. History of Asthma (Symptoms & Episodes in past year)

IF LAST SYMPTOMS (3.5) WERE WITHIN THE PAST 3 MONTHS CONTINUE. IF LAST SYMPTOMS WERE 3 MONTHS TO 1 YEAR AGO, SKIP TO EPISODE INTRODUCTION (EPIS_INT - BETWEEN 4.4 AN 4.5); IF SYMPTOMS WERE 1-5+ YEARS AGO, SKIP TO SECTION 5; IF NEVER HAD SYMPTOMS, SKIP TO SECTION 5, IF DK/REFUSED, CONTINUE.

**IF LASTSYMP = 1, 2, 3 then continue
IF LASTSYMP = 4 SKIP TO EPIS_INT (between 4.4 and 4.5)
IF LASTSYMP = 88, 5, 6, 7 SKIP TO INS1 (Section 5)
IF LASTSYMP = 77, 99 then continue**

SYMP_30D (4.1) During the past 30 days, on how many days did {child's name} have any symptoms of asthma?

__ __ DAYS

[RANGE CHECK: (01-30, 77, 88, 99)]

CLARIFICATION: [1-29, 77, 99]

[SKIP TO 4.3

ASLEEP30]

(88) NO SYMPTOMS IN THE PAST 30 DAYS [SKIP TO EPIS_INT]

(30) EVERY DAY [CONTINUE]

(77) DON'T KNOW [SKIP TO 4.3 ASLEEP30]

(99) REFUSED [SKIP TO 4.3 ASLEEP30]

DUR_30D (4.2) Does { he/she } have symptoms all the time? "All the time" means symptoms that continue throughout the day. It does not mean symptoms for a little while each day.

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

ASLEEP30 (4.3) During the past 30 days, on how many days did symptoms of asthma make it difficult for { him/her } to stay asleep?

__ __ DAYS/NIGHTS
[RANGE CHECK: (01-30, 77, 88, 99)]

(88) NONE

(30) Every day

(77) DON'T KNOW

(99) REFUSED

SYMPFREE (4.4) If LASTSYMP = 88 (never) or = 04, 05, 06, or 07 (more than 3 months ago) then have CATI code SYMPFREE = 14

If SYMP_30D = 88 (no symptoms in the past 30 days) then have CATI code SYMPFREE = 14

During the past two weeks, on how many days was {child's name} completely symptom-free, that is no coughing, wheezing, or other symptoms of asthma?

___ Number of days
[RANGE CHECK: (01-14, 77, 88, 99)]

(88) NONE

(77) DON'T KNOW

(99) REFUSED

EPIS_INT

IF LAST SYMPTOMS WAS 3 MONTHS TO 1 YEAR AGO (LASTSYMP = 4) PICK UP HERE, SYMPTOMS WITHIN THE PAST 3 MONTHS CONTINUE HERE AS WELL WELL
[BACKCODE SYMPFREE (4.4) TO 14 IF LASTSYMP = 88 (never) or = 04, 05, 06, or 07 OR IF SYMP_30D = 88] 8/06

READ: Asthma attacks, sometimes called episodes, refer to periods of worsening asthma symptoms that make you limit your activity more than you usually do, or make you seek medical care.

EPIS_12M (4.5) During the past 12 months' has {child's name} had an episode of asthma or an asthma attack?

(1) YES

(2) NO

in Section 5]

[SKIP TO INS1

(7) DON'T KNOW

in Section 5]

[SKIP TO INS1

(9) REFUSED

in Section 5]

[SKIP TO INS1

EPIS_TP (4.6)

During the past three months, how many asthma episodes or attacks has { he/she } had?

[RANGE CHECK: (001-100, 777, 888, 999)]

(888) NONE

(777) DON'T KNOW
(999) REFUSED

**[CATI CHECK: IF RESPONSE = 77, 88, 99 VERIFY THAT 777, 888
AND 999 WERE NOT THE INTENT]**

DUR_ASTH (4.7) How long did {his/her} most recent asthma episode or attack last?

- 1__ Minutes
- 2__ Hours
- 3__ Days
- 4__ Weeks
- 5 5 5 Never
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

Interviewer note:

If answer is #.5 to #.99 round up

If answer is #.01 to #.49 ignore fractional part

ex. 1.5 should be recorded as 2

1.25 should be recorded as 1

ADDED 12/15/05

COMPASTH (4.8) Compared with other episodes or attacks, was this most recent attack shorter, longer, or about the same?

- (1) SHORTER
- (2) LONGER
- (3) ABOUT THE SAME
- (4) THE MOST RECENT ATTACK WAS ACTUALLY THE FIRST ATTACK

- (7) DON'T KNOW
- (9) REFUSED

Section 5. Health Care Utilization

All respondents continue here:

INS1 (5.1) Does {child's name} have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Medicaid?

- | | |
|----------------|--------------------|
| (1) YES | [continue] |
| (2) NO | [SKIP TO FLU_SHOT] |
| (7) DON'T KNOW | [SKIP TO FLU_SHOT] |
| (9) REFUSED | [SKIP TO FLU_SHOT] |

INS_TYP (5.2) What kind of health care coverage does (he/she) have? Is it paid for through the parent's employer, or is it Medicaid, Medicare, Children's Health Insurance Program (CHIP), or some other type of insurance?

- (1) parent's employer
- (2) medicaid/medicare
- (3) CHIP {replace with state specific name}
- (4) Other

- (7) DON'T KNOW
- (9) REFUSED

INS2 (5.3) During the past 12 months was there any time that {he/she} did not have any health insurance or coverage?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

FLU_SHOT (5.4) A flu shot is an influenza vaccine injected in your arm. During the past 12 months, did {CHILD'S NAME} have a flu shot?

- (1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

FLU_SPRAY (5.5) A flu vaccine that is sprayed in the nose is called FluMist™. During the past 12 months, did { he/she } have a flu vaccine that was sprayed in his/her nose?

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

[IF SAMPLED PERSON DOES NOT CURRENTLY HAVE ASTHMA AND THEY ANSWERED “NEVER “ OR “MORE THAN ONE YEAR AGO” TO ALL THREE - SEEING A DOCTOR ABOUT ASTHMA, TAKING ASTHMA MEDICATION, AND SHOWING SYMPTOMS OF ASTHMA, SKIP TO HH_INT – Section 6]

ACT_DAYS (5.6) During the past 12 months, would you say {child's name} limited {his/her} usual activities due to asthma not at all, a little, a moderate amount, or a lot?

(1) NOT AT ALL

(2) A LITTLE

(3) A MODERATE AMOUNT

(4) A LOT

(7) DON'T KNOW

(9) REFUSED

NR_TIMES (5.7) [IF LAST_MD= 88, 05, 06, 07; SKIP TO Section 6 (have not seen a doctor in the past 12 months)]

During the past 12 months how many times did { he/she } see a doctor or other health professional for a routine checkup for {his/her} asthma?

__ __ __ ENTER NUMBER

[RANGE CHECK: (001-365, 777, 888, 999)] [Verify any value >50]

[CATI CHECK: IF RESPONSE = 77, 88, 99 VERIFY THAT 777, 888, AND 999 WERE NOT THE INTENT]

(888) NONE

(777) DON'T KNOW

(999) REFUSED

ER_VISIT (5.8) An urgent care center treats people with illnesses or injuries that must be addressed immediately and cannot wait for a regular medical appointment. During the past 12 months, has {child's name} had to visit an emergency room or urgent care center because of {his/her} asthma?

(1) YES
(2) NO [SKIP TO URG_TIME]

(7) DON'T KNOW [SKIP TO URG_TIME]
(9) REFUSED [SKIP TO URG_TIME]

ER_TIMES (5.9) During the past 12 months, how many times did {he/she} visit an emergency room or urgent care center because of {his/her} asthma?

__ __ __ ENTER NUMBER
[RANGE CHECK: (001-365, 777, 999)] [Verify any entry >50]

(777) DON'T KNOW
(999) REFUSED

[CATI CHECK: IF RESPONSE = 77, 99 VERIFY THAT 777 AND 999 WERE NOT THE INTENT]

[CATI CHECK: IF RESPONSE TO 5.8 IS "YES" AND RESPONDENT SAYS NONE OR ZERO TO 5.9 ALLOW LOOPING BACK TO CORRECT 5.8 TO "NO"]

ADDED 12/15/05

[HELP SCREEN: An urgent care center treats people with illnesses or injuries that must be addressed immediately and cannot wait for a regular medical appointment.]

URG_TIME (5.10) [IF ONE OR MORE ER VISITS (ER_VISIT (5.8) = 1) INSERT "Besides those emergency room or urgent care center visits,"]

During the past 12 months, how many times did {child's name} see a doctor or other health professional for urgent treatment of worsening asthma symptoms or an asthma episode or attack?

__ __ __ ENTER NUMBER
[RANGE CHECK: (001-365, 777, 888, 999)] [Verify any entry >50]

(888) NONE

(777) DON'T KNOW
(999) REFUSED

[CATI CHECK: IF RESPONSE = 77, 88, 99 VERIFY THAT 777, 888 AND 999 WERE NOT THE INTENT]

[HELP SCREEN: An urgent care center treats people with illnesses or injuries that must be addressed immediately and cannot wait for a regular medical appointment.]

HOSP_VST (5.11)

During the past 12 months, that is since [1 YEAR AGO TODAY], has {child's name} had to stay overnight in a hospital because of {his/her} asthma? Do not include an overnight stay in the emergency room.

(1) YES

(2) NO

[SKIP TO Section 6]

(7) DON'T KNOW

[SKIP TO Section 6]

(9) REFUSED

[SKIP TO Section 6]

HOSPTIME (5.12)

During the past 12 months, how many different times did {he/she} stay in any hospital overnight or longer because of {his/her} asthma?

__ __ __ TIMES

[RANGE CHECK: (001-365, 777, 999)] [Verify any entry >50]

(777) DON'T KNOW

(999) REFUSED

[CATI CHECK: IF RESPONSE = 77, 99 VERIFY THAT 777 AND 999 WERE NOT THE INTENT]

HOSPPLAN (5.13)

The last time {he/she} left the hospital, did a health professional talk with you or {child's name} about how to prevent serious attacks in the future?

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

[HELP SCREEN: Health professional includes doctors, nurses, physician assistants, nurse practitioners, and health educators]

Section 6. Knowledge of Asthma/Management Plan

TCH_SIGN (6.1) Has a doctor or other health professional ever taught you or {child's name}....

a. How to recognize early signs or symptoms of an asthma episode?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

TCH_RESP (6.2) Has a doctor or other health professional ever taught you or {child's name}....

b. What to do during an asthma episode or attack?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

TCH_MON (6.3) A peak flow meter is a hand held device that measures how quickly you can blow air out of your lungs. Has a doctor or other health professional ever taught you or {child's name}....

c. How to use a peak flow meter to adjust **his/her** daily medications?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

MGT_PLAN (6.4) An asthma action plan, or asthma management plan, is a form with instructions about when to change the amount or type of medicine, when to call the doctor for advice, and when to go to the emergency room.

Has a doctor or other health professional EVER given you or {child's name}....an asthma action plan?

[HELP SCREEN: Health professional includes doctors, nurses, physician assistants, nurse practitioners, and health educators]

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

MGT_CLAS (6.5) Have you or {child's name} ever taken a course or class on how to manage {his/her} asthma?

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

Section 7. Modifications to Environment

HH_INT **READ:** The following questions are about {child's name} household and living environment. I will be asking about various things that may be related to experiencing symptoms of asthma.

AIRCLEANER (7.1) **An air cleaner or air purifier can filter out pollutants like dust, pollen, mold and chemicals. It can be attached to the furnace or free standing. It is not, however, the same as a normal furnace filter.**

home? **Is an air cleaner or purifier regularly used inside {child's name}**

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

DEHUMID (7.2) **Is a dehumidifier regularly used to reduce moisture inside {his/her**
home?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

KITC_FAN (7.3) **Is an exhaust fan that vents to the outside used regularly when**
cooking in the kitchen in {his/her } home?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

COOK_GAS (7.4) **Is gas used for cooking in {his/her } home?**

- (1) Yes
- (2) NO

- (7) DON'T KNOW

(9) REFUSED

ENV_MOLD (7.5) In the past 30 days, has anyone seen or smelled mold or a musty odor inside in {his/her} home? Do not include mold on food.

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

ENV_PETS (7.6) Does {child's name} home have pets such as dogs, cats, hamsters, birds or other feathered or furry pets that spend time indoors?

(1) YES

(2) NO (SKIP TO 7.8)

(7) DON'T KNOW (SKIP TO 7.8)

(9) REFUSED (SKIP TO 7.8)

PETBEDRM (7.7) Is the pet allowed in {his/her} bedroom?

[SKIP THIS QUESTION IF ENV_PETS = 2, 7, 9]

(1) YES

(2) NO

(3) SOME ARE/SOME AREN'T

(7) DON'T KNOW

(9) REFUSED

C_ROACH (7.8) In the past 30 days, has anyone seen cockroaches inside {child's name} home?

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

[HELP SCREEN: Studies have shown that cockroaches may be a cause of asthma. Cockroach droppings and carcasses can also cause symptoms of asthma.]

C_RODENT (7.9) In the past 30 days, has anyone seen mice or rats inside {his/her} home? Do not include mice or rats kept as pets.

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

[HELP SCREEN: Studies have shown that rodents may be a cause of asthma.]

WOOD_STOVE (7.10) Is a wood burning fireplace or wood burning stove used in {child's name} home?

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

HELP SCREEN: OCCASIONAL USE SHOULD BE CODED AS "YES".

GAS_STOVE (7.11) Are unvented gas logs, unvented gas fireplaces, or unvented gas stoves used in {his/her} home?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

[**HELP SCREEN:** “Unvented” means no chimney or the chimney flue is kept closed during operation.]

S_INSIDE (7.12) In the past week, has anyone smoked inside {his/her} home?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

HELP SCREEN: “The intent of this question is to measure smoke resulting from tobacco products (cigarettes, cigars, pipes) or illicit drugs (cannibus, marijuana) delivered by smoking (inhaling intentionally). Do not include things like smoke from incense, candles, or fireplaces, etc.”

MOD_ENV (7.13) **INTERVIEWER READ:** Now, back to questions specifically about {child's name}.

Has a health professional ever advised you to change things in {his/her} home, school, or work to improve his/her asthma?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

[**HELP SCREEN:** Health professional includes doctors, nurses, physician assistants, nurse practitioners, and health educators]

MATTRESS (7.14) Does {he/she} use a mattress cover that is made especially for controlling dust mites?

[**INTERVIEWER:** If needed: This does not include normal mattress covers used for padding or sanitation (wetting). These covers are for the purpose of controlling allergens (like dust mites) from inhabiting the mattress. They are made of special fabric, entirely enclose the mattress, and have zippers.]

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

E_PILLOW (7.15) Does { **he/she** } use a pillow cover that is made especially for controlling dust mites?

[INTERVIEWER: If needed: This does not include normal pillow covers used for fabric protection. These covers are for the purpose of controlling allergens (like dust mites) from inhabiting the pillow. They are made of special fabric, entirely enclose the pillow, and have zippers.]

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

CARPET (7.16) Does {child's name} have carpeting or rugs in {his/her} bedroom?
This does not include throw rugs small enough to be laundered.

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

HOTWATER (7.17) Are { **his/her** } sheets and pillowcases washed in cold, warm, or hot water?

- (1) COLD
- (2) WARM
- (3) HOT

- DO NOT READ**
- (4) VARIES

- (7) DON'T KNOW
- (9) REFUSED

BATH_FAN (7.18) In {child's name} bathroom, does {he/she} regularly use an exhaust fan that vents to the outside?

- (1) YES
- (2) NO OR "NO FAN"

- (7) DON'T KNOW
- (9) REFUSED

HELP SCREEN: IF RESPONDENT INDICATES THEY HAVE MORE THAN ONE BATHROOM, THIS QUESTION REFERS TO THE BATHROOM THE CHILD USES MOST FREQUENTLY FOR SHOWERING AND BATHING.

Section 8. Medications

OTC (8.1) [IF LAST_MED = 88 (NEVER), SKIP TO SECTION 9. ELSE,
CONTINUE.]

The next set of questions is about medications for asthma. The first few questions are very general, but later questions are very specific to {child's name} medication use.

Over-the-counter medication can be bought without a doctor's order. Has {child's name} ever used over-the-counter medication for {his/her} asthma?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

INHALERE (8.2) Has {he/she} ever used a prescription inhaler?

- (1) YES
- (2) NO [SKIP TO SCR_MED1]

- (7) DON'T KNOW [SKIP TO SCR_MED1]
- (9) REFUSED [SKIP TO SCR_MED1]

INHALERH (8.3) Did a health professional show {him/her} how to use the inhaler?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

[HELP SCREEN: Health professional includes doctors, nurses, physician assistants, nurse practitioners, and health educators]

INHALERW (8.4) Did a doctor or other health professional watch {him/her} use the inhaler?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

SCR_MED1 (8.5)

[IF LAST_MED = 88, 4, 5, 6, 7, 77, or 99, SKIP TO SECTION 9] ~~struck 12/06~~

Now I am going to ask questions about specific prescription medications {child's name} may have taken for asthma in the past 3 months. I will be asking for the names, amount, and how often {he/she} takes each medicine. I will ask separately about medication taken in various forms: pill or syrup, inhaler, and Nebulizer.

It will help to get {child's name} medicines so you can read the labels. ~~Are {child's name} asthma medicines handy?~~ changed 1/5/06

Can you please go get the asthma medicines while I wait on the phone?

(1) YES

(2) NO

[SKIP TO INH_SCR]

(3) RESPONDENT KNOWS THE MEDS

[SKIP TO INH_SCR]

(7) DON'T KNOW

[SKIP TO INH_SCR]

(9) REFUSED

[SKIP TO INH_SCR]

~~SCR_MED2 (8.6)~~

~~[Leave field in data file layout for 8.6 blank]~~

~~changed 1/5/06~~

~~[INTERVIEWER: Read if necessary]~~

~~(1) YES~~

~~(2) NO [SKIP TO INH_SCR]~~

~~(7) DON'T KNOW [SKIP TO INH_SCR]~~

~~(9) REFUSED [SKIP TO INH_SCR]~~

SCR_MED3 (8.7)

[when Respondent returns to phone:] Am I correct that Do you have all the medications?

changed 1/5/06

[INTERVIEWER: Read if necessary]

(1) YES I HAVE ALL THE MEDICATIONS

(2) YES I HAVE SOME OF THE MEDICATIONS BUT NOT ALL

(3) NO

(7) DON'T KNOW

(9) REFUSED

INH_SCR (8.8)

[IF INHALERE (8.2) = 2 (NO) SKIP TO PILLS]

In the past 3 months has {child's name} taken prescription asthma medicine using an inhaler?

(1) YES

(2) NO

[SKIP TO PILLS]

(7) DON'T KNOW

[SKIP TO PILLS]

(9) REFUSED

[SKIP TO PILLS]

INH_MEDS (8.9)

In the past 3 months, what **prescription asthma** medications did { **he/she** } take by inhaler? [MARK ALL THAT APPLY. PROBE: Any other **prescription asthma** inhaler medications?]

[INTERVIEWER: IF NECESSARY, ASK THE RESPONDENT TO SPELL THE NAME OF THE MEDICATION.]

	Brand Name	Type (not shown in CATI)
01	Advair (17 + 26)	combination
02	Aerobid (16)	corticosteroid
03	<u>Albuterol</u>	beta 2 agonist (Short-Acting)
04	Alupent (21)	beta 2 agonist (Short-Acting)
05	Atrovent (19)	anti-cholinergic
06	Azmacort (31)	corticosteroid
07	<u>Beclomethasone dipropionate</u>	corticosteroid
08	Beclovent (07)	corticosteroid
09	<u>Bitolterol</u>	beta 2 agonist (Short-Acting)
10	Brethaire (28)	beta 2 agonist (Short-Acting)
11	<u>Budesonide</u>	corticosteroid
12	Combivent (19 + 03)	combination
13	<u>Cromolyn</u>	anti-inflammatory
14	Flovent (17)	inhaled corticosteroid
15	Flovent Rotadisk (17)	inhaled corticosteroid
16	<u>Flunisolide</u>	corticosteroid
17	<u>Fluticasone</u>	inhaled corticosteroid
34	Foradil (35)	beta 2 agonist (Long-acting)
35	<u>Formoterol</u>	beta 2 agonist (Long-acting)
18	Intal (13)	anti-inflammatory
19	<u>Ipratropium Bromide</u>	anti-cholinergic
20	Maxair (23)	beta 2 agonist (Short-Acting)
21	<u>Metaproteronol</u>	beta 2 agonist (Short-Acting)
22	<u>Nedocromil</u>	anti-inflammatory
23	<u>Pirbuterol</u>	beta 2 agonist (Short-Acting)
24	Proventil (03)	beta 2 agonist (Short-Acting)
25	Pulmicort Turbuhaler (11)	corticosteroid
36	QVAR (07)	inhaled corticosteroid
26	<u>Salmeterol</u>	beta 2 agonist (Long-acting)
27	Serevent (26)	beta 2 agonist (Long-acting)
28	<u>Terbutaline</u>	beta 2 agonist (Short-Acting)
29	Tilade (22)	anti-inflammatory
30	Tornalate (09)	beta 2 agonist (Short-Acting)
31	<u>Triamcinolone acetonide</u>	corticosteroid
32	Vanceril (08)	corticosteroid
33	Ventolin (03)	beta 2 agonist (Short-Acting)

66	Other, Please Specify	[SKIP TO OTH_I1]
----	-----------------------	------------------

[IF RESPONDENT SELECTS ANY ANSWER <66, SKIP TO ILP01]

(88) NO PRESCRIPTION INHALERS [SKIP TO PILLS]

(77) DON'T KNOW [SKIP TO PILLS]

(99) REFUSED [SKIP TO PILLS]

[100 ALPHANUMERIC CHARACTER LIMIT FOR 48]

OTH_I1 (8.10) ENTER OTHER MEDICATION FROM (8.9) IN TEXT FIELD
IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE
LINE.

[LOOP BACK TO ILP01 AS NECESSARY TO ADMINSTER QUESTIONS ILP01 THRU
ILP10 FOR EACH MEDICINE REPORTED IN INH_MEDS

[FOR FILL [MEDICINE FROM INH_MEDS SERIES] FOR QUESTIONS ILP01
THROUGH ILP10]

[IF {MEDICINE FROM INH_MEDS SERIES} IS 03, 04, 21, 24, OR 33 ASK ILP01 ELSE SKIP TO ILP02

ILP01 (8.11) Are there 80, 100, or 200 puffs in the [MEDICINE FROM INH_MEDS
SERIES] inhaler that {he/she} uses?

[INTERVIEWER: A puff is a single inhalation or a single dose. Inhalers
sometimes say "100 metered doses". Instructions are to use 2-3 inhalations (doses, puffs)
each time. The 80 puff canister may say 6.8 g. **The 100 puff canister may say 9 g and
the 200 puff canister may say 17 g. or 18 g. depending on the brand being used. If it
says 90 mcg (micrograms) it is referring to the individual puff, not the size of the
canister]**

clarified 6/2006

- (1) 80 PUFFS
- (2) 100 PUFFS
- (3) 200 PUFFS
- (4) Other number of puffs
- (5) USED DIFFERENT SIZES OF THIS MEDICATION IN PAST 3 MONTHS

(7) DON'T KNOW

(9) REFUSED

ILP02 (8.12) How long has{child's name} been taking [MEDICINE FROM INH_MEDS
SERIES]? Would you say less than 6 months, 6 months to 1 year, or longer
than 1 year.

- (1) Less than 6 months

- (2) 6 months to 1 year
- (3) Longer than 1 year

- (7) DON'T KNOW
- (9) REFUSED

IF [MEDICINE FROM INH_MEDS SERIES] IS ADVAIR (01) OR FLOVENT ROTADISK (15) SKIP TO 8.14

ILP03 (8.13) A spacer is a small attachment for an inhaler that makes it easier to use. Does { he/she } use a spacer with [MEDICINE FROM INH_MEDS SERIES]?

- (1) YES
- (2) NO
- (3) Medication is a disk inhaler not a canister inhaler
- (7) DON'T KNOW
- (9) REFUSED

[HELP SCREEN: A spacer is a device that attaches to a metered dose inhaler. It holds the medicine in its chamber long enough for you to inhale it in one or two slow, deep breaths. The spacer makes it easy to take the medicines the right way.]

[HELP SCREEN: The response category 3 (disk not canister) is primarily intended for medications Serevent (27), Salmeterol (26) and Flovent (14) which are known to come in disk type inhalers (which do not use a spacer). However, new medications may come on the market that will need this category so it can be used for other than 14, 26, and 27.]

ILP04 (8.14) In the past 3 months, did {child's name} take [MEDICINE FROM INH_MEDS SERIES] when he/she had an asthma episode or attack?

- (1) YES
- (2) NO
- (3) NO ATTACK IN PAST 3 MONTHS

- (7) DON'T KNOW
- (9) REFUSED

ILP05 (8.15) In the past 3 months, did { he/she } take [MEDICINE FROM INH_MEDS SERIES] before exercising?

- (1) YES
- (2) NO
- (3) DIDN'T EXERCISE IN PAST 3 MONTHS

- (7) DON'T KNOW
- (9) REFUSED

ILP06 (8.16) In the past 3 months, did { he/she } take [MEDICINE FROM INH_MEDS SERIES] on a regular schedule everyday?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

ILP07 (8.17) On average, how many puffs did { he/she } take each time he/she used [MEDICINE FROM INH_MEDS SERIES]?

__ __ PUFFS EACH TIME
[RANGE CHECK: (01-76, 77, 99)]

- (77) DON'T KNOW
- (99) REFUSED

INTERVIEWER: PROBE FOR NUMBER OF PUFFS IF RANGE IS GIVEN.

ILP08 (8.18) How many times per day or per week did { he/she } use [MEDICINE FROM INH_MEDS SERIES]?

3 __ Days

4 __ Weeks
5 5 5 Never
6 6 6 LESS OFTEN THAN ONCE A WEEK

7 7 7 Don't know / Not sure
9 9 9 Refused

[ASK ILP10 ONLY IF INH_MEDS = 3, 4, 9, 10, 20, 21, 23, 24, 28, 30, 33, OTHERWISE SKIP TO PILLS (8.20)]

ILP10 (8.19) How many canisters of [MEDICINE FROM INH_MEDS SERIES] has {child's name} used in the past 3 months?

[INTERVIEWER: IF RESPONDENT USED LESS THAN ONE FULL CANISTER IN THE PAST THREE MONTHS, CODE IT AS '88']

__ CANISTERS

(77) DON'T KNOW

(88) NONE

(99) REFUSED

[RANGE CHECK: (01-76, 77, 88, 99)]

[HELP SCREEN: IF RESPONDENT INDICATES THAT <CHILD> HAS MULTIPLE CANISTERS, (I.E., ONE IN THE CAR, ONE AT SCHOOL, ETC.) ASK THE RESPONDENT TO ESTIMATE HOW MANY FULL CANISTERS HE/SHE USED. THE INTENT IS TO ESTIMATE HOW MUCH MEDICATION IS USED, NOT HOW MANY DIFFERNT INHALERS.]

PILLS (8.20) In the past 3 months, has {he/she} taken any prescription medicine in pill form for his/her asthma?

(1) YES

(2) NO

[SKIP TO SYRUP]

(7) DON'T KNOW

[SKIP TO SYRUP]

(9) REFUSED

[SKIP TO SYRUP]

PILLS_MD (8.21) What **prescription asthma** medications does {**child's name**} take in pill form?

[MARK ALL THAT APPLY. PROBE: Any other **prescription asthma** pills?]

[INTERVIEWER: IF NECESSARY, ASK THE RESPONDENT TO SPELL THE NAME OF THE MEDICATION.]

	Medication	Type not shown in CATI)
01	Accolate	Leukotriene Modifier
02	Aerolate	Methylxanthine
03	<u>Albuterol</u>	Beta 2 agonist – Rescue Bronchodilator
04	Alupent	Beta 2 agonist – Rescue Bronchodilator
05	choledyl	Methylxanthins
06		
07	Deltasone	Corticosteriod
08	Elixophyllin	Methylxanthine
09		
10	Marax	Methylxanthine
11	Medrol	Corticosteriod
12	Metaprel	Beta 2 agonist – Rescue Bronchodilator
13	<u>Metaproteronol</u>	Beta 2 agonist – Rescue Bronchodilator
14	<u>Methylpredinisol one</u>	Corticosteriod
15	<u>Montelukast</u>	Leukotriene Modifier
16		
17	Pediapred	Corticosteriod
18	<u>Prednisolone</u>	Corticosteriod
19	<u>Prednisone</u>	Corticosteriod
20	Prelone	Corticosteriod
21	Proventil	Beta 2 agonist – Rescue Bronchodilator
22	Quibron	Methylxanthine
23	Respid	Methylxanthine
24	Singulair	Leukotriene Modifier
25	Slo-phyllin	Methylxanthine
26	Slo-bid	Methylxanthine
27	Sustaire	Methylxanthine
28	Theo-24	Methylxanthine
29	Theobid	Methylxanthine
30	Theochron	Methylxanthine
31	Theoclear	Methylxanthine
32	Theodur	Methylxanthine
33	Theo-Dur	Methylxanthine
34	Theolair	Methylxanthine
35	<u>Theophylline</u>	Methylxanthine
36	Theo-Sav	Methylxanthine
37	Theospan	Methylxanthine

38	Theox	Methylxanthine
39		
40	T-Phyl	Methylxanthine
41	Unidur	Methylxanthine
42	Uniphyl	Methylxanthine
43	Ventolin	Beta 2 agonist – Rescue Bronchodilator
44	Volmax	Beta 2 agonist – Rescue Bronchodilator
45	Zafirlukast	Leukotriene Modifier
46	Zileuton	Leukotriene Modifier
47	Zyflo Filmtab	Leukotriene Modifier
66	Other, Please Specify: [SKIP TO OTH_P1]	

[IF RESPONDENT SELECTS ANY ANSWER FROM 01-47, SKIP TO PILLX]

(88) NO PILLS

[SKIP TO SYRUP]

(77) DON'T KNOW

[SKIP TO SYRUP]

(99) REFUSED

[SKIP TO SYRUP]

[100 ALPHANUMERIC CHARACTER LIMIT FOR 48]

OTH_P1

ENTER OTHER MEDICATION IN TEXT FIELD

IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.

[REPEAT QUESTION PILLX AS NECESSARY FOR EACH PILL REPORTED IN PILLS_MD FOR FILL [MEDICATION LISTED IN PILLS_MD] FOR QUESTION PILLX]

**PILLX (8.22)
PILLS_MD]?**

How long has{child's name} been taking [MEDICATION LISTED IN

(1) Less than 6 months

(2) 6 months to 1 year

(3) Longer than 1 year

(7) DON'T KNOW

(9) REFUSED

SYRUP (8.23)
syrup form?

In the past 3 months, has { **he/she** } taken prescription medicine in

(1) YES

(2) NO

[SKIP TO

NEB_SCR]

(7) DON'T KNOW

[SKIP TO

NEB_SCR]

(9) REFUSED

[SKIP TO

NEB_SCR]

SYRUP_ID (8.24)

What prescription **asthma** medications has {**child's name**} taken as a syrup? [MARK ALL THAT APPLY. PROBE: Any other **prescription syrup medications for asthma?**]

[INTERVIEWER: IF NECESSARY, ASK THE RESPONDENT TO SPELL THE NAME OF THE MEDICATION.]

	Medication
01	Aerolate (09)
02	<u>Albuterol</u>
03	Alupent (04)
04	<u>Metaproteronol</u>
05	<u>Prednisolone</u>
06	Prelone (05)
07	Proventil (02)
08	Slo-Phyllin (09)
09	<u>Theophylline</u>
10	Ventolin (02)
66	Other, Please Specify: [SKIP TO OTH_S1]

[IF RESPONDENT SELECTS ANY ANSWER FROM 01-10, SKIP TO NEB_SCR]

(88) NO PILLS

[SKIP TO NEB_SCR]

(77) DON'T KNOW

[SKIP TO NEB_SCR]

(99) REFUSED

[SKIP TO NEB_SCR]

OTH_S1

[100 ALPHANUMERIC CHARACTER LIMIT FOR 11]

ENTER OTHER MEDICATION.

IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.

NEB_SCR (8. 25) A nebulizer is a small machine with a tube and facemask or mouthpiece that you breathe through continuously. In the past 3 months, were any of {child's name} **prescription** asthma medicines used with a nebulizer?

- (1) YES
- (2) NO [SKIP TO Section 9]
- (7) DON'T KNOW [SKIP TO Section 9]
- (9) REFUSED [SKIP TO Section 9]

NEB_PLC(8. 26) I am going to read a list of places where your child might have used a nebulizer. Please answer yes if your child has used a nebulizer in the place I mention, otherwise answer no. In the past 3 months did {child's name} use a nebulizer ...

- (8.26a) (1) AT HOME YES NO DK
- (8.26b) (2) AT A DOCTOR'S OFFICE YES NO DK
- (8.26c) (3) IN AN EMERGENCY ROOM YES NO DK
- (8.26d) (4) AT WORK OR AT SCHOOL YES NO DK
- (8.26e) (5) AT ANY OTHER PLACE YES NO DK

NEB_ID (8.27) In the past 3 months, what prescription **asthma** medications has {he/she} taken using a nebulizer?

[INTERVIEWER: IF NECESSARY, ASK THE RESPONDENT TO SPELL THE NAME OF THE MEDICATION.]

[MARK ALL THAT APPLY. PROBE: Has your child taken any other prescription **asthma** medications with a nebulizer in the past 3 months?]

	Medication
01	<u>Albuterol</u>
02	Alupent (11)
03	Atrovent (09)
04	<u>Bitolterol</u>
05	<u>Budesonide</u>
06	<u>Cromolyn</u>
07	Duoneb (01 + 09)
08	Intal (06)
09	<u>Ipratropium bromide</u>
10	<u>Levalbuterol</u>
11	<u>Metaproteronol</u>
12	Proventil (01)
13	Pulmicort (05)

14	Tornalate (04)
15	Ventolin (01)
16	Xopenex (10)
66	Other, Please Specify: [SKIP TO OTH_N1]

(88) NONE

[SKIP TO Section 9]

(77) DON'T KNOW

[SKIP TO Section 9]

(99) REFUSED

[SKIP TO Section 9]

OTH_N1

**ENTER OTHER MEDICATION
IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE
LINE.**

Section 9. Cost of Care

If No to “still” from BRFSS core or CUR_ASTH (2.2) = 2 [or either are missing] skip to section 10

If Yes to “still” from BRFSS core or CUR_ASTH (2.2) = 1, continue

Added 12/15/05

If No, DK, or Refused to “still” from BRFSS core [or to CUR_ASTH (2.2)] skip to section 10

If Yes to “still” from BRFSS core [or CUR_ASTH (2.2)] continue

Clarification 6/06

ASMDCOST (9.1) Was there a time in the past 12 months when {child’s name} needed to see his/her primary care doctor for asthma but could not because of the cost?

- (1) YES
- (2) NO

- (7) DON’T KNOW
- (9) REFUSED

ASSPCOST (9.2) Was there a time in the past 12 months when you were referred to a specialist for {his/her} asthma care but could not go because of the cost?

- (1) YES
- (2) NO

- (7) DON’T KNOW
- (9) REFUSED

ASRXCOST (9.3) Was there a time in the past 12 months when {he/she} needed medication for his/her asthma but you could not buy it because of the cost?

- (1) YES
- (2) NO

- (7) DON’T KNOW
- (9) REFUSED

Section 10. School Related Asthma

SCH_STAT (10.1) Next, we are interested in things that might affect {child's name} asthma when he/she is not at home.

Does {child's name} currently go to school or pre school outside the home?

- (1) YES [SKIP TO SCHGRADE]
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

NO_SCHL (10.2) What is the main reason { he/she } is not now in school? READ RESPONSE CATEGORIES

- (1) NOT OLD ENOUGH [SKIP TO DAYCARE]
- (2) HOME SCHOOLED [SKIP TO SCHGRADE]
- (3) UNABLE TO ATTEND FOR HEALTH REASONS
- (4) ON VACATION OR BREAK
- (5) OTHER

- (7) DON'T KNOW
- (9) REFUSED

SCHL_12 (10.3) Has {child's name} gone to school in the past 12 months?

- (1) YES
- (2) NO [SKIP TO DAYCARE]

- (7) DON'T KNOW [SKIP TO DAYCARE]
- (9) REFUSED [SKIP TO DAYCARE]

SCHGRADE (10.4) [IF SCHL_12 = 1]
What grade was { he/she } in the last time he/she was in school?

[IF SCH_STAT = 1 OR NO_SCHL = 2]
What grade is { he/she } in?

- (88) PRE SCHOOL
- (66) KINDERGARDEN
- __ __ ENTER GRADE 1 TO 12

(77) DON'T KNOW
(99) REFUSED

If **No** to “still” from BRFSS core or CUR_ASTH (2.2) = 2 [or either are missing] skip to 10.8

If **Yes** to “still” from BRFSS core or CUR_ASTH (2.2) = 1, continue

Added 12/15/05

If **No, DK, or Refused** to “still” from BRFSS core [or to CUR_ASTH (2.2)] skip to Q10.8

If **Yes** to “still” from BRFSS core [or CUR_ASTH (2.2)] continue

Clarification 6/06

MISS_SCHL (10.5) During the past 12 months, about how many days of school did {he/she} miss because of {his/her} asthma?

___ __ _ ENTER NUMBER DAYS

[3 NUMERIC-CHARACTER-FIELD, RANGE CHECK: (001-365, 777, 888, 999)] [Verify any entry >50]

[DISPLAY THE THREE POSSIBILITIES BELOW ON THE CATI SCREEN FOR THIS QUESTION TO ASSIST THE INTERVIEWER]

(888) ZERO

(777) DON'T KNOW

(999) REFUSED

[CATI CHECK: IF RESPONSE = 77, 88, 99 VERIFY THAT 777, 888 AND 999 WERE NOT THE INTENT]

[IF NO_SCHL = 2 (HOME SCHOOLED) SKIP TO SECTION 11]

[IF SCHL_12 (10.3) = 1 READ ‘PLEASE ANSWER THESE NEXT FEW QUESTIONS ABOUT THE SCHOOL {CHILD’S NAME} WENT TO LAST]

SCH_APL (10.6) Earlier I explained that an asthma action plan contains instructions about how to care for the child’s asthma.

Does {child’s name} have a written asthma action plan or asthma management plan on file at school?

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

SCH_MED (10.7) Does the school { **he/she** } goes to allow children with asthma to carry their medication with them while at school?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

SCH_ANML (10.8) Are there any pets such as dogs, cats, hamsters, birds or other feathered or furry pets in { **his/her** } CLASSROOM?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

SCH_MOLD (10.9) Are you aware of any mold problems in {child's name} school?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

DAYCARE (10.10) [IF CHLDAGE2 > 10 SKIP TO SECTION 11]
Does {child's name} go to day care outside his/her home?

- (1) YES [SKIP TO **DCARE_APL**] should be
MISS_DCAR
- (2) NO changed
1/3/06

- (7) DON'T KNOW [SKIP TO SECTION 11]
- (9) REFUSED [SKIP TO SECTION 11]

DAYCARE1 (10.11) Has { **he/she** } gone to daycare in the past 12 months?

- (1) YES
- (2) NO [SKIP TO SECTION 11]

- (7) DON'T KNOW [SKIP TO SECTION 11]
- (9) REFUSED [SKIP TO SECTION 11]

MISS_DCAR (10.12) **If No to “still” from BRFSS core or CUR_ASTH (2.2) = 2 [or either are missing] skip to 10.14**
If Yes to “still” from BRFSS core or CUR_ASTH (2.2) = 1, continue
Added 12/15/05

(2.2)] **If No, DK, or Refused to “still” from BRFSS core [or to CUR_ASTH**
skip to Q 10.14

If Yes to “still” from BRFSS core [or CUR_ASTH (2.2)] continue
Clarification 6/06

During the past 12 months, about how many days of daycare did { he/she } miss because of { his/her } asthma?

__ __ __ ENTER NUMBER DAYS
[3 NUMERIC-CHARACTER-FIELD, RANGE CHECK: (001-365, 777, 888, 999)] [Verify any entry >50]

[DISPLAY THE THREE POSSIBILITIES BELOW ON THE CATI SCREEN FOR THIS QUESTION TO ASSIST THE INTERVIEWER]

(888) ZERO

(777) DON'T KNOW

(999) REFUSED

[CATI CHECK: IF RESPONSE = 77, 88, 99 VERIFY THAT 777, 888 AND 999 WERE NOT THE INTENT]

DCARE_APL (10.13) **[IF DAYCARE1 (10.11) = YES (1) THEN READ: “Please answer these next few questions about the daycare { child’s name } went to last. “**

Does { child’s name } have a written asthma action plan or asthma management plan on file at daycare?

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

DCARE_ANML(10.14) **Are there any**
pets such as dogs, cats, hamsters, birds or other feathered or furry
pets in { his/her } room at daycare?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

DCARE_MLD (10.15)
aware of any mold problems in { his/her } daycare?

Are you

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

DCARE_SMK (10.16) Is smoking allowed at { his/her } daycare?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

Section 11. Complimentary and Alternative Therapy

If **No** to “still” from BRFSS core or CUR_ASTH (2.2) = 2 [or either are missing] skip to section 12

If **Yes** to “still” from BRFSS core or CUR_ASTH (2.2) = 1 continue

Added 12/15/05

If **No, DK, or Refused** to “still” from BRFSS core [or to CUR_ASTH (2.2)] skip to section 12

If **Yes** to “still” from BRFSS core [or CUR_ASTH (2.2)] continue

Clarification 6/06

READ: Sometimes people use methods other than prescription medications to help treat or control their asthma. These methods are called non-traditional, complementary, or alternative health care. I am going to read a list of these alternative methods. For each one I mention, please answer “yes” if {child’s name} has used it to control asthma in the past 12 months. Answer “no” if {he/she} has not used it in the past 12 months.

In the past 12 months, has { he/she } used ... to control asthma?
[interviewer: repeat prior phrasing as needed]

CAM_HERB (11.1)	herbs	(1) YES	(2) NO	(7) DK (9) REF
CAM_VITA (11.2)	vitamins	(1) YES	(2) NO	(7) DK (9) REF
CAM_PUNC (11.3)	acupuncture	(1) YES	(2) NO	(7) DK (9) REF
CAM_PRES (11.4)	acupressure	(1) YES	(2) NO	(7) DK (9) REF
CAM_AROM (11.5)	aromatherapy	(1) YES	(2) NO	(7) DK (9) REF
CAM_HOME (11.6)	homeopathy	(1) YES	(2) NO	(7) DK (9) REF
CAM_REFL (11.7)	reflexology	(1) YES	(2) NO	(7) DK (9) REF
CAM_YOGA (11.8)	yoga	(1) YES	(2) NO	(7) DK (9) REF
CAM_BR (11.9)	breathing techniques	(1) YES	(2) NO	(7) DK (9) REF
CAM_NATR (11.10)	naturopathy	(1) YES	(2) NO	(7) DK (9) REF

[INTERVIEWER: If respondent does not recognize the term “naturopathy” the response should be no”]

[HELP SCREEN: Naturopathy (nay-chur-o-PATH-ee) is an alternative treatment based on the principle that there is a healing power in the body that establishes, maintains, and restores health. Naturopaths prescribe treatments such as nutrition and lifestyle counseling, dietary supplements, medicinal plants, exercise, homeopathy, and treatments from traditional Chinese medicine.]

CAM_OTHR (11.11) Besides the types I have just asked about, has {child's name} used any other type of alternative care for asthma in the past 12 months?

- (1) YES
- (2) NO [SKIP TO SECTION 12]
- (7) DON'T KNOW [SKIP TO SECTION 12]
- (9) REFUSED [SKIP TO SECTION 12]

CAM_TEXT (11.13) What else has {he/she} used?

[100 ALPHANUMERIC CHARACTER LIMIT FOR 48]

**ENTER OTHER ALTERNATIVE MEDICINE IN TEXT FIELD
IF MORE THAN ONE IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.**

Section 12. Additional Child Demographics

READ "I have just a few more questions about {child's name}."

HEIGHT1 (12.1)

How tall is {child's name}?

[INTERVIEWER: if needed: Ask the respondent to give their best guess.]

__ __ __ __ = Height (ft/inches)
7 7 7 7 = Don't know/Not sure
9 9 9 9 = Refused

If respondent answers in metric, put "9" in the first space, otherwise the first space is left blank.

Examples:

24 inches = 200 (2 feet)	30 inches = 206 (2 feet 6 inches),
36 inches = 300 (3 feet)	40 inches = 304 (3 feet 4 inches),
48 inches = 400 (4 feet)	50 inches = 402 (4 feet 2 inches),
60 inches = 500 (5 feet)	65 inches = 505 (5 feet 5 inches),
6 feet = 600 (6 feet, zero inches)	
5'3" = 503 (5 feet, 3 inches)	

VALUES OF GREATER THAN 8 FEET 11 INCHES OR 250 CENTIMETERS SHOULD NOT BE ALLOWED, VALUE RANGE FOR INCHES 00-11.

HELP SCREEN: WE ARE INTERESTED IN LOOKING AT HOW HEIGHT AND WEIGHT MAY BE RELATED TO ASTHMA.

WEIGHT1 (12.2)

How much does {he/she} weigh?

[INTERVIEWER: if needed: Ask the respondent to give their best guess.]

__ __ __ __	Weight (pounds/kilograms)
7 7 7 7	Don't know / Not sure
9 9 9 9	Refused

For pounds from left to right, positions one will hold a leading zero, two to four will hold the value of pounds.

For kilograms from left to right, position one will hold a leading nine, two to four will hold the value of kilograms.

[VALUES OF GREATER THAN 500 POUNDS OR 230 KILOGRAMS SHOULD NOT BE ALLOWED]]

HELP SCREEN: WE ARE INTERESTED IN LOOKING AT HOW HEIGHT AND WEIGHT MAY BE RELATED TO ASTHMA.

BIRTHW1 (12.3)

How much did { he/she } weigh at birth (in pounds)?

-----	Weight (pounds/kilograms)
777777	Don't know / Not sure
999999	Refused

For pounds and ounces from left to right, positions one and two will hold two leading zeros, three and four will hold the value of pounds from 0 to 30 and the last two columns will hold 00 to 15 ounces.

For kilograms and grams from left to right, position one will hold a leading nine, two and three will hold the value of kilograms 1-30 and the last three positions will hold the number of grams.

[VALUES OF GREATER THAN 30 POUNDS OR SHOULD NOT BE ALLOWED]

[IF BIRTH WEIGHT (12.3) IS DON'T KNOW OR REFUSED ASK BIRTHRF, ELSE SKIP TO CWEND.]

BIRTHRF (12.4)

At birth, did {child's name} weigh less than 5 ½ pounds?

[INTERVIEWER NOTE: 5 ½ pounds = 2500 GRAMS]

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

CWEND

Those are all the questions I have. I'd like to thank you on behalf of the {Minnesota/Michigan/Oregon} Health Department and the Centers for Disease Control and Prevention for the time and effort you've spent answering these questions. If you have any questions about this survey, you may call my supervisor toll-free at 1 - xxx-xxx-xxxx. If you have questions about your rights as a survey participant, you may call the chairman of the Institutional Review Board at 1-800-xxx-xxxx. Thanks again.

**BRFSS/ASTHMA SURVEY
ADULT QUESTIONNAIRE - 2007
CATI SPECIFICATIONS**

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[CATI: IF INTERVIEW BREAKS OFF AT ANY POINT LEAVE REMAINING FIELDS BLANK. DO NOT FILL WITH ANY VALUE.]

Section 1. Introduction

INTRODUCTION TO THE BRFSS Asthma call back for Adult respondents with asthma:

Hello, my name is _____. I'm calling on behalf of the New York State health department and the Centers for Disease Control and Prevention about an asthma {ALTERNATE: a health} study we are doing in your state. During a recent phone interview {sample person first name or initials} indicated {he/she} would be willing to participate in this study.

ALTERNATE (no reference to asthma):

Hello, my name is _____. I'm calling on behalf of the New York State health department and the Centers for Disease Control and Prevention about a health study we are doing in your state. During a recent phone interview {sample person first name or initials} indicated {he/she} would be willing to participate in this study.

1.4 Are you {sample person's name}?

1. Yes (go to informed consent)
2. No

1.5 May I speak with {sample person's name}?

1. Yes (go to 1.3 when sample person comes to phone)
2. No

If not available set time for return call

1.3 Hello, my name is _____. I'm calling on behalf of the New York State health department and the Centers for Disease Control and Prevention about an asthma study we are doing in your state. During a recent phone interview you indicated that you had asthma and would be able to complete the follow-up interview on asthma at this time.

ALTERNATE (no reference to asthma):

Hello, my name is _____. I'm calling on behalf of the New York State health department and the Centers for Disease Control and Prevention about a health study we are doing in your state. During a recent phone interview you indicated that you would be able to complete the follow-up interview at this time.

Section 2: Informed Consent

INFORMED CONSENT

Before we continue, I'd like you to know that this survey is authorized by the U.S. Public Health Service Act

You were selected to participate in this study about asthma because of your responses to questions in a prior survey.

[If “yes” to lifetime and “no” to still in Core BRFSS survey, read:]

Your answers to the asthma questions during the earlier survey indicated that a doctor or other health professional told you that you had asthma sometime in your life, but you do not have it now. Is that correct?

(IF YES, READ:) (IF NO, Go to REPEAT (2.0))

Since you no longer have asthma, your interview will be very brief (about 5 minutes). You may choose not to answer any question you don't want to answer or stop at any time. In order to evaluate my performance, my supervisor may listen as I ask the questions. I'd like to continue now unless you have any questions. **[Go to section 3]**

[If “yes” to lifetime and “yes” to still in Core BRFSS survey, read:]

Your answers to the asthma questions in the earlier survey indicated that that a doctor or other health professional told you that you had asthma sometime in your life, and that you still have asthma. Is that correct?

(IF YES, READ:) (IF NO, Go to REPEAT (2.0))

Since you have asthma now, your interview will last about 15 minutes. You may choose not to answer any question you don't want to answer or stop at any time. In order to evaluate my performance, my supervisor may listen as I ask the questions. I'd like to continue now unless you have any questions. **[Go to section 3]**

REPEAT (2.0) Check if correct person from core survey is on phone. Ask “is this {sample person’s name} and are you {sample person’s age} years old. If yes, continue. If not the correct respondent, ask to speak to that person, and start over at section 1. Keep a disposition code for this,

I would like to repeat the questions from the previous survey now to make sure you qualify for this study.

EVER_ASTH (2.1) Have you ever been told by a doctor or other health professional that you have asthma?

- (1) YES
- (2) NO [Go to TERMINATE]

- (7) DON'T KNOW [Go to TERMINATE]
- (9) REFUSED [Go to TERMINATE]

CUR_ASTH (2.2) Do you still have asthma?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

READ: You do qualify for this study, I'd like to continue unless you have any questions.

You may choose not to answer any question you don't want to answer or stop at any time. In order to evaluate my performance, my supervisor may listen as I ask the questions

[If YES to 2.2 read:]

Since you have asthma now, your interview will last **about 15 minutes**. [Go to section 3]

[If NO to 2.2 read:]

Since do not have asthma now, your interview will last **about 5 minutes**. [Go to section 3]

[If Don't know or refused to 2.2 read:]

Since you are not sure if you have asthma now, your interview will probably last **about 10 minutes**. [Go to section 3]

Some states may require the following section:

READ: Some of the information that you shared with us when we called you before could be useful in this study.

PERMISS (2.3) May we combine your answers to this survey with your answers from the survey you did a few weeks ago?

- (1) YES (Skip to Section 3)
- (2) NO (GO TO TERMINATE)

- (7) DON'T KNOW (GO TO TERMINATE)
- (10) REFUSED (GO TO TERMINATE)

[CATI: keep a disposition code for PERMISS (2.3)]

TERMINATE:

Upon survey termination, READ:

Those are all the questions I have. I'd like to thank you on behalf of the {Minnesota/Michigan/Oregon} Health Department and the Centers for Disease Control and Prevention for answering these questions. If you have any questions about this survey, you may call my supervisor toll-free at 1 - xxx-xxx-xxxx. If you have questions about your rights as a survey participant, you may call the chairman of the Institutional Review Board at 1-800-xxx-xxxx. Thanks again. Goodbye

Section 3. Recent History

**AGEDX (3.1) How old were you when you were first told by a doctor or other health professional that you had asthma?
[INTERVIEWER: ENTER 888 IF LESS THAN ONE YEARS OLD]**

_____(ENTER AGE IN YEARS)
[RANGE CHECK: IS 001-115, 777, 888, 999]

- (777) DON'T KNOW
- (888) under one year old
- (999) REFUSED

**[CATI CHECK: AGEDX LESS THAN OR EQUAL TO AGE OF RESPONDENT FROM CORE SURVEY]
[CATI CHECK:
IF RESPONSE = 77, 99 VERIFY THAT 777 AND 999 WERE NOT THE INTENT
IF RESPONSE = 88 VERIFY THAT 88 IS 88 YEARS OLD AND 888 IS UNDER 1]**

INCIDNT (3.2) How long ago was that? Was it .." READ CATEGORIES

- (4) Within the past 12 months
- (5) 1-5 years ago
- (6) more than 5 years ago

- (7) DON'T KNOW
- (9) REFUSED

LAST_MD (3.3) How long has it been since you last talked to a doctor or other health professional about your asthma? This could have been in your doctor's office, the hospital, an emergency room or urgent care center.

[INTERVIEWER: READ RESPONSE OPTIONS IF NECESSARY]

[INTERVIEWER: OTHER PROFESSIONAL INCLUDES HOME NURSE]

- (88) NEVER
- (04) WITHIN THE PAST YEAR
- (05) 1 YEAR TO LESS THAN 3 YEARS AGO
- (06) 3 YEARS TO 5 YEARS AGO
- (07) MORE THAN 5 YEARS AGO

- (77) DON'T KNOW
- (99) REFUSED

LAST_MED (3.4) How long has it been since you last took asthma medication?
[INTERVIEWER: READ RESPONSE OPTIONS IF NECESSARY]

- (88) NEVER
- (01) LESS THAN ONE DAY AGO
- (02) 1-6 DAYS AGO
- (03) 1 WEEK TO LESS THAN 3 MONTHS AGO
- (04) 3 MONTHS TO LESS THAN 1 YEAR AGO
- (05) 1 YEAR TO LESS THAN 3 YEARS AGO
- (06) 3 YEARS TO 5 YEARS AGO
- (07) MORE THAN 5 YEARS AGO

- (77) DON'T KNOW
- (99) REFUSED

INTRODUCTION FOR LASTSYMP:

READ: Symptoms of asthma include coughing, wheezing, shortness of breath, chest tightness or phlegm production when **you do not** have a cold or respiratory infection.

LASTSYMP (3.5) How long has
it been since you last had any symptoms of asthma?

[INTERVIEWER: READ RESPONSE OPTIONS IF NECESSARY]

- (88) NEVER
- (01) LESS THAN ONE DAY AGO
- (02) 1-6 DAYS AGO
- (03) 1 WEEK TO LESS THAN 3 MONTHS AGO
- (04) 3 MONTHS TO LESS THAN 1 YEAR AGO
- (05) 1 YEAR TO LESS THAN 3 YEARS AGO
- (06) 3 YEARS TO 5 YEARS AGO
- (07) MORE THAN 5 YEARS AGO

- (77) DON'T KNOW
- (99) REFUSED

IF AN ADULT AND THEY DO NOT CURRENTLY HAVE ASTHMA AND THEY ANSWERED “NEVER” OR “MORE THAN ONE YEAR AGO” TO EACH OF 1) SEEING A DOCTOR ABOUT ASTHMA, 2) TAKING ASTHMA MEDICATION, AND 3) SHOWING SYMPTOMS OF ASTHMA THEN SKIP SECTION 4.

IF (CUR_ASTH (2.2) = 2 AND LAST_MD (3.3) = 88, 05, 06, 07 AND LAST_MED (3.4) = 88, 05, 06, 07, AND LASTSYMP (3.5) = 88, 05, 06, 07), THEN SKIP TO INS1 (Section 5). (NOTE: in order for the “if statement” to work here the BRFSS core values must be copied into 2.2. Otherwise the if needs to add a reference to the

Yes to still, do section 4

No to still and nothing within a year, skip all of section 4 because all questions reference 2 weeks to 1 year

No to still, and something within a year, do parts of Section 4

DK/REFUSED to still, do Section 4

Section 4. History of Asthma (Symptoms & Episodes in past year)

IF LAST SYMPTOMS (3.5) WERE WITHIN THE PAST 3 MONTHS CONTINUE. IF LAST SYMPTOMS WERE 3 MONTHS TO 1 YEAR AGO, SKIP TO EPISODE INTRODUCTION (EPIS_INT - BETWEEN 4.4 AN 4.5); IF SYMPTOMS WERE 1-5+ YEARS AGO, SKIP TO SECTION 5; IF NEVER HAD SYMPTOMS, SKIP TO SECTION 5, IF DK/REF CONTINUE.

**IF LASTSYMP = 1, 2, 3 then continue
IF LASTSYMP = 4 SKIP TO EPIS_INT (between 4.4 and 4.5)
IF LASTSYMP = 88, 05, 06, 07 SKIP TO INS1 (Section 5)
IF LASTSYMP = 77, 99 then continue**

SYMP_30D (4.1) During the past 30 days, on how many days did you have any symptoms of asthma?

**__ __ DAYS
[RANGE CHECK: (01-30, 77, 88, 99)]**

**CLARIFICATION: [1-29, 77, 99] [SKIP TO 4.3
ASLEEP30]**

**(88) NO SYMPTOMS IN THE PAST 30 DAYS [SKIP TO
EPIS_INT]
(30) EVERY DAY [CONTINUE]**

**(77) DON'T KNOW [SKIP TO 4.3
ASLEEP30]
(99) REFUSED [SKIP TO 4.3
ASLEEP30]**

DUR_30D (4.2) Do you have symptoms all the time? "All the time" means symptoms that continue throughout the day. It does not mean symptoms for a little while each day.

**(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED**

ASLEEP30 (4.3) During the past 30 days, on how many days did symptoms of asthma make it difficult

for you to stay asleep?

 DAYS/NIGHTS

[RANGE CHECK: (01-30, 77, 88, 99)]

(88) NONE

(77) DON'T KNOW

(99) REFUSED

SYMPFREE (4.4) If LASTSYMP = 88 (never) or = 04, 05, 06, or 07 (more than 3 months ago) then have CATI code SYMPFREE = 14

If SYMP_30D = 88 (no symptoms in the past 30 days) then have CATI code SYMPFREE = 14

During the past two weeks, on how many days were you completely symptom-free, that is no coughing, wheezing, or other symptoms of asthma?

___ Number of days
[RANGE CHECK: (01-14, 77, 88, 99)]

- (88) NONE
- (77) DON'T KNOW
- (99) REFUSED

EPIS_INT

IF LAST SYMPTOMS WAS 3 MONTHS TO 1 YEAR AGO (LASTSYMP = 4) PICK UP HERE, SYMPTOMS WITHIN THE PAST 3 MONTHS CONTINUE HERE AS WELL [BACKCODE SYMPFREE (4.4) TO 14 IF LASTSYMP = 88 (never) or = 04, 05, 06, or 07 OR IF SYMP_30D = 88] 8/06

READ: Asthma attacks, sometimes called episodes, refer to periods of worsening asthma symptoms that make you limit your activity more than you usually do, or make you seek medical care.

EPIS_12M (4.5) During the past 12 months, have you had an episode of asthma or an asthma attack?

- (1) YES [SKIP TO INS1 (section 5)]
- (2) NO [SKIP TO INS1 (section 5)]
- (7) DON'T KNOW [SKIP TO INS1 (section 5)]
- (9) REFUSED [SKIP TO INS1 (section 5)]

EPIS_TP (4.6) During the past three months, how many asthma episodes or attacks have you had?

___ [RANGE CHECK: (001-100, 777, 888, 999)]

- (888) NONE

(777) DON'T KNOW
(999) REFUSED

**[CATI CHECK: IF RESPONSE = 77, 88, 99 VERIFY THAT 777, 888
AND 999 WERE NOT THE INTENT]**

DUR_ASTH (4.7) How long did your most recent asthma episode or attack last?

- 1_ _ Minutes
- 2_ _ Hours
- 3_ _ Days
- 4_ _ Weeks
- 5 5 5 Never
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

Interviewer note:

If answer is #.5 to #.99 round up

If answer is #.01 to #.49 ignore fractional part

ex. 1.5 should be recorded as 2

1.25 should be recorded as 1

ADDED 12/15/05

COMPASTH (4.8) Compared with other episodes or attacks, was this most recent attack shorter, longer, or about the same?

- (5) SHORTER
- (6) LONGER
- (7) ABOUT THE SAME
- (8) THE MOST RECENT ATTACK WAS ACTUALLY THE FIRST ATTACK

- (7) DON'T KNOW
- (9) REFUSED

Section 5. Health Care Utilization

All respondents continue here:

INS1 Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Medicaid?

- | | |
|----------------|--------------------|
| (1) YES | [continue] |
| (2) NO | [SKIP TO NER_TIME] |
| (7) DON'T KNOW | [SKIP TO NER_TIME] |
| (9) REFUSED | [SKIP TO NER_TIME] |

INS2 During the past 12 months was there any time that you did not have any health insurance or coverage?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

[IF SAMPLED PERSON DOES NOT CURRENTLY HAVE ASTHMA AND THEY ANSWERED "NEVER " OR "MORE THAN ONE YEAR AGO" TO SEEING A DOCTOR ABOUT ASTHMA, TAKING ASTHMA MEDICATION, AND SHOWING SYMPTOMS OF ASTHMA, SKIP TO SECTION 6]

This should be interpreted to mean:

- if still is not equal to 1 (is equal to 2,7,9) and LAST_MD (3.3) =4 or LAST_MED (3.4) =1,2,3,4 or LASTSYMP (3.5) = 1,2,3,4 then ask the following questions. (the respondent doesn't have current asthma but something happened in the past year)
- if still is not equal to 1 (is equal to 2,7,9) and LAST_MD (3.3) Not equal = 4 and LAST_MED (3.4) not equal to 1,2,3,4 and LASTSYMP (3.5) not equal to 1,2,3,4 then skip the following questions (the respondent doesn't have current asthma and nothing happened in the past year)
- if still is equal to 1 then ask the following questions (the respondent has current asthma)
- if all three "LAST" questions are "dk or refused" follow the second bullet.

NER_TIME (5.1) [IF LAST_MD (3.3) = 88, 05, 06, 07; SKIP TO MISS_DAY]

During the past 12 months how many times did you see a doctor or other health professional for a routine checkup for your asthma?

__ __ __ ENTER NUMBER

[RANGE CHECK: (001-365, 777, 888, 999)] [Verify any value >50]

[CATI CHECK: IF RESPONSE = 77, 88, 99 VERIFY THAT 777, 888 AND 999 WERE NOT THE INTENT]

(888) NONE

(777) DON'T KNOW

(999) REFUSED

ER_VISIT (5.2)

An urgent care center treats people with illnesses or injuries that must be addressed immediately and cannot wait for a regular medical appointment. During the past 12 months, have you had to visit an emergency room or urgent care center because of your asthma?

(1) YES

(2) NO

[SKIP TO URG_TIME]

(7) DON'T KNOW

[SKIP TO URG_TIME]

(9) REFUSED

[SKIP TO URG_TIME]

ER_TIMES (5.3)

During the past 12 months, how many times did you visit an emergency room or urgent care center because of your asthma?

___ __ ENTER NUMBER

[RANGE CHECK: (001-365, 777, 999)] [Verify any entry >50]

(777) DON'T KNOW

(999) REFUSED

[CATI CHECK: IF RESPONSE = 77, 99 VERIFY THAT 777 AND 999 WERE NOT THE INTENT]

[CATI CHECK: IF RESPONSE TO 5.2 IS "YES" AND RESPONDENT SAYS NONE OR ZERO TO 5.3 ALLOW LOOPING BACK TO CORRECT 5.2 TO "NO"]

ADDED 12/15/05

[HELP SCREEN: An urgent care center treats people with illnesses or injuries that must be addressed immediately and cannot wait for a regular medical appointment.]

URG_TIME (5.4)

[IF ONE OR MORE ER VISITS (ER_TIMES (5.3)) INSERT "Besides those emergency room or urgent care center visits,"]

During the past 12 months, how many times did you see a doctor or other health professional for urgent treatment of worsening asthma symptoms or for an asthma episode or attack?

___ __ ENTER NUMBER

[RANGE CHECK: (001-365, 777, 888, 999)] [Verify any entry >50]

(888) NONE

(777) DON'T KNOW

(999) REFUSED

[CATI CHECK: IF RESPONSE = 77, 88, 99 VERIFY THAT 777, 888 AND 999 WERE NOT THE INTENT]

[HELP SCREEN: An urgent care center treats people with illnesses or injuries that must be addressed immediately and cannot wait for a regular medical appointment.]

HOSP_VST (5.5)

**[IF LASTSYMP \geq 5 AND \leq 7, SKIP TO MISS_DAY
IF LASTSYMP=88 (NEVER), SKIP TO MISS_DAY]**

**During the past 12 months, that is since [1 YEAR AGO TODAY],
have you had to stay overnight in a hospital because of your asthma?
Do not include an overnight stay in the emergency room.**

(1) YES

(2) NO [SKIP TO MISS_DAY]

(7) DON'T KNOW [SKIP TO MISS_DAY]

(9) REFUSED [SKIP TO MISS_DAY]

HOSPTIME (5.6A)

**During the past 12 months, how many different times did you stay in any hospital
overnight or longer because of your asthma?**

__ __ __ TIMES

[RANGE CHECK: (001-365, 777, 999)] [Verify any entry >50]

(777) DON'T KNOW

(999) REFUSED

**[CATI CHECK: IF RESPONSE = 77, 99 VERIFY THAT 777 AND
999 WERE NOT THE INTENT]**

HOSPPLAN (5.7)

**The last time you left the hospital, did a health professional talk with
you about how to prevent serious attacks in the future?**

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

**[HELP SCREEN: Health professional includes doctors, nurses, physician assistants,
nurse practitioners, and health educators]**

MISS_DAY (5.8A)

During the past 12 months, how many days were you unable to work or carry out your usual activities because of your asthma?

[INTERVIEWER: If response is, "I don't work", emphasize USUAL ACTIVITIES"]

__ __ __ ENTER NUMBER DAYS

[3 NUMERIC-CHARACTER-FIELD, RANGE CHECK: (001-365, 777, 888, 999)] [Verify any entry >50]

[DISPLAY THE THREE POSSIBILITIES BELOW ON THE CATI SCREEN FOR THIS QUESTION TO ASSIST THE INTERVIEWER]

(888) ZERO

(777) DON'T KNOW

(999) REFUSED

[CATI CHECK: IF RESPONSE = 77, 88, 99 VERIFY THAT 777, 888 AND 999 WERE NOT THE INTENT]

ACT_DAYS (5.9)

During the past 12 months, would you say you limited your usual activities due to asthma not at all, a little, a moderate amount, or a lot?

(1) NOT AT ALL

(2) A LITTLE

(3) A MODERATE AMOUNT

(4) A LOT

(7) DON'T KNOW

(9) REFUSED

Section 6. Knowledge of Asthma/Management Plan

- TCH_SIGN (6.1) Has a doctor or other health professional ever taught you....**
- a. How to recognize early signs or symptoms of an asthma episode?
- (1) YES
 - (2) NO

 - (7) DON'T KNOW
 - (9) REFUSED

- TCH_RESP (6.2) Has a doctor or other health professional ever taught you**
- b. What to do during an asthma episode or attack?
- (1) YES
 - (2) NO

 - (7) DON'T KNOW
 - (9) REFUSED

- TCH_MON (6.3) A peak flow meter is a hand held device that measures how quickly you can blow air out of your lungs. Has a doctor or other health professional ever taught you ...**
- c. How to use a peak flow meter to adjust your daily medications?
- (1) YES
 - (2) NO

 - (7) DON'T KNOW
 - (9) REFUSED

- MGT_PLAN (6.4) An asthma action plan, or asthma management plan, is a form with instructions about when to change the amount or type of medicine, when to call the doctor for advice, and when to go to the emergency room.**

Has a doctor or other health professional EVER given you an asthma action plan?

[HELP SCREEN: Health professional includes doctors, nurses, physician assistants, nurse practitioners, and health educators]

- (1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

MGT_CLAS (6.5) Have you ever taken a course or class on how to manage your asthma?

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

Section 7. Modifications to Environment

HH_INT **READ:** The following questions are about your household and living environment. I will be asking about various things that may be related to experiencing symptoms of asthma.

AIRCLEANER (7.1) **An air cleaner or air purifier can filter out pollutants like dust, pollen, mold and chemicals. It can be attached to the furnace or free standing. It is not, however, the same as a normal furnace filter.**

Is an air cleaner or purifier regularly used inside your home?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

DEHUMID (7.2) **Is a dehumidifier regularly used to reduce moisture inside your home?**

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

KITC_FAN (7.3) **Is an exhaust fan that vents to the outside used regularly when cooking in your kitchen?**

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

COOK_GAS (7.4) **Is gas used for cooking?**

- (1) Yes
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

ENV_MOLD (7.5) In the past 30 days, has anyone seen or smelled mold or a musty odor inside your home? Do not include mold on food.

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

ENV_PETS (7.6) Does your household have pets such as dogs, cats, hamsters, birds or other feathered or furry pets that spend time indoors?

- (1) YES
- (2) NO (SKIP TO 7.8)

- (7) DON'T KNOW (SKIP TO 7.8)
- (9) REFUSED (SKIP TO 7.8)

PETBEDRM (7.7) Are pets allowed in your bedroom?

[SKIP THIS QUESTION IF ENV_PETS = 2, 7, 9]

- (1) YES
- (2) NO
- (3) SOME ARE/SOME AREN'T

- (7) DON'T KNOW
- (9) REFUSED

C_ROACH (7.8) In the past 30 days, has anyone seen a cockroach inside your home?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

HELP SCREEN: Studies have shown that cockroaches may be a cause of asthma. Cockroach droppings and carcasses can also cause symptoms of asthma.

C_RODENT (7.9) In the past 30 days, has anyone seen mice or rats inside your home? Do not include mice or rats kept as pets.

- (1) YES
- (2) NO

(7) DON'T KNOW

(9) REFUSED

HELP SCREEN: Studies have shown that rodents may be a cause of asthma.

WOOD_STOVE (7.10) Is a wood burning fireplace or wood burning stove used in your home?

(1) YES

(2) NO

(7) DON'T KNOW

(9) REFUSED

HELP SCREEN: OCCASIONAL USE SHOULD BE CODED AS "YES".

GAS_STOVE (7.11) **Are unvented gas logs, unvented gas fireplaces, or unvented gas stoves used in your home?**

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

HELP SCREEN: “Unvented” means no chimney or the chimney flue is kept closed during operation.

Transition...

S_INSIDE (7.12) **In the past week, has anyone smoked inside your home?**

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

HELP SCREEN: “The intent of this question is to measure smoke resulting from tobacco products (cigarettes, cigars, pipes) or illicit drugs (cannibus, marijuana) delivered by smoking (inhaling intentionally). Do not include things like smoke from incense, candles, or fireplaces, etc.”

MOD_ENV (7.13) **INTERVIEWER READ:** Now, back to questions specifically about you.

Has a health professional ever advised you to change things in your home, school, or work to improve your asthma?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

[**HELP SCREEN:** Health professional includes doctors, nurses, physician assistants, nurse practitioners, and health educators]

MATTRESS (7.14) **Do you use a mattress cover that is made especially for controlling dust mites?**

[**INTERVIEWER:** If needed: This does not include normal mattress covers used for padding or sanitation (wetting). These covers are for the purpose of controlling allergens (like dust mites) from inhabiting the mattress. They are made of special fabric, entirely enclose the mattress, and have zippers.]

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

E_PILLOW (7.15) Do you use a pillow cover that is made especially for controlling dust mites?

[INTERVIEWER: If needed: This does not include normal pillow covers used for fabric protection. These covers are for the purpose of controlling allergens (like dust mites) from inhabiting the pillow. They are made of special fabric, entirely enclose the pillow, and have zippers.]

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

CARPET (7.16) Do you have carpeting or rugs in your bedroom? This does not include throw rugs small enough to be laundered.

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

HOTWATER (7.17) Are your sheets and pillowcases washed in cold, warm, or hot water?

- (1) COLD
- (2) WARM
- (3) HOT

- DO NOT READ**
- (4) VARIES

- (7) DON'T KNOW

(9) REFUSED

BATH_FAN (7.18) In your bathroom, do you regularly use an exhaust fan that vents to the outside?

(1) YES

(2) NO OR "NO FAN"

(7) DON'T KNOW

(9) REFUSED

HELP SCREEN: IF RESPONDENT INDICATES THEY HAVE MORE THAN ONE BATHROOM, THIS QUESTION REFERS TO THE BATHROOM THEY USE MOST FREQUENTLY FOR SHOWERING AND BATHING.

Section 8. Medications

OTC (8.1) [IF LAST_MED = 88 (NEVER), SKIP TO SECTION 9. ELSE,
CONTINUE.]

The next set of questions is about medications for asthma. The first few questions are very general, but later questions are very specific to your medication use.

Over-the-counter medication can be bought without a doctor's order. Have you ever used over-the-counter medication for your asthma?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

INHALERE (8.2) Have you ever used a prescription inhaler?

- (1) YES
- (2) NO [SKIP TO SCR_MED1]

- (7) DON'T KNOW [SKIP TO SCR_MED1]
- (9) REFUSED [SKIP TO SCR_MED1]

INHALERH (8.3) Did a doctor or other health professional show you how to use the inhaler?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

[HELP SCREEN: Health professional includes doctors, nurses, physician assistants, nurse practitioners, and health educators]

INHALERW (8.4) Did a doctor or other health professional watch you use the inhaler?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

SCR_MED1 (8.5)

[IF LAST_MED = 88, 4, 5, 6, 7, 77, or 99, SKIP TO SECTION 9]

Now I am going to ask questions about specific prescription medications you may have taken for asthma in the past 3 months. I will be asking for the names, amount, and how often you take each medicine. I will ask separately about medication taken in various forms: pill or syrup, inhaler, and Nebulizer.

It will help to get your medicines so you can read the labels. ~~Are your asthma medicines handy?~~ Changed 1/5/06
Can you please go get the asthma medicines while I wait on the phone?

(4) YES

(5) NO

[SKIP TO INH_SCR]

(6) RESPONDENT KNOWS THE MEDS

[SKIP TO INH_SCR]

(7) DON'T KNOW

[SKIP TO INH_SCR]

(9) REFUSED

[SKIP TO INH_SCR]

SCR_MED2 (8.6) [Leave field in data file layout for 8.6 blank]

Changed 1/5/06

~~[INTERVIEWER: Read if necessary]~~

~~(3) YES~~

~~(4) NO _____ [SKIP TO INH_SCR]~~

~~(7) DON'T KNOW _____ [SKIP TO INH_SCR]~~

~~(9) REFUSED _____ [SKIP TO INH_SCR]~~

SCR_MED3 (8.7)

[when Respondent returns to phone:] ~~Am I correct that~~ Do you have all the medications?

Changed 1/5/06

[INTERVIEWER: Read if necessary]

(4) YES I HAVE ALL THE MEDICATIONS

(5) YES I HAVE SOME OF THE MEDICATIONS BUT NOT ALL

(6) NO

(7) DON'T KNOW

(9) REFUSED

INH_SCR (8.8)

[IF INHALERE (8.2) = 2 (NO) SKIP TO PILLS]

In the past 3 months have you taken prescription asthma medicine using an inhaler?

(1) YES

(2) NO

[SKIP TO PILLS]

(7) DON'T KNOW

[SKIP TO PILLS]

(9) REFUSED

[SKIP TO PILLS]

INH_MEDS (8.9)

In the past 3 months, what **prescription asthma** medications did you take by inhaler? [MARK ALL THAT APPLY. PROBE: Any other **prescription asthma** inhaler medications?]

[INTERVIEWER: IF NECESSARY, ASK THE RESPONDENT TO SPELL THE NAME OF THE MEDICATION.]

	Brand Name	Type (not shown in CATI)
01	Advair (17 + 26)	combination
02	Aerobid (16)	corticosteroid
03	<u>Albuterol</u>	beta 2 agonist (Short-Acting)
04	Alupent (21)	beta 2 agonist (Short-Acting)
05	Atrovent (19)	anti-cholinergic
06	Azmacort (31)	corticosteroid
07	<u>Beclomethasone dipropionate</u>	corticosteroid
08	Beclovent (07)	corticosteroid
09	<u>Bitolterol</u>	beta 2 agonist (Short-Acting)
10	Brethaire (28)	beta 2 agonist (Short-Acting)
11	<u>Budesonide</u>	corticosteroid
12	Combivent (19 + 03)	combination
13	<u>Cromolyn</u>	anti-inflammatory
14	Flovent (17)	inhaled corticosteroid
15	Flovent Rotadisk (17)	inhaled corticosteroid
16	<u>Flunisolide</u>	corticosteroid
17	<u>Fluticasone</u>	inhaled corticosteroid
34	Foradil (35)	beta 2 agonist (Long-acting)
35	<u>Formoterol</u>	beta 2 agonist (Long-acting)
18	Intal (13)	anti-inflammatory
19	<u>Ipratropium Bromide</u>	anti-cholinergic
20	Maxair (23)	beta 2 agonist (Short-Acting)
21	<u>Metaproteronol</u>	beta 2 agonist (Short-Acting)
22	<u>Nedocromil</u>	anti-inflammatory
23	<u>Pirbuterol</u>	beta 2 agonist (Short-Acting)
24	Proventil (03)	beta 2 agonist (Short-Acting)
25	Pulmicort Turbuhaler (11)	corticosteroid
36	QVAR (07)	inhaled corticosteroid
26	<u>Salmeterol</u>	beta 2 agonist (Long-acting)
27	Serevent (26)	beta 2 agonist (Long-acting)
28	<u>Terbutaline</u>	beta 2 agonist (Short-Acting)
29	Tilade (22)	anti-inflammatory
30	Tornalate (09)	beta 2 agonist (Short-Acting)
31	<u>Triamcinolone acetonide</u>	corticosteroid
32	Vanceril (08)	corticosteroid
33	Ventolin (03)	beta 2 agonist (Short-Acting)

66	Other, Please Specify	[SKIP TO OTH_I1]
----	-----------------------	------------------

[IF RESPONDENT SELECTS ANY ANSWER <66, SKIP TO ILP01]

(88) NO PRESCRIPTION INHALERS [SKIP TO PILLS]

(77) DON'T KNOW [SKIP TO PILLS]

(99) REFUSED [SKIP TO PILLS]

[100 ALPHANUMERIC CHARACTER LIMIT FOR 48]

OTH_I1 (8.10) ENTER OTHER MEDICATION FROM (8.9) IN TEXT FIELD
IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.

[LOOP BACK TO ILP01 AS NECESSARY TO ADMINSTER QUESTIONS ILP01 THRU ILP10 FOR EACH MEDICINE REPORTED IN INH_MEDS

[FOR FILL [MEDICINE FROM INH_MEDS SERIES] FOR QUESTIONS ILP01 THROUGH ILP10]

[IF {MEDICINE FROM INH_MEDS SERIES} IS 03, 04, 21, 24, OR 33 ASK ILP01 ELSE SKIP TO ILP02

ILP01 (8.11) Are there 80, 100, or 200 puffs in the [MEDICINE FROM INH_MEDS SERIES] inhaler that you use?

[INTERVIEWER: A puff is a single inhalation or a single dose. Inhalers sometimes say "100 metered doses". Instructions are to use 2-3 inhalations (doses, puffs) each time. The 80 puff canister may say 6.8 g. The 100 puff canister may say 9 g and the 200 puff canister may say 17 g. or 18 g. depending on the brand being used. If it says 90 mcg (micrograms) it is referring to the individual puff, not the size of the canister]

clarified 6/2006

- (1) 80 PUFFS
- (2) 100 PUFFS
- (3) 200 PUFFS
- (4) Other number of puffs
- (5) USED DIFFERENT SIZES OF THIS MEDICATION IN PAST 3 MONTHS

(7) DON'T KNOW

(9) REFUSED

ILP02 (8.12) How long have you been taking [MEDICINE FROM INH_MEDS SERIES]?
Would you say less than 6 months, 6 months to 1 year, or longer than 1 year.

- (1) Less than 6 months
- (2) 6 months to 1 year
- (3) Longer than 1 year

- (7) DON'T KNOW
- (9) REFUSED

IF [MEDICINE FROM INH_MEDS SERIES] IS ADVAIR (01) OR FLOVENT ROTADISK (15) SKIP TO 8.14

ILP03 (8.13) A spacer is a small attachment for an inhaler that makes it easier to use. Do you use a spacer with [MEDICINE FROM INH_MEDS SERIES]?

- (1) YES
- (2) NO
- (3) Medication is a disk inhaler not a canister inhaler

- (7) DON'T KNOW
- (9) REFUSED

[HELP SCREEN: A spacer is a device that attaches to a metered dose inhaler. It holds the medicine in its chamber long enough for you to inhale it in one or two slow, deep breaths. The spacer makes it easy to take the medicines the right way.]

[HELP SCREEN: The response category 3 (disk not canister) is primarily intended for medications Serevent (27), Salmeterol (26) and Flovent (14) which are known to come in disk type inhalers (which do not use a spacer). However, new medications may come on the market that will need this category so it can be used for other than 14, 26, and 27.]

ILP04 (8.14) In the past 3 months, did you take [MEDICINE FROM INH_MEDS SERIES] when you had an asthma episode or attack?

- (1) YES
- (2) NO
- (3) NO ATTACK IN PAST 3 MONTHS

- (7) DON'T KNOW
- (9) REFUSED

ILP05 (8.15) In the past 3 months, did you take [MEDICINE FROM INH_MEDS SERIES] before exercising?

- (1) YES
- (2) NO
- (3) DIDN'T EXERCISE IN PAST 3 MONTHS

- (7) DON'T KNOW
- (9) REFUSED

ILP06 (8.16) In the past 3 months, did you take [MEDICINE FROM INH_MEDS SERIES] on a regular schedule everyday?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

ILP07 (8.17) On average, how many puffs do you take each time you use [MEDICINE FROM INH_MEDS SERIES]?

__ __ PUFFS EACH TIME
[RANGE CHECK: (01-76, 77, 99)]

- (77) DON'T KNOW
- (99) REFUSED

INTERVIEWER: PROBE FOR NUMBER OF PUFFS IF RANGE IS GIVEN.

ILP08 (8.18) How many times per day or per week do you use [MEDICINE FROM INH_MEDS SERIES]?

3 __ Days
4 __ Weeks
5 5 5 Never
6 6 6 LESS OFTEN THAN ONCE A WEEK

7 7 7 Don't know / Not sure
9 9 9 Refused

[ASK ILP10 ONLY IF INH_MEDS = 3, 4, 9, 10, 20, 21, 23, 24, 28, 30, 33, OTHERWISE SKIP TO PILLS (8.20)]

ILP10 (8.19) How many canisters of [MEDICINE FROM INH_MEDS SERIES] have you used in the past 3 months?

[INTERVIEWER: IF RESPONDENT USED LESS THAN ONE FULL CANISTER IN THE PAST THREE MONTHS, CODE IT AS '88']

___ CANISTERS

(77) DON'T KNOW

(88) NONE

(99) REFUSED

[RANGE CHECK: (01-76, 77, 88, 99)]

[HELP SCREEN: IF RESPONDENT INDICATES HE/SHE HAS MULTIPLE CANISTERS, (I.E., ONE IN THE CAR, ONE IN PURSE, ETC.) ASK THE RESPONDENT TO ESTIMATE HOW MANY FULL CANISTERS HE/SHE USED. THE INTENT IS TO ESTIMATE HOW MUCH MEDICATION IS USED, NOT HOW MANY DIFFERNT INHALERS.]

PILLS (8.20) In the past 3 months, have you taken any **prescription medicine in pill form for your asthma?**

(1) YES

(2) NO

[SKIP TO SYRUP]

(7) DON'T KNOW

[SKIP TO SYRUP]

(9) REFUSED

[SKIP TO SYRUP]

PILLS_MD (8.21) What **prescription asthma** medications do you take in pill form?
 [MARK ALL THAT APPLY. PROBE: Any other **prescription asthma** pills?]

[INTERVIEWER: IF NECESSARY, ASK THE RESPONDENT TO SPELL THE NAME OF THE MEDICATION.]

	Medication	Type not shown in CATI)
01	Accolate	Leukotriene Modifier
02	Aerolate	Methylxanthine
03	<u>Albuterol</u>	Beta 2 agonist – Rescue Bronchodilator
04	Alupent	Beta 2 agonist – Rescue Bronchodilator
05	choledyl	Methylxanthins
06		
07	Deltasone	Corticosteriod
08	Elixophyllin	Methylxanthine
09		
10	Marax	Methylxanthine
11	Medrol	Corticosteriod
12	Metaprel	Beta 2 agonist – Rescue Bronchodilator
13	<u>Metaproteronol</u>	Beta 2 agonist – Rescue Bronchodilator
14	<u>Methylpredinisol one</u>	Corticosteriod
15	<u>Montelukast</u>	Leukotriene Modifier
16		
17	Pediapred	Corticosteriod
18	<u>Prednisolone</u>	Corticosteriod
19	<u>Prednisone</u>	Corticosteriod
20	Prelone	Corticosteriod
21	Proventil	Beta 2 agonist – Rescue Bronchodilator
22	Quibron	Methylxanthine
23	Respil	Methylxanthine
24	Singulair	Leukotriene Modifier
25	Slo-phyllin	Methylxanthine
26	Slo-bid	Methylxanthine
27	Sustaire	Methylxanthine
28	Theo-24	Methylxanthine
29	Theobid	Methylxanthine
30	Theochron	Methylxanthine
31	Theoclear	Methylxanthine
32	Theodur	Methylxanthine
33	Theo-Dur	Methylxanthine
34	Theolair	Methylxanthine
35	<u>Theophylline</u>	Methylxanthine
36	Theo-Sav	Methylxanthine
37	Theospan	Methylxanthine

38	Theox	Methylxanthine
39		
40	T-Phyl	Methylxanthine
41	Unidur	Methylxanthine
42	Uniphyl	Methylxanthine
43	Ventolin	Beta 2 agonist – Rescue Bronchodilator
44	Volmax	Beta 2 agonist – Rescue Bronchodilator
45	Zafirlukast	Leukotriene Modifier
46	Zileuton	Leukotriene Modifier
47	Zyflo Filmtab	Leukotriene Modifier
66	Other, Please Specify: [SKIP TO OTH_P1]	

[IF RESPONDENT SELECTS ANY ANSWER FROM 01-47, SKIP TO PILLX]

(88) NO PILLS

[SKIP TO SYRUP]

(77) DON'T KNOW

[SKIP TO SYRUP]

(99) REFUSED

[SKIP TO SYRUP]

[100 ALPHANUMERIC CHARACTER LIMIT FOR 48]

OTH_P1

ENTER OTHER MEDICATION IN TEXT FIELD

IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.

[REPEAT QUESTION PILLX AS NECESSARY FOR EACH PILL REPORTED IN PILLS_MD FOR FILL [MEDICATION LISTED IN PILLS_MD] FOR QUESTION PILLX]

PILLX (8.22) How long have you been taking [MEDICATION LISTED IN PILLS_MD]? Would you say less than 6 months, 6 months to 1 year, or longer than 1 year.

(1) Less than 6 months

(2) 6 months to 1 year

(3) Longer than 1 year

(7) DON'T KNOW

(9) REFUSED

SYRUP (8.23) In the past 3 months, have you taken any prescription asthma medication in syrup form?

(1) YES
(2) NO [SKIP TO
NEB_SCR]

(7) DON'T KNOW [SKIP TO
NEB_SCR]

(9) REFUSED [SKIP TO
NEB_SCR]

SYRUP_ID (8.24) What prescription **asthma** medications have you taken as a syrup?
[MARK ALL THAT APPLY. PROBE: Any other **prescription** syrup medications **for asthma?**]

[INTERVIEWER: IF NECESSARY, ASK THE RESPONDENT TO SPELL THE NAME OF THE MEDICATION.]

	Medication
01	Aerolate (09)
02	<u>Albuterol</u>
03	Alupent (04)
04	<u>Metaproteronol</u>
05	<u>Prednisolone</u>
06	Prelone (05)
07	Proventil (02)
08	Slo-Phyllin (09)
09	<u>Theophylline</u>
10	Ventolin (02)
66	Other, Please Specify: [SKIP TO OTH_S1]

[IF RESPONDENT SELECTS ANY ANSWER FROM 01-10, SKIP TO NEB_SCR]

(88) NO SYRUPS [SKIP TO
NEB_SCR]

(77) DON'T KNOW [SKIP TO
NEB_SCR]

(99) REFUSED [SKIP TO
NEB_SCR]

OTH_S1 [100 ALPHANUMERIC CHARACTER LIMIT FOR 11]

ENTER OTHER MEDICATION.

IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.

NEB_SCR (8. 25) **Read: A nebulizer is a small machine with a tube and facemask or mouthpiece that you breathe through continuously. In the past 3 months, were any of your **prescription** asthma medicines used with a nebulizer?**

- (1) YES
- (2) NO [SKIP TO Section 9]
- (7) DON'T KNOW [SKIP TO Section 9]
- (9) REFUSED [SKIP TO Section 9]

NEB_PLC(8. 26) **I am going to read a list of places where you might have used a nebulizer. Please answer yes if you have used a nebulizer in the place I mention, otherwise answer no. In the past 3 months did you use a nebulizer ...**

- (8.26a) (1) AT HOME YES NO DK
- (8.26b) (2) AT A DOCTOR'S OFFICE YES NO DK
- (8.26c) (3) IN AN EMERGENCY ROOM YES NO DK
- (8.26d) (4) AT WORK OR AT SCHOOL YES NO DK
- (8.26e) (5) AT ANY OTHER PLACE YES NO DK

NEB_ID (8.27) **In the past 3 months, what prescriptions **asthma** medications have you taken using a nebulizer?**

[INTERVIEWER: IF NECESSARY, ASK THE RESPONDENT TO SPELL THE NAME OF THE MEDICATION.]

[MARK ALL THAT APPLY. PROBE: Have you taken any other prescription **asthma** medications with your nebulizer in the past 3 months?]

	Medication
01	<u>Albuterol</u>
02	Alupent (11)
03	Atrovent (09)
04	<u>Bitolterol</u>
05	<u>Budesonide</u>
06	<u>Cromolyn</u>
07	Duoneb (01 + 09)
08	Intal (06)
09	<u>Ipratropium bromide</u>
10	<u>Levalbuterol</u>
11	<u>Metaproteronol</u>
12	Proventil (01)
13	Pulmicort (05)

14	Tornalate (04)
15	Ventolin (01)
16	Xopenex (10)
66	Other, Please Specify: [SKIP TO OTH_N1]

(88) NO Nebulizers

[SKIP TO Section 9]

(77) DON'T KNOW

[SKIP TO Section 9]

(99) REFUSED

[SKIP TO Section 9]

OTH_N1

ENTER OTHER MEDICATION

IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.

Section 9. Cost of Care

If No to “still” from BRFSS core or CUR_ASTH (2.2) = 2 [or either are missing] skip to section 10

If Yes to “still” from BRFSS core or CUR_ASTH (2.2) = 1, continue

Added 12/15/05

If No, DK, or Refused to “still” from BRFSS core [or to CUR_ASTH (2.2)] skip to section 10

If Yes to “still” from BRFSS core [or CUR_ASTH (2.2)] continue

Clarification 6/06

ASMDCOST (9.1) Was there a time in the past 12 months when you needed to see your primary care doctor for your asthma but could not because of the cost?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

ASSPCOST (9.2) Was there a time in the past 12 months when you were referred to a specialist for asthma care but could not go because of the cost?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

ASRXCOST (9.3) Was there a time in the past 12 months when you needed to buy medication for your asthma but could not because of the cost?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

Section 10. Work Related Asthma

EMP_STAT (10.1) Next, we are interested in things that affect asthma in the workplace. However, first I'd like to ask how you would describe your current employment status? Would you say ...

[INTERVIEWER: Include self employed as employed. Full time is 40+ hours.]

- | | |
|------------------------|---------------------------|
| (1) Employed full-time | [SKIP TO WORKENV1] |
| (2) Employed part-time | [SKIP TO WORKENV1] |
| (3) Not employed | |
|
 | |
| (7) DON'T KNOW | [SKIP TO EMPL_EVER |
| (10.3)] | |
| (9) REFUSED | [SKIP TO EMPL_EVER |
| (10.3)] | |

UNEMP_R (10.2) What is the main reason you are not now employed?

- (01) KEEPING HOUSE
- (02) GOING TO SCHOOL
- (03) RETIRED
- (04) DISABLED
- (05) UNABLE TO WORK FOR OTHER HEALTH REASONS
- (06) LOOKING FOR WORK
- (07) LAID OFF
- (08) OTHER

- (77) DON'T KNOW
- (99) REFUSED

EMP_EVER (10.3) Have you ever been employed outside the home?

- | | |
|----------------|-----------------------------|
| (1) YES | [SKIP TO WORKENV3] |
| (2) NO | [SKIP TO SECTION 11] |
|
 | |
| (7) DON'T KNOW | [SKIP TO SECTION 11] |
| (9) REFUSED | [SKIP TO SECTION 11] |

WORKENV1 (10.4) Was your asthma CAUSED by chemicals, smoke, fumes or dust in your CURRENT job?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

[HELP SCREEN: THE INTENT HERE IS TO INCLUDE CONDITIONS BOTH SPECIFIC TO THE JOB AND ALSO TO INCLUDE THINGS THAT HAPPEN AT WORK. FOR EXAMPLE, FLOUR DUST IN A BAKERY, AND ALSO NORMAL DUST IN AN OFFICE; FUMES FROM PAINT IN A PAINT MANUFACTURING COMPANY, AND ALSO PAINT FUMES FROM REPAINTING AN OFFICE; SMOKE FROM A MANUFACTURING PROCESS AND ALSO SMOKE FROM A COWORKER'S CIGARETTE]

If No to “still” from BRFSS core or CUR_ASTH (2.2) = 2 [or either are missing] skip to 10.6

If Yes to “still” from BRFSS core or CUR_ASTH (2.2) = 1, continue

Added 12/15/05

If No, DK, or Refused to “still” from BRFSS core [or to CUR_ASTH (2.2)] skip to 10.6

If Yes to “still” from BRFSS core [or CUR_ASTH (2.2)] continue

Clarification 6/06

WORKENV2 (10.5) Is your asthma MADE WORSE by chemicals, smoke, fumes or dust in your CURRENT job?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

[IF WORKENV1 (10.4) = 1 (yes) skip to WORKSEN1]

WORKENV3 (10.6) Was your asthma CAUSED by chemicals, smoke, fumes or dust in any PREVIOUS job you ever had?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

WORKENV4 (10.7) Was your asthma **MADE WORSE by chemicals, smoke, fumes or dust in any **PREVIOUS** job you ever had?**

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

**[ASK 10.75 ONLY IF:
WORKENV2 (10.5) = 1 (YES) OR
WORKENV3 (10.6) = 1 (YES) OR
WORKENV4 (10.7) = 1 (YES)
OTHERWISE SKIP TO WORKSENS1 (10.8)]**

WORKQUIT (10.75) Did you ever change or quit a job because chemicals, smoke, fumes, or dust caused your asthma or made your asthma worse?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (10) REFUSED

WORKSEN1 (10.8) Were you ever told by a doctor or other health professional that your asthma was related to any job you ever had?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

WORKSEN2 (10.9) Did you ever tell a doctor or other health professional that your asthma was related to any job you ever had?

- (1) YES
- (2) NO

(7) DON'T KNOW
(9) REFUSED

Section 11. Comorbid Conditions

We have just a few more questions. Besides asthma we are interested in some other medical conditions you may have.

COPD (11.1) Have you ever been told by a doctor or health professional that you have chronic obstructive pulmonary disease also known as COPD?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

EMPHY (11.2) Have you ever been told by a doctor or other health professional that you have emphysema?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

BRONCH (11.3) Have you ever been told by a doctor or other health professional that you have Chronic Bronchitis?

- (1) YES
- (2) NO

- (7) DON'T KNOW
- (9) REFUSED

[HELP SCREEN: Chronic Bronchitis is repeated attacks of bronchitis over a long period of time. Chronic Bronchitis is not the type of bronchitis you might get occasionally with a cold.]

DEPRESS (11.4) Have you ever been told by a doctor or other health professional that you were depressed?

(1) YES

(2) NO

(7) DON'T KNOW

(10) REFUSED

Section 12. Complimentary and Alternative Therapy

If **No** to “still” from BRFSS core or CUR_ASTH (2.2) = 2 [or either are missing] skip to CWEND

If **Yes** to “still” from BRFSS core or CUR_ASTH (2.2) = 1 continue

Added 12/15/05

If **No, DK, or Refused** to “still” from BRFSS core [or to CUR_ASTH (2.2)] skip to **CWEND**

If **Yes** to “still” from BRFSS core [or CUR_ASTH (2.2)] continue

Clarification 6/06

READ: Sometimes people use methods other than prescription medications to help treat or control their asthma. These methods are called non-traditional, complementary, or alternative health care. I am going to read a list of these alternative methods. For each one I mention, please answer “yes” if you have used it to control your own asthma in the past 12 months. Answer “no” if you have not used it in the past 12 months.

In the past 12 months, have you used ... to control your asthma?
[interviewer: repeat prior phrasing as needed]

CAM_HERB (12.1)	herbs	(1) YES	(2) NO	(7) DK (9) REF
CAM_VITA (12.2)	vitamins	(1) YES	(2) NO	(7) DK (9) REF
CAM_PUNC (12.3)	acupuncture	(1) YES	(2) NO	(7) DK (9) REF
CAM_PRES (12.4)	acupressure	(1) YES	(2) NO	(7) DK (9) REF
CAM_AROM (12.5)	aromatherapy	(1) YES	(2) NO	(7) DK (9) REF
CAM_HOME (12.6)	homeopathy	(1) YES	(2) NO	(7) DK (9) REF
CAM_REFL (12.7)	reflexology	(1) YES	(2) NO	(7) DK (9) REF
CAM_YOGA (12.8)	yoga	(1) YES	(2) NO	(7) DK (9) REF
CAM_BR (12.9)	breathing techniques	(1) YES	(2) NO	(7) DK (9) REF
CAM_NATR (12.10)	naturopathy	(1) YES	(2) NO	(7) DK (9) REF

[INTERVIEWER: If respondent does not recognize the term “naturopathy” the response should be no”]

[HELP SCREEN: Naturopathy (nay-chur-o-PATH-ee) is an alternative treatment based on the principle that there is a healing power in the body that establishes, maintains, and restores health. Naturopaths prescribe treatments such as nutrition and lifestyle counseling, dietary supplements, medicinal plants, exercise, homeopathy, and treatments from traditional Chinese medicine.]

CAM_OTHR (12.11) Besides the types I have just asked about, have you used any other type of alternative care for your asthma in the past 12 months?

(3) YES

(4) NO

[SKIP TO CWEND]

(7) DON'T KNOW

[SKIP TO CWEND]

(9) REFUSED

[SKIP TO CWEND]

CAM_TEXT (12.13) What else have you used?

[100 ALPHANUMERIC CHARACTER LIMIT FOR 48]

**ENTER OTHER ALTERNATIVE MEDICINE IN TEXT FIELD
IF MORE THAN ONE IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.**

CWEND

Those are all the questions I have. I'd like to thank you on behalf of the {Minnesota/Michigan/Oregon} Health Department and the Centers for Disease Control and Prevention for the time and effort you've spent answering these questions. If you have any questions about this survey, you may call my supervisor toll-free at 1 – xxx-xxx-xxxx. If you have questions about your rights as a survey participant, you may call the chairman of the Institutional Review Board at 1-800-xxx-xxxx. Thanks again.

Attachment 14

14. HRI Appendix A
(See Attached PDF File)

HEALTH RESEARCH, INC.
APPENDIX A

The parties to the attached contract further agree to be bound by the following, which are hereby made a part of said contract:

1. This contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or disposed of without the previous consent, in writing, of HRI.
2. The Contractor specifically agrees, as required by provisions of the Labor Law, Section 220-e as amended, that:
 - (a) In hiring of employees for the performance of work under this contract or any subcontract hereunder, or for the manufacture, sale or distribution of materials, equipment or supplies hereunder, no contractor, subcontractor nor any person acting on behalf of such contractor or subcontractor shall, by reason of race, creed, color, sex or national origin, discriminate against any citizen of the State of New York who is qualified and available to perform the work to which the employment relates.
 - (b) No contractor, subcontractor, nor any person on his behalf shall in any manner discriminate against or intimidate any employee hired for the performance of work under this contract on account of race, creed, color, sex or national origin.
 - (c) There may be deducted from the amount payable to the Contractor by HRI under this contract a penalty of Five Dollars (\$5.00) for each person for each calendar day during which such person was discriminated against or intimidated in violation of the provisions of the contract; and,
 - (d) This contract may be canceled or terminated by HRI and all moneys due or to become due hereunder may be forfeited for a second or any subsequent violation of the terms or conditions of this section of the contract.
3. During the performance of this contract, the Contractor agrees as follows:
 - (a) The Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, age, disability or marital status.
 - (b) If directed to do so by the Commissioner of Human Rights, the Contractor will send to each labor union or representative of workers within which the Contractor has or is bound by a collective bargaining or other agreement or understanding, a notice, to be provided by the State Commissioner of Human Rights, advising such labor union or representative of the Contractor's agreement under clauses (a) through (g) (hereinafter called "non-discrimination clauses"). If the Contractor was directed to do so by the contracting agency as part of the bid or negotiation of this contract, the Contractor shall request such labor union or representative to furnish a written statement that such labor union or representative will not discriminate because of race, creed, color, sex, national origin, age, disability or marital status and that such labor union or representative will cooperate, within the limits of its legal and contractual authority, in the implementation of the policy and provisions of these non-discrimination clauses and that it consents and agrees that recruitment, employment, and the terms and conditions of employment under this contract shall be in accordance with the purposes and provisions of these nondiscrimination clauses. If such labor union or representative fails or refuses to comply with such a request that it furnishes such a statement, the Contractor shall promptly notify the State Commissioner of Human Rights of such failure or refusal.
 - (c) If directed to do so by the Commissioner of Human Rights, the Contractor will post and keep posted in conspicuous places, available to employees and applicants for employment, notices to be provided by the State Commissioner of Human Rights setting forth the substance of the provisions of Clauses (a) and (b) and such provisions of the State's laws against discrimination as the State Commissioner of Human Rights shall determine.
 - (d) The Contractor will state, in all solicitations or advertisement for employees placed by or on behalf of the Contractor, that all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, sex, national origin, age, disability or marital status.
 - (e) The contractor will comply with the provisions of Sections 290-299 of the Executive Law and with the Civil Rights Law, will furnish all information and reports deemed necessary by the State Commissioner of Human Rights under these non-discriminatory clauses and such actions of the Executive Law, and will permit access to the Contractor's books, records, and accounts by the State Commissioner of Human Rights, the Attorney General, and the Industrial Commissioner for the purposes of investigation to ascertain compliance with these non-discrimination clauses and such sections of the Executive Law and Civil Rights Law.
 - (f) This contract may be forthwith canceled, terminated or suspended, in whole or in part, by the contracting agency upon the basis of a finding made by the State Commissioner of Human Rights that the Contractor has not complied with these non-discrimination clauses, and the Contractor may be declared ineligible for future contracts made by or on behalf of HRI, the State or a public authority or agency of the State, until the Contractor satisfies the State Commissioner of Human Rights that the Contractor has established and is carrying out a program in conformity with the provisions of these non-discrimination clauses. Such finding shall be made by the State Commissioner of Human Rights after conciliation efforts by the Commissioner have failed to achieve compliance with these non-discrimination clauses and after a verified complaint has been filed with the Commissioner, notice thereof has been afforded to the Contractor, and an opportunity has been afforded to the Contractor to be heard publicly in accordance with the Executive Law. Such sanctions may be imposed and remedies invoked independently of or in addition to sanctions and remedies otherwise provided by law.
 - (g) The Contractor will include the provisions of clause (a) through (f) in every subcontract or purchase order in such a manner that such provisions will be binding upon each subcontractor or vendor as to operations to be performed within the State of New York. The contractor will take such action in enforcing such provisions of such subcontract or purchase order as the State Commissioner of Human Rights or the contracting agency may direct, including sanctions or remedies for non-compliance. If the Contractor becomes involved in or is threatened with litigation with a subcontractor or vendor as a result of such direction by the State Commissioner of Human Rights or the contracting agency, the Contractor shall promptly notify HRI.
4. The Agreement shall be void and of no force and effect unless the Contractor shall provide coverage for the benefit of, and keep covered during the life of this Agreement, such employees as are required to be covered by the provisions of Workers' Compensation Law.

5. Unless otherwise specifically provided for in the contract to which this Appendix has been attached, the Contractor will not use the names of Health Research, Inc., the New York State Department of Health, the State of New York or any employees or officials of these entities, without the expressed written approval of HRI.

6. Assurances Required by DHHS--PHS (Where Applicable)

(a) Human Subjects, Derived Materials or Data

The Contractor and HRI both agree to abide by DHHS regulations concerning Human Subjects. The DHHS regulation, 45 CFR 46, provides a systematic means, based on established ethical principles, protecting the rights and welfare of individuals who may be exposed to the possibility of physical, psychological or social injury while they are participating as subjects in research, development or related activities. The regulation extends to the human fetus (either in utero or ex utero), the dead, organs, tissues, and body fluids, and graphic, written or recorded information derived from human sources.

The DHHS regulation requires institutional assurances, including the implementation of procedures for review, and the assignment of responsibilities for adequately protecting the rights and welfare of human subjects. Safeguarding these rights and welfare is, by DHHS policy, primarily the responsibility of the grantee. The Contractor is responsible for ensuring that the activity described or covered by this Agreement, and additional information relating to human subjects, derived materials or data are annually reviewed and approved by the Institutional Review Board of the Contractor. The Contractor and HRI agree to complete a HHS 596 form on an annual basis.

(b) Laboratory Animals

The Contractor agrees to abide by PHS policy requiring that laboratory animals not suffer unnecessary discomfort, pain or injury. The Contractor must assure PHS, in writing, that it is committed to following the standards established by the Animal Welfare Acts and by the documents entitled "Principles for Use of Animals" and "Guide for the Care and Use of Laboratory Animals."

(c) Recombinant DNA

The Contractor agrees to abide by the current PHS Guidelines for Research involving Recombinant DNA Molecules. All research involving recombinant DNA techniques that is supported by the Public Health Service must meet the requirements of these Guidelines, which were developed in response to the concerns of the scientific and lay communities about the possible effects of recombinant DNA research. Their purpose is to specify practices for the construction and handling of recombinant DNA molecules and organisms or viruses containing recombinant DNA. As defined by the Guidelines, "recombinant DNA" corresponds to: (1) molecules that are constructed outside living cells by joining natural or synthetic DNA segments to DNA molecules that can replicate in a living cell; or (2) DNA molecules that result from the replication of a molecule described in (1).

Several types of studies involving recombinant DNA are exempt from the Guidelines while others are prohibited by the Guidelines. For the remainder, the Contractor must establish and implement policies that provide for the safe conduct of the research in full conformity with the Guidelines. This responsibility includes establishing an institutional biosafety committee to review all recombinant DNA research to be conducted at or sponsored by the Contractor and to approve those projects that are in conformity with the Guidelines. For each approved project, a valid Memorandum of Understanding and Agreement (MUA) shall be prepared for submission when solicited by an appropriate PHS staff member. The MUA is considered approved after review and acceptance by ORDA and by the Contractor.

(d) Other DHHS-PHS Regulations

The Contractor agrees to comply with applicable DHHS regulations concerning Civil Rights and Equal Opportunity, Student Unrest Provisions, Handicapped Individuals and Sex Discrimination.

(e) Additional Assurances

Under this grant, should any additional DHHS-PHS regulations be promulgated, the Contractor and HRI will review and agree, if feasible, to include them as part of this Agreement.

7. Anti-Kickback Act Compliance

If this subject contract or any subcontract hereunder is in excess of \$2,000 and is for construction or repair, Contractor agrees to comply and to require all subcontractors to comply with the Copeland "Anti-Kickback" Act (18 U.S.C. 874), as supplemented by Department of Labor regulations (29 CFR part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States"). The Act provides that each contractor or subrecipient shall be prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he is otherwise entitled. The Contractor shall report all suspected or reported violations to the Federal-awarding agency.

8. Davis-Bacon Act Compliance

If required by Federal programs legislation, and if this subject contract or any subcontract hereunder is a construction contract in excess of \$2,000, Contractor agrees to comply and/or to require all subcontractors hereunder to comply with the Davis-Bacon Act (40 U.S.C. 276a to a-7) and as supplemented by Department of Labor regulations (29 CFR part 5, "Labor Standards Provisions Applicable to Contracts Governing Federally Financed and Assisted Construction"). Under this Act, contractors shall be required to pay wages to laborers and mechanics at a rate not less than the minimum wages specified in a wage determination made by the Secretary of Labor. In addition, contractors shall be required to pay wages not less than once a week. The recipient shall place a copy of the current prevailing wage determination issued by the Department of Labor in each solicitation and the award of a contract shall be conditioned upon the acceptance of the wage determination. The contractor shall report all suspected or reported violations to the Federal-awarding agency.

9. Contract Work Hours and Safety Standards Act Compliance

Contractor agrees that, if this subject contract is a construction contract in excess of \$2,000 or a non-construction contract in excess of \$2,500 and involves the employment of mechanics or laborers, Contractor shall comply, and shall require all subcontractors to comply, with Sections 102 and 107 of the Contract Work Hours and Safety Standards Act (40 U.S.C. 327-333), as supplemented by Department of Labor regulations (29 CFR part 5). Under Section 102 of the Act, each Contractor shall be required to compute the wages of every mechanic and laborer on the basis of a standard workweek of 40 hours. Work in excess of the standard workweek is permissible provided that the worker is compensated at rate of not less than 1 1/2 times the basic rate of pay for all hours worked in excess of 40 hours in the workweek. Section 107 of the Act is applicable to construction work and provides that no laborer or mechanic shall be required to work in surroundings or under working conditions which are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market or contracts for transportation or transmission of intelligence. Contractor agrees that this clause shall be included in all lower tier contracts hereunder as appropriate.

10. Clean Air Act Compliance

If this subject contract is in excess of \$100,000, Contractor agrees to comply and to require that all subcontractors have complied, where applicable, with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.). Violations shall be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

11. Notice as Required Under Public Law 103-333

The Contractor is hereby notified of the following statement made by the Congress at Section 507(a) of Public Law 103-333 (The DHHS Appropriations Act, 1995, hereinafter the "Act"): It is the sense of the Congress that, to the greatest extent practicable, all equipment and products purchased with funds made available in this Act should be American-made.

12. Americans with Disabilities Act

This agreement is subject to the provisions of Subtitle A of Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. 12132 ("ADA") and regulations promulgated pursuant thereto, see 28 CFR Part 35. The Contractor shall not discriminate against an individual with a disability, as defined in the ADA, in providing services, programs or activities pursuant to this Agreement.

13. Required Federal Certifications

Acceptance of this Agreement by Contractor constitutes certification that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any Federal department or agency.

Acceptance of this Agreement constitutes certification that the Contractor is not delinquent on any Federal debt.

Acceptance of this Agreement constitutes certification by the Contractor that:

No Federal appropriated funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan or cooperative agreement.

If funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a Federal contract, grant, loan, or cooperative agreement, the contractor shall complete and submit to HRI the Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

Acceptance of this Agreement constitutes certification by the Contractor that it shall comply with the requirements of the Pro-Children Act of 1994 and shall not allow smoking within any portion of any indoor facility used for the provision of health, day care, early childhood development, education or library services to children under the age of eighteen (18) if the services are funded by a federal program, as this Agreement is, or if the services are provided in indoor facilities that are constructed, operated or maintained with such federal funds.

The Contractor shall require that the language of all of the above certifications will be included in the award documents for all subawards under this Agreement (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

The Contractor agrees to notify HRI immediately if there is a change in its status relating to any of the above certifications.

14. Any reimbursement payable hereunder by HRI to the subcontractor shall be subject to retroactive reduction and/or repayment for amounts included therein which are found by HRI on the basis of any audit of this Agreement by HRI, a representative of HRI or the original contract sponsor for which the reimbursement did not constitute an allowable charge or cost hereunder.

15. The failure of HRI to assert a right hereunder or to insist upon compliance with any term or condition of this Agreement shall not constitute a waiver of that right by HRI or excuse a similar subsequent failure to perform any such term or condition by Contractor.

Attachment 15

15. HRI Consultant Agreement

(See Attached PDF File)

CONSULTANT AGREEMENT

THIS AGREEMENT, made this ____ day of _____ 2003, by and between **HEALTH RESEARCH, INC.**, a not for profit corporation organized and existing under the laws of the State of New York, with principal offices located at One University Place, Rensselaer, NY 12144-3447, hereinafter referred to as **HRI**, and "**Consultant's NAME**", located at "Consultant Address", herein after referred to as the **CONSULTANT**.

WITNESSETH

WHEREAS, HRI has been awarded a grant from "Sponsor's Name" for the conduct of a project entitled ""Project Title""; and,

WHEREAS, HRI desires the Consultant's performance of certain services for HRI in connection with such project; and,

WHEREAS, Consultant has represented to HRI that "he/she/it" is competent, willing and able to perform such service for HRI.

NOW THEREFORE, in consideration of the premises and the mutual covenants and agreements contained herein, it is mutually agreed by and between the respective parties as follows:

1) Consultant agrees to perform, as an independent contractor and not as an agent of HRI, all the services set forth in Exhibit "A", appended hereto and made a part hereof, to the satisfaction of HRI's Principal Investigator, "PI's Name".

2) In full and complete consideration of Consultant's performance hereunder, HRI agrees to compensate Consultant at a rate of "\$rate" per "per hr or day" for a maximum of "\$max amount" plus travel expenses in an amount not to exceed "\$travel amount" pursuant to the breakdown in Exhibit "A" attached. Final invoices are due within 60 days of the termination date of this Agreement. Requests received after this 60-day period may not be honored.

3) The Scope of Work and Budget in Exhibit "A" may be modified as conditions warrant by mutual agreement between HRI and Consultant. In no event shall the total consideration under this Agreement exceed "total contract amount typed out" Dollars ("total contract amount in numbers").

4) Consultant acknowledges that all materials produced or delivered by Consultant in the performance of its obligations hereunder are "work for hire". Consultant further agrees that "he/she/it" shall not claim or assert any proprietary interest in any of the data or materials required to be produced or delivered by Consultant in the performance of its obligation hereunder. Consultant warrants that any such material produced by Consultant hereunder shall be original except for such portion from copyrighted works as may be included with the permission of the copyright owner(s) thereof, that it shall contain no libelous or unlawful statements or materials, and will not infringe upon any copyright, trademark or patent, statutory or other proprietary rights of others and that it will hold harmless HRI from any costs, expenses and damages resulting from any breach of this warranty.

Consultant further agrees that "he/she/it" will not publish, permit to be published, or distribute for public consumption, any information, oral or written, concerning the results or conclusions made pursuant to this Agreement without the prior written consent of HRI.

5) Neither party shall use the name of the other or any adaptation, abbreviation or derivative of any of them, whether oral or written, without the prior written permission of the other party. For the purposes of this paragraph "party" on the part of HRI shall include the New York State Department of Health and the State of New York.

6) It is understood and agreed that the services to be rendered by Consultant are unique and that Consultant shall not assign, transfer, subcontract or otherwise dispose of its rights or duties hereunder, in whole or in part, to any other person, firm or corporation.

7) The nature of the relationship which the Consultant shall have to HRI pursuant to this Agreement shall be that of an independent contractor. Under no circumstance shall the Consultant be considered an employee of HRI. This Agreement shall not be construed to contain any authority, either express or implied, enabling the Consultant to incur any expense or perform any act on behalf of HRI.

8) The Consultant agrees to abide by the terms and conditions of Appendix "A" attached hereto and made a part hereof.

9) This agreement represents the entire Agreement and understanding of the parties hereto and no prior writings, conversations or representations of any nature shall be deemed to vary the provisions hereof. This Agreement may not be amended in any way except by a writing duly executed by both parties hereto.

10) The Agreement shall be effective and allowable costs may be incurred by the Consultant from "start date" and shall continue until "end date" unless terminated sooner as hereinafter provided.

11) HRI may terminate this Agreement with or without cause at any time by giving advance notice, when, in its sole discretion, HRI determines that it is in the best interests of HRI to do so. Such termination shall not affect any commitments which, in the judgment of HRI, have become legally binding prior to the effective date of termination.

It is understood and agreed, however, that in the event that Consultant is in default upon any of its obligations hereunder at the time of such termination, such right of termination on the part of HRI shall expressly be in addition to any other rights or remedies which HRI may have against Consultant by reason of such default.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement the day and year first written above.

HEALTH RESEARCH, INC.

"CONSULTANT'S NAME"

Michael J. Nazarko
Executive Director

Soc. Sec. No. "SS #"