NOTICE – All information which would permit identification of the individual will be held in strict confidence; will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any purposes.

BUDGET BUREAU NO. 68-R1600
APPROVAL EXPIRES MARCH 31, 1969

FORM NHS-HIS-4
(12-67)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
U.S. PUBLIC HEALTH SERVICE

Book _____ of _____ Books

PSU | Segment No.

Serial No. | Sample No. B–

U.S. HEALTH INTERVIEW SURVEY
NON-FOSDIC SUPPLEMENT

HOSPITAL PAGE

DOCTOR'S AND SURGEON'S BILL SUPPLEMENT– *Fill for each completed hospital stay.*

Enter the person number and the date of entry →

PERSON NO.	DATE OF ENTRY Month	Day	Year

INTERVIEWER CHECK ITEM:
0 ☐ No operation *(Next hospital page)*
1 ☐ Operation or delivery/birth (1a)

DOCTOR/SURGEON Dollars	Cents

1a. What was the amount of the surgeon's (doctor's) bill for this operation (delivery)?

b. Is the $_____ for the surgeon's (doctor's) bill included in the $ _____ amount you gave for the hospital bill?

1 ☐ Yes (In a footnote, indicate the actual amount of the hospital bill after deducting the surgeon's (doctor's) bills; also indicate any changes in the amounts paid by health insurance or other sources if the entries in questions 9 and 10 include payments for expenses other than the hospital bill). (2)

4 ☐ No (2)

2a. Did (will) health insurance pay any part of the surgeon's (doctor's) bill? ☐ Yes ☐ No (3a)

Name of Insurance Plan	Dollars	Cents

b. What is the name of the insurance plan?

c. Did (will) any other health insurance plan pay part of the surgeon's (doctor's) bill? ☐ Yes *(Reask b)* ☐ No *(d)*

Ask for each health insurance plan named, then go to 3b.

d. What was (will be) the amount paid by (Name of plan)?

Enter total amount paid by health insurance in line A
Enter any amount paid by Social Security Medicare in line B

3a. Who paid (will pay) the surgeon's (doctor's) bill?

b. Did (you or) any other person or agency pay any other part of the surgeon's (doctor's) bill? ☐ Yes *(c and Reask b)* ☐ No (d or next hosp. p.)

c. Who was this?

d. What was the amount paid by – – ?

Source of Payment	Dollars	Cents
A. 1 ☐ Health Insurance *(All plans excluding Medicare)*		
B. 2 ☐ Social Security Medicare		
C. 3 ☐ Self and Family in Household		
D. 4 ☐ Other *(Specify)* → _____		

NOTE: Turn to back cover (p. 8) for additional Surgeon's (Doctor's) Bill Supplement.

FOOTNOTES:

NOTE: Fill pages 2-7 after asking Q. 27 on the Fosdic Questionnaire. Begin with the Interviewer Check Item below.		**Age**
		①
INTERVIEWER CHECK ITEM If person is under 17 years, or not in Labor Force (Q.26a-d blank) check "Not in Labor Force." If in Labor Force (Q.26 filled) refer to Question 13 (cond.) and make appropriate entry.		0 ☐ Not in Labor Force or Under 17 *(NP)* 1 ☐ No work-loss days in Labor Force *(NP)* ☐ Work-loss days ________ *(4a)*
Earlier you said that -- lost -- days from work during the past 2 weeks – (If self-employed, ask c; for other workers, ask a) **4a. On how many of these -- days that he lost from work was he paid any wages by his employer?**	**4a.**	00 ☐ None *(4c)* ____ Days *(4b)*
b. On how many of these -- days was he paid his full day's pay?	**b.**	00 ☐ None *(4c)* 15 ☐ All of them *(4g)* ____ Days *(4c)*
c. (In addition to this sick leave pay) will -- be paid for some of the income he lost on these days, through some other source, such as, loss of pay insurance, workman's compensation or State temporary disability insurance?	**c.**	☐ Yes *(4d)* ☐ No *(4e)*
d. Who will pay this? (Enter verbatim response)	**d.**	*(4e)* ☐
e. How much income did he lose because of the -- days lost from work?	**e.**	$________________
f. Is this before or after taxes?	**f.**	1 ☐ Before 2 ☐ After
g. How much does -- usually earn per week? If not regularly employed, ask: **How much would -- have earned in a week if he wasn't sick?**	**g.**	$________________
h. Is this before or after taxes?	**h.**	1 ☐ Before *(NP)* 2 ☐ After *(NP)*

These next questions are about health insurance. We are interested in all kinds of health insurance plans except those which pay only for accidents.

5a. (Not counting Social Security Medicare), is anyone in the family covered by hospital insurance, that is, a health insurance plan which pays any part of a hospital bill?	☐ Yes *(5b, c)*	☐ No *(5d)*
b. What is the name of the plan? (Record in Table H.I.)		
c. (Again not counting Medicare), is anyone in the family covered by any other health insurance plan which pays any part of a hospital bill?	☐ Yes *(5b, c)*	☐ No *(5d)*
d. (Besides Medicare **and the -- plan(s) you already told me about)is anyone in the family covered by any health insurance plan which pays any part of a doctor's or surgeon's bill?**	☐ Yes *(5e, f)*	☐ No *(If no plans in Q. 5a-d) go to Q. 6)*
e. What is the name of the plan? (Record in Table H.I.)		*(Complete Table H.I. for each plan)*
f. Does anyone in the family have any other health insurance plan (besides Medicare)?	☐ Yes *(5e, f)*	☐ No

If 65 or over, ask: **6. These next questions are about Social Security Medicare. Does -- have a Medicare card?**	**6.**	0 ☐ Und. 65 *(NP)* ① ☐ Yes *(NP)* ☐ No *(NP)*
If "Yes" for one or more persons in Q. 6, ask: **7. It would be helpful if I could see -- (and --) Medicare card (s) to determine what type of coverage he has (they have). May I please see this (those) card(s)?** (Transcribe the information from the card or check the appropriate "No card" box.)	**7.**	From card: 1 ☐ Hospital 2 ☐ Medical *NP* No card: 4 ☐ Can't loc. 5 ☐ Refused *NP* 6 ☐ Other ____________ ☐
For each person with "No" in Q. 6 or "No card" in Q. 7, ask: **8a. Is -- covered by that part of Social Security Medicare which pays for hospital bills?**	**8a.**	☐ Yes ☐ No
b. Is -- covered by that part of Medicare which pays for doctor's bills? That is, the Medicare plan for which he or some agency must pay $3.00 a month?	**b.**	☐ Yes *(NP)* ☐ No *(NP)*
I For each person check Table H.I. and Q. 7 and 8 and determine. if "Covered" by insurance or Medicare or "Not Covered" by either.		0 ☐ Covered *(NP)* ☐ Not covered *(9)*
9. (Many people do not carry health insurance for various reasons), Would you mind telling me why -- does not have health insurance?	**9.**	☐ *(NP)*

FOOTNOTES:

WASHINGTON USE ONLY

	H	S	D
No. of plans			
Type of plans			
Cov. of head			

h. 1 [ ] Bef. (NP) 2 [ ] Aft.(NP) | 1 [ ] Before (NP) 2 [ ] After (NP) | h. 1 [ ] Bef. (NP) 2 [ ] Aft.(NP) | ...

TABLE H.I.

Line No.	Name of plan (1)	Which members of the family are covered by (name of plan)? Circle column numbers. Is anyone else in the family covered under this policy? (2)	If 2 or more members of family covered by this plan ask: Do all these persons have the same benefits under this -- plan? (*If no, fill separate line for each person(s) with different benefits) (3)	Does -- pay any part of a hospital bill? (4)	Does -- pay any part of a surgeon's bill? (5)	Does this plan pay any part of a doctor's bill for office visits or home calls? * Yes (Next plan) ** No (Column 7) (6)	Does this plan pay any part of a doctor's bill for office visits or home calls after a certain amount has been paid by the family? (7)
A		1 2 3 4 5 6 7 8 9 10	[ ] Yes [ ] No*	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes* [ ] No**	[ ] Yes [ ] No
B		1 2 3 4 5 6 7 8 9 10	[ ] Yes [ ] No*	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes* [ ] No**	[ ] Yes [ ] No
C		1 2 3 4 5 6 7 8 9 10	[ ] Yes [ ] No*	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes* [ ] No**	[ ] Yes [ ] No
D		1 2 3 4 5 6 7 8 9 10	[ ] Yes [ ] No*	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes* [ ] No**	[ ] Yes [ ] No
E		1 2 3 4 5 6 7 8 9 10	[ ] Yes [ ] No*	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes* [ ] No**	[ ] Yes [ ] No

Item	(2)	(3)	(4)	(5)	(6)
6.	0 [ ] Und.65 (NP) [ ] Yes (NP) [ ] No (NP)	0 [ ] Und.65 (NP) [ ] Yes (NP) [ ] No (NP)	0 [ ] Und.65 (NP) [ ] Yes (NP) [ ] No (NP)	0 [ ] Und.65 (NP) [ ] Yes (NP) [ ] No (NP)	0 [ ] Und.65 (NP) [ ] Yes (NP) [ ] No (NP)
7.	From card: 1 [ ] Hospital 2 [ ] Medical } NP No card: 4 [ ] Can't loc. 5 [ ] Refused } NP 6 [ ] Other____ [ ]	From card: 1 [ ] Hospital 2 [ ] Medical } NP No card: 4 [ ] Can't loc. 5 [ ] Refused } NP 6 [ ] Other____ [ ]	From card: 1 [ ] Hospital 2 [ ] Medical } NP No card: 4 [ ] Can't loc. 5 [ ] Refused } NP 6 [ ] Other____ [ ]	From card: 1 [ ] Hospital 2 [ ] Medical } NP No card: 4 [ ] Can't loc. 5 [ ] Refused } NP 6 [ ] Other____ [ ]	From card: 1 [ ] Hospital 2 [ ] Medical } NP No card: 4 [ ] Can't loc. 5 [ ] Refused } NP 6 [ ] Other____ [ ]
8a.	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No
b.	[ ] Yes (NP) [ ] No (NP)	[ ] Yes (NP) [ ] No (NP)	[ ] Yes (NP) [ ] No (NP)	[ ] Yes (NP) [ ] No (NP)	[ ] Yes (NP) [ ] No (NP)
	0 [ ] Covered (NP) [ ] Not covered (9)	0 [ ] Covered (NP) [ ] Not covered (9)	0 [ ] Covered (NP) [ ] Not covered (9)	0 [ ] Covered (NP) [ ] Not covered (9)	0 [ ] Covered (NP) [ ] Not covered (9)
9.	[ ] (NP)	[ ] (NP)	[ ] (NP)	[ ] (NP)	[ ] (NP)

WASHINGTON USE ONLY (repeated in each of the five columns)

	H	S	D
No. of plans			
Type of plans			
Cov. of head			

INTERVIEWER CHECK ITEM

Check questions 22a-22d and 23c on pages 4 and 5 of the Fosdic Questionnaire.

Is a Home Care Page required? → ☐ Yes – *Fill Home Care Page(s).*
☐ No – *Go to Q. 10 on Page 6.*

HOME CARE PAGE

Person No.	Control

Earlier in the interview you mentioned that -- needed help of some kind here at home. I am going to read a list of different kinds of personal care some people need in the home. Please tell me if -- needs help in any of the following ways.

1a. Does -- need help at home –	No	Yes	1b. Who helps --?	For each "Yes" answer to 1a, ask: Does anyone else help --?	WASH. USE
in walking up stairs or getting from room to room?				☐ No	
in dressing or putting on shoes?				☐ No	
Does -- need help at home – with bathing (shaving) or other toilet activities?				☐ No	
in eating or having meals served in bed?				☐ No	
Does -- need help at home – with changing bandages?				☐ No	
in receiving injections?				☐ No	
with other treatments? . . . . . If "Yes," ask: What kinds of treatment? *Specify* _____				☐ No	
Does -- need help at home – in changing bed positions?				☐ No	
in exercising or physical therapy?				☐ No	
in cutting toenails?				☐ No	
Does -- get any OTHER help or care here at home? . . . . If "Yes," ask: What kinds of other help or care? *Specify* _____				☐ No	

IF PERSON DOES NOT NEED OR RECEIVE CARE (All "No's" to question 1a), reconcile differences between answers in question 22 or 23 and question 1_a above or describe the situation in the footnote space below.

2. For what condition(s) does -- need this help or care? *(Specify condition(s))* _____

Any other conditions? _____

3. How long has -- received help or care at home? *(Mark one box)*

1 ☐ 1 month or less
2 ☐ Over 1-6 months
3 ☐ Over 6 to 12 months
4 ☐ Over 1 to 3 years
5 ☐ Over 3 to 5 years
6 ☐ Over 5 years

4. Because of --'s health, must someone be in the house with him all of the time, part of the time, or only when providing the needed help or care?

1 ☐ All of the time
2 ☐ Part of the time
3 ☐ Only when providing the needed help or care

For each person, other than a nurse, listed in 1b, ask:

5a. Is -- a nurse, a physical therapist, or some other kind of health worker?
If "Nurse," reported in Q. 1b or 5a, ask:
b. Is the nurse that cares for -- a registered nurse, a practical nurse, or some other kind of nurse?

(Determine the type(s) of person(s) providing the care in question 1 and mark appropriate box in column (1) of Table H.)

FOOTNOTES:

TABLE H

Type of persons providing care (1)		During the past two weeks on about how many days did -- receive help or care from (relative, nurse, etc.)? (2)		About how many hours a day does -- receive help or care from (relative, nurse, etc.)? (3)			Is (relative, nurse, etc.) paid for these services? (4)	
		Days	xx Don't know	Hours	00 Less than 1 hour	xx Don't know	1 Yes	2 No
NON-HEALTH WORKERS	A. 8 ☐ Related household members							X
	B. 1 ☐ Related persons not in household							
	C. 2 ☐ Friend or neighbor							
	D. 3 ☐ Other *(Specify)* → _____							
HEALTH WORKERS	E. 4 ☐ Nurse - Registered							
	F. 5 ☐ Nurse - Practical or other							
	G. 6 ☐ Physical therapist							
	H. 7 ☐ Other *(Specify)* → _____							

INTERVIEWER: Mark the appropriate box before going to Q's 6-8.

☐ Person 65 + and "Yes" in column (4) *(Go to 6)*
☐ Person 55-64 and "Yes" in column (4) *(Go to 7)*
☐ All "No's" in column (4) *(Go to 8)*

6. Are any of these services paid for by Medicare? 1 ☐ Yes 2 ☐ No x ☐ Don't know

7a. Who pays (the remainder of the bill) for these services?
b. Anyone else?

1 ☐ Self or family
2 ☐ Other relative or friend
3 ☐ Health insurance
4 ☐ Agency or organization (Visiting Nurses Association, etc.)
5 ☐ Welfare
6 ☐ Other *(Specify)* _____

8a. During the past 12 months, has -- received any care at home from a nurse? ☐ Yes *(8b)* 000 ☐ No *(Stop)*

b. During the past 12 months, ABOUT how many visits did a nurse make to care for --? Number of visits _____.

FOOTNOTES:

WASHINGTON USE

		①
These next questions are about motor vehicle accidents, that is, accidents, involving cars, trucks, buses, motorcycles, and so forth. We are interested in all types of motor vehicle accidents even if no one was injured. 10a. During the past 12 months, has -- been in a motor vehicle accident either as a (driver), passenger or pedestrian?	10a.	☐ Yes *(10b)* ☐ No *(NP)*
b. How many motor vehicle accidents has -- been in during the past 12 months?	b.	____Number of accidents
c. On what date(s) did the accident(s) happen?	c.	Month / Day / Year 1. / / / 2. / / / 3. / / /
d. Was -- in any other motor vehicle accident during the past 12 months?	d.	☐ Yes *(10c & d)* ☐ No *(NP)*
For all persons 14 years of age and older, ask: 11a. Has -- driven a motor vehicle during the past 12 months?	11a.	X0 ☐ Under 14 yrs. *(NP)* ☐ Yes *(11b)* X1 ☐ No *(NP)*
b. How many years has -- been driving?	b.	00 ☐ Less than 1 year ____Number of years

INTERVIEWER CHECK ITEM

☐ None

Fill a Motor Vehicle Accident Supplement for each motor vehicle accident reported in Q. 10 above.
If no motor vehicle accidents reported – fill the Household Page and end interview.

Number of MVA supplements:

12. Which of these income groups represents your total combined family income for the past 12 months – that is, yours, your -- 's, etc? (Show Card I) Include income from all sources such as wages, salaries, social security or retirement benefits, help from relatives, rent from property, and so forth.	12.	☐ A* ☐ F ☐ B* ☐ G ☐ C* ☐ H ☐ D* ☐ I ☐ E* ☐ J * Ask 13
For each family with A through E checked in 12, ask: 13a. During the past 12 months, has anyone in the family (you, your --, etc.) received any public assistance, relief, or welfare money from State or local governments?	13a.	☐ Yes *(b)* ☐ No *(Household page)*
b. At present, are you or any member of your family receiving any of this aid?	b.	☐ Yes *(c)* ☐ No *(Household page)*
c. What kind of aid is this? (Write in)	c.	_____

FOOTNOTES:

Enter the person number and the date of entry →

PERSON NO.	DATE OF ENTRY Month	Day	Year

INTERVIEWER CHECK ITEM:
0 ☐ No operation *(Next hospital page)*
1 ☐ Operation or delivery/birth (1a)

DOCTOR/SURGEON Dollars	Cents

1a. What was the amount of the surgeon's (doctor's) bill for this operation (delivery)?

b. Is the $_____ for the surgeon's (doctor's) bill included in the $ _____ amount you gave for the hospital bill?

1 ☐ Yes (In a footnote, indicate the actual amount of the hospital bill after deducting the surgeon's (doctor's) bills; also indicate any changes in the amounts paid by health insurance or other sources if the entries in questions 9 and 10 include payments for expenses other than the hospital bills). (2)

4 ☐ No (2)

2a. Did (will) health insurance pay any part of the surgeon's (doctor's) bill? ☐ Yes ☐ No (3a)

	Name of Insurance Plan	Dollars	Cents
b. What is the name of the insurance plan?			
c. Did (will) any other health insurance plan pay part of the surgeon's (doctor's) bill? ☐ Yes *(Reask b)* ☐ No *(d)*			
Ask for each health insurance plan named, then go to 3b. **d. What was (will be) the amount paid by (Name of plan)?**			

Enter total amount paid by health insurance in line A
Enter any amount paid by Social Security Medicare in line B

3a. Who paid (will pay) the surgeon's (doctor's) bill?

b. Did (you or) any other person or agency pay any other part of the surgeon's (doctor's) bill? ☐ Yes *(c and Reask b)* ☐ No (d or next hosp. page)

c. Who was this?

d. What was the amount paid by – – ?

Source of Payment	Dollars	Cents
A. 1 ☐ Health Insurance *(All plans excluding Medicare)*		
B. 2 ☐ Social Security Medicare		
C. 3 ☐ Self and Family in Household		
D. 4 ☐ Other *(Specify)* → _____		

FOOTNOTES

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