NEW YORK STATE DEPARTMENT OF HEALTH
and HEALTH RESEARCH INCORPORATED

A Request for Proposal for

Bureau of Chronic Disease Research and Evaluation

RFP No. 16526

Behavioral Risk Factor Surveillance System (BRFSS)

Schedule of Key Events

RFP Release Date	April 22, 2016
Written Questions Due	May 6, 2016
Letter of Interest Due (optional)	May 6, 2016
Response to Written Questions on or about	May 20, 2016
Proposal Due Date	4:00PM ET, June 7, 2016
Anticipated Contract Start Date	October 1, 2016

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:

Elizabeth Wood
NYS Department of Health, Bureau of Contracts
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Albany, New York 12237
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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:

1. Submission of written proposals or bids
2. Submission of Written Questions
3. Debriefings
4. Negotiation of Contract Terms after Award

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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 contractor to assist the New York State Department of Health (NYSDOH) and Health Research, Inc. (HRI), a not-for-profit organization responsible for grants administration of non-state funding sources for the NYSDOH, with conducting the NYS Behavioral Risk Factor Surveillance System (BRFSS) according to the standardized protocol developed by the Centers for Disease Control and Prevention (CDC) (Attachments 1, 2, and 3).

It is the intent of the NYSDOH and HRI to enter into contracts with the one (1) bidder selected as a result of this RFP. Both contracts will be for a period of five (5) years and three (3) months. The NYSDOH (State) contract period is anticipated to be October 1, 2016 through March 31, 2022, contingent upon performance of the required activities on schedule and within cost, adherence to CDC BRFSS and NYSDOH protocols, and on-going availability of funds. During the period from October 1 through December 31, prior to each survey year, the contractor will be responsible for start-up activities in advance of the beginning of data collection in January for each survey year. It is anticipated that the contractor will conduct the 2017, 2018, 2019, 2020 and 2021 annual BRFSS January through December of each year. During the period from January 1 through March 31 following each survey year, the contractor will be responsible for data cleaning and preparation and submission of the final data set. The HRI contract period is anticipated to be October 1, 2016 through March 31, 2022. The HRI contract will be renewed annually contingent upon performance of the required activities on schedule and within cost, adherence to CDC BRFSS and NYSDOH protocols, and on-going availability of funds. During the period from January 1 – December 31 of each survey year, the contractor will be conducting surveys. Please see Attachment 18 for a visual of the State/HRI contract period and activities. The contractor shall be responsible for providing the Contract Deliverables in accordance with the specifications in this RFP.

B. BACKGROUND

Overview of BRFSS

The BRFSS is an annual phone survey conducted by all 50 states in the United States in coordination with the CDC. The NYSDOH/HRI has conducted the statewide BRFSS according to CDC protocol since 1985. The annual statewide telephone survey of adults is administered through the Bureau of Chronic Disease Evaluation and Research, Division of Chronic Disease Prevention. Data obtained from the BRFSS is vital and used by multiple NYSDOH programs and partners around NYS 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 NYSDOH website at http://www.health.ny.gov/statistics/brfss/.

The BRFSS is supported by a cooperative agreement with the CDC and by State funding provided by NYSDOH programs and other State agencies to support the inclusion of program specific questions. As part of the BRFSS annual survey, a randomly selected sample of non-institutionalized adults (aged 18 years and older) is administered survey questions that assess modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population (Attachment3). The BRFSS was developed by the CDC to promote consistent data collection across states, while simultaneously affording flexibility to meet the annual information needs of the NYSDOH and others. The BRFSS questionnaire includes 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 and can address their emerging public health issues through the use of state-added questions. States also have the option of conducting split surveys, fielding two or more questionnaires consisting of a common core set of questions and a different mix of optional and state-added questions within a survey year. This allows states to obtain information on a greater variety of topics and, importantly, for a larger sample. The NYSDOH 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, geography and the racial/ethnic composition of the population. In 2014, BRFSS completed approximately 6,800 interviews using a single questionnaire design. Approximately one-third (2,169) were cell phone interviews. NYS BRFSS surveys are conducted in both English and Spanish. Each year NYSDOH determines the number of completed surveys to be attained based on available funding.

The CDC BRFSS methodology and protocol has also been applied to other NYSDOH telephone surveys. Both the CDC and NYSDOH/HRI have used the BRFSS survey as the basis for completing call back surveys with a portion of the sample completing the annual survey. Between 2006 and 2015 the NYS BRFSS incorporated an Asthma Call Back Survey (see attachments 2 for protocol and 4 and 5 for questionnaires). It is anticipated that the Asthma Call Back Survey as a component of the NYS BRFSS will continue through the 2017 survey year and future years covered through this contract. This RFP includes criteria and scoring to assess the experience and ability of bidders to conduct a call back survey should there be the need and funding available for these purposes within the contract period.

The CDC BRFSS methodology was also used for the 2003, 2009 and 2013 Expanded BRFSS projects for county and local-level BRFSS surveillance. In 2013, the Expanded (county-level) BRFSS

collected approximately 32,000 complete surveys. Of the total, 25% (8,000 approximately) were cell phone interviews. Information regarding the Expanded BRFSS projects may be found on the NYSDOH website at http://www.health.ny.gov/statistics/brfss/expanded/. These surveys require using stratification, over-sampling, and other survey techniques to improve survey efficiency and reduce bias. They also require the application of statistical methods to weight the data to produce statistically valid population estimates. This RFP will serve as the basis of completing the scope of work for completing the annual BRFSS and the Expanded BRFSS survey that is expected to occur in 2018.

Since 2009, the NYS BRFSS has included a cell phone survey component. Beginning in 2011 the CDC required States to administer the annual BRFSS by cell phone (Attachment 1). The 2017 NYS BRFSS will also include both a land line and cell phone data collection survey component which shall be administered in adherence to the CDC protocol within the contract period.

The CDC has encouraged states to pursue alternative formats for administering the BRFSS, including by mail, Internet or smartphone application. This RFP includes criteria and scoring to assess the experience and ability of bidders to conduct the survey using alternative formats (i.e., other than landline or cell phone) should there be the need and funding available for these purposes within the contract period.

C. DETAILED SPECIFICATIONS

1. Annual Statewide NYS BRFSS

The average survey length is approximately 25 minutes, with approximately 140 questions including core, optional, and state-added modules for the annual NYS BRFSS. Typically a larger number of additional questions are included, requiring the questions to be asked via split survey methods to maintain an appropriate length of survey.

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 protocols for landline and cell phone data collection, anticipated to begin with the 2017 survey:

a. Maintain the current methodology for using list-assisted random digit dialing telephone survey procedures identified through CDC protocol to select a statewide probability sample of the non-institutionalized, civilian adult population aged 18 years and over;

b. Set up and test the survey questionnaire(s) to be conducted using contractor supplied Computer Assisted Telephone Interviewing (CATI) application software methods in both English and Spanish, and describe procedures that will be used for conducting Spanish speaking interviews; questionnaire content for the BRFSS is revised on an annual basis (September – December) with data collection occurring from January 1 through December 31. NYSDOH develops the questionnaire content in collaboration with the CDC. Public health programs routinely request questions to be included on the NYS BRFSS that have neither been included on the national BRFSS nor other surveys administered by phone. This may necessitate the contractor to perform question development, including cognitive testing, pretesting, writing interview prompts, developing coding for open-ended questions and performing analyses to determine the reliability of questions;

c. Develop methods and procedures for administering the BRFSS by cell phone in accordance with the CDC guidelines for cell phone data collection included within this RFP;

d. Collect questionnaire data in either English or Spanish from adult respondents by trained interviewers using CATI application software, and methodology adhering to the BRFSS protocols for landline and cell phone data collection. The contractor's responsibilities will include all aspects of data collection using CATI application software including computerization of the questionnaire, interviewer training, interview administration, and CATI application software data management; a completed phone interview is defined according to CDC guidelines as an interview in which the selected respondent has been asked all questions up to and including the demographic questions which will be used for weighting;

e. Collect questionnaire data through single survey or split survey methods as directed by NYSDOH during questionnaire development;

f. As needed, make mid-year adjustments to the survey questionnaire and/or sampling plan and/or methods in response to emergent state or federal data collection requirements;

g. Develop procedures which minimize both sampling and non-sampling error while maximizing the sample size achievable with the funding available;

h. Employ widely recognized quality control indicators, disposition codes and response rate measures common to telephone survey methodologies and in accordance with BRFSS protocol;

i. Develop methodologies to conduct timely correction of data errors identified by NYSDOH or CDC staff;

j. Produce clean monthly data files and a final year-end data file for submission to the CDC and NYSDOH according to the timeline provided by the CDC and CDC BRFSS specifications in the BRFSS Data Collection Protocol with Disposition Table (Attachment 1); and

k. Submit quality assurance reports to NYSDOH on a regular basis as directed;

l. Maintain adequate staffing to include project management, supervisors, interviewers (including Spanish speaking), a senior statistician (10+ years with experience in complex sample designs and weighting methods), information technology staff, quality improvement staff, and others as needed. Contractor must adjust staffing patterns within and between survey years to accommodate changes in sample size requirements as needed to complete the scope of work;

m. The contractor will submit resumes of staff hired under the terms of this contract for DOH review prior to the start of work. The Department reserves the right to approve or disapprove the contractor's proposed staffing;

n. The call center will be located and operated within the continental United States.

2. NYS Expanded BRFSS

The selected contractor will also be responsible for conducting survey activities to produce representative data for each of the 62 counties as part of the Expanded (county level) BRFSS. The additional surveys to achieve representative county level estimates will be integrated with New York's annual BRFSS and should be conducted in accordance with the detailed specifications provided under Section C1 of this RFP. In the years the Expanded BRFSS is implemented, the selected contractor will be responsible for designing a stratified sampling plan to achieve a minimum of 400 observations in each of the 62 counties in New York state. The sampling plan would build upon the regional sampling plan used for the annual BRFSS and oversample smaller counties. The contractor will also be responsible for: 1) combining the data from the annual BRFSS with the supplemental sampling, 2) developing weights to produce valid county level estimates, and 3) generating documentation (data dictionary, technical report) and datafiles. NYSDOH has included options for the expanded BRFSS anticipated to be completed in

2018 or 2019, pending the availability of funding, and an additional expanded BRFSS that may be conducted in 2021 or 2022.

The survey length is approximately 25 minutes, with approximately 140 questions. An estimated minimum number of 220 interviews by landline and an estimated minimum number of 180 interviews by cell phone will be completed in each county or borough (55% by landline and 45% by cell phone).

The goal number of interviews to be completed per county will be established in advance of the survey start date.

3. Asthma Call Back Surveys

The selected contractor will also be responsible for conducting all aspects of the Asthma Call Back Surveys (adult and child versions, both asked of the adult, depending on who is identified as having asthma) as a component of the 2017 NYS BRFSS, should funds be made available for this purpose.

The Asthma Call Back Survey length is approximately 20 minutes, with approximately 110 questions for each survey. Interviews are conducted with respondents to the annual NYS BRFSS who previously agreed to be called back. The surveys should be conducted in accordance with the detailed specifications provided under Section C1 of this RFP and Attachment 2 Asthma Call-back Survey Guidelines. Continuation is contingent upon the need for the data and the availability of funding.

4. Funding

The amount of annual funding made available for the project will vary from year to year. The NYS BRFSS is financed through 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 will be administered under the terms of the HRI contract. Therefore, this RFP will be used to establish contracts with both NYSDOH and HRI to conduct each year's statewide survey. The contractor will work with NYSDOH to manage and track payment through both contracts.

5. Goals

    a. Annual BRFSS Survey

    The goal number of interviews to be completed varies from year to year based on availability of funding, but typically is around 10,000 (5,500 by landline, 4,500 by cell phone) to 12,000 (6,600 by landline, 5,400 by cell phone) completed interviews in total. The proportion of interviews by cell phone and landline is set by the Centers for Disease Control and Prevention. The goal number of interviews to be completed will be established in advance of the survey start date, to be determined.

b. Expanded BRFSS Survey

The goal number of interviews to be completed varies from year to year based on available funding, but typically is around 33,000 (18,150 by landline, 14,850 by cell phone) to 37,000 (20,350 by landline, 16,650 by cell phone) completed interviews in total. The proportion of interviews by cell phone and landline is set by the Centers for Disease Control Prevention. The goal number of interiews to be completed per county will be established in advance of the survey start date, to be determined.

c. Asthma Call Back Survey

The goal number of interviews to be completed varies from year to year based on available funding, but typically is around 250 (138 by landline, 112 by cell phone) to 350 (193 by landline, 157 by cell phone) completed interviews in total. The proportion of interviews by cell phone and landline is set by the Centers for Disease Control Prevention. The goal number of interiews to be completed will be established in advance of the survey start date, to be determined.

d. Asthma Call Back Survey – Expanded (County-Level) BRFSS Years

The goal number of interviews to be completed varies from year to year based on available funding, but typically is around 500 (275 by landline, 225 by cell phone) to 700 (385 by landline, 315 by cell phone) completed interviews in total. The proportion of interviews by cell phone and landline is set by the Centers for Disease Control Prevention. The goal number of interviews to be completed will be established in advance of the survey start date, to be determined.

D. PROPOSAL

NYSDOH/HRI reserves the right to change requirements at any time during the bidding 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 NYSDOH and HRI websites. Submission of proposals indicates acceptance of all conditions contained in this RFP.

Entities that choose not to bid are requested to fill out Attachment 9, No Bid Form, and return it to the address listed in Section F. 3. Submission of Proposals.

1. Eligible Bidders

   Eligible bidders include any company or organization which meets the following Mandatory Requirements:
   - Minimum of three (3) years of telephone based survey experience administering dual-path phone surveys of at least 100 questions in length; and
   - Minimum of three (3) years of experience using Computer Assisted Telephone Interviewing (CATI) application software methodology for developing and administering telephone surveys in English and Spanish;
   - Bidder must attest in Attachment 6, Transmittal Letter, they have the ability to have and will have under the contract, if awarded, the call center located and operated within the continental United States.

   To verify minimum experience requirements, the bidder should provide references and contact information from a minimum of two (2) organizations. Bidders are requested to complete Attachment 17, Reference Submission Form. For each reference, provide the name of the organization, a contact name and professional title, address and telephone number. Also provide a project-identifying title, brief description of the scope of the services provided, dates of service, deadlines, reports produced and other relevant information.

2. Preferred Qualifications

   Bidders that demonstrate experience with the following requirements are preferred:
   - Experience administering the BRFSS for a state or US Territory;
   - Experience administering phone surveys requiring approximately 20,000 outgoing contacts (outgoing calls to distinct phone numbers) per month;
   - Experience completing interviews for approximately 1,500 households/cellphones per month;
   - Experience achieving Council of American Survey Research Organizations (CASRO) or American Association for Public Opinion Research (AAPOR) response rates of at least 25% for surveys of at least 100 questions in length.

3. Instructions for Completing Technical Proposal (70%)

   a. Organizational Experience, Capacity, and Ability

   - Please describe your organization's experience, capacity, and ability in the following areas:

     - Conducting population-based RDD telephone interviews (landline) according to CDC protocol (BRFSS) using CATI application software to conduct annual BRFSS and if applicable, county-level BRFSS;

     - Conducting population-based RDD telephone interviews (cell phone) according to CDC guidelines for annual and county-level BRFSS;

     - Conducting Asthma Call Back interviews according to CDC guidelines as a component of population-based telephone surveys;

     - Conducting pilot studies for alternative formats and administering interviews using alternative formats (i.e. mail or web-based) according to CDC guidelines for annual and county-level BRFSS;

     - Conducting surveys in county-level (sub-state) geographical areas, and among population groups defined by socio-economic and demographic characteristics (please describe experience and capacity as detailed in Section C. Detailed Specifications, 2. NYS Expanded BRFSS);

     - Developing questions for inclusion in surveys using CDC (BRFSS) guidelines, including cognitive testing, pretesting and reliability analysis for annual and county-level;

     - Fielding split-surveys that include two or more questionnaires with a common core set of questions and a different mix of optional and state-added questions within a survey year; and

     - Making mid-year changes to modify the annual and/or county-level BRFSS to meet the need for information on emerging public health issues.

   - Provide a description of how the bidder will provide adequate staffing to meet the deliverables outlined in Section C. Detailed Specifications. The description should include:

     - the roles and responsibilities, by title, for all contractor staff carrying out the deliverables as well as the expected number of staff;

     - the expected number of staff needed to provide a full complement of staff;

- an organizational structure, including an organizational chart, that documents the ratio of supervisors to agents typically maintained within the organization and the turnover ratio of interviewers;

- the background and experience of the officers, executives and staff needed to perform the deliverables;

- include job descriptions of key staff which includes project management, supervisors, a senior statistician (10+ years with experience in complex sample designs and weighting methods), information technology staff, quality improvement staff;

- describe how the staff and their functions relate to the successful completion of the contract deliverables;

- a description of how the staff will be trained;

- a description of the process to be used to recruit and retain an adequate level of staff meeting the description in Section C Detailed Specifications;

- a description of how the bidder plans to adjust staffing patterns within and between surveys to accommodate changes in sample size requirements;

- Describe experience, capacity, and ability to develop questionnaires and conduct interviews in English and Spanish.

- Bidder should submit the following in support of meeting the bidder eligibility requirements as stated in RFP Section D 1 Eligible Bidders:

    - A description of how the bidder meets the minimum of three (3) years of telephone based survey experience administering dual-path phone surveys of at least 100 questions in length; and

    - A description of how the bidder meets the minimum of three (3) years of experience using Computer Assisted Telephone Interviewing (CATI) application software methodology for developing and administering telephone surveys in English and Spanish.

- Bidder should submit the following in support of the Preferred Qualifications as stated in RFP Section D.2 Preferred Qualifications:

    - Provide a description, which includes name of state or US Territory, of bidder's experience administering the BRFSS for a state or US Territory;

- Provide a description of bidder's experience administering phone surveys requiring approximately 20,000 outgoing contacts (outgoing calls to distinct phone numbers) per month;

- Provide a description of bidder's experience completing interviews for approximately 1,500 households/cellphones per month;

- Provide evidence of acceptable performance which shows the bidder achieving Council of American Survey Research Organizations (CASRO) or American Association for Public Opinion Research (AAPOR) response rates of at least 25% for surveys of at least 100 questions in length.

- Detailed description and availability of equipment, call-center facilities, capacity, and administrative support to conduct the annual and county-level BRFSS (when directed by the Department), using landline interviews, cell phone interviews, call back interviews, and interviews using alternative formats. 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.

b. Methodology

- Provide a detailed methodology using list-assisted random digit dialing telephone survey procedures following CDC BRFSS protocol to obtain probability samples representative of NYS adults with respect to the age, sex, and race/ethnicity (white/non-white). This should include a description of procedures employed to recruit and interview Spanish speaking respondents.

- Provide a detailed methodology to conduct the cell phone portion of the BRFSS survey referring to the CDC guidelines included with this RFP.

- Provide a detailed methodology to conduct a call back survey as a component of the 2017 NYS BRFSS referring to the CDC guidelines included with this RFP.

- Provide a detailed methodology to conduct an alternative format (i.e. web-based, mail) portion of the BRFSS survey referring to the CDC guidelines included with this RFP and pilot studies of new formats for the BRFSS.

- Provide a detailed description of survey procedures and operations to ensure maximum survey quality and minimum error across modes of survey administration. This may include but is not limited to a description 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 description of procedures to ensure confidentiality and issues related to informed consent.

- Provide a detailed 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 respondent confidentiality and data security.

c. Diversity Practices Questionnaire (Attachment 19)

Bidder should submit the Diversity Practices Questionnaire (Attachment 19).

The Department has determined, pursuant to New York State Executive Law Article 15-A, that the assessment of the diversity practices of respondents to this procurement is practical, feasible, and appropriate. Accordingly, respondents to this procurement should include as part of their response **Attachment 19**, "Diversity Practices Questionnaire". Responses to the questionnaire will be formally evaluated.

d. Prescribed Format

- The Technical Proposal should be no longer than 35 double-spaced, one-sided pages excluding directly relevant appendices (i.e. completed forms included in attachments section; documentation of mandatory requirements, organizational experience, capacity, and capability; and methodology). Only the first 35 pages of the Technical Proposal will be read and scored.

- The Technical Proposal pages should be numbered and printed on 8.5 x 11 inch paper, with one inch margins, using Times New Roman font with a minimum size of 12.

- The Bidder organization's name should be on the header of each page.

4. Instructions for Completing Bid Price Cost Proposal (30%)

Bidders must complete the Bid Price Cost Proposal Form (Attachment 7) provided with this RFP to be considered for this contract, including providing a price for both Option 1, Expanded BRFSS (county level), and Option 2, Expanded BRFSS (county level). Failure to submit a complete Bid Price Cost Proposal Form will result in disqualification.

The annual BRFSS is conducted by landline and cell phone. In Year 1 approximately 45% of interviews will be completed via cell phone and approximately 55% of interviews completed via landline. A corresponding Asthma Call Back survey also occurs annually, pending available funding, and is completed via cell phone (approximately 45%) and landline (approximately 55%).

In addition, it is anticipated that the Expanded (county-level) BRFSS (bid as Option 1) will be conducted via landline and cell phone during 2018 or 2019. An additional Expanded (county-level) BRFSS (bid as Option 2) may be conducted in 2021 or 2022 via landline and cell phone.

A completed interview is defined according to the standards of the American Association for Public Opinion Research and reflects an interview in which the selected respondent has been asked all questions up to and including the demographic questions which will be used for weighting.

a. Bid Price Cost Proposal

1. Annual BRFSS (Part A):

   The goal number of interviews varies from year to year. In some years, a larger number of additional questions are needed, requiring additional questions to be asked in two or more separate survey questionnaires to maintain an appropriate length of survey. The completed interviews will be distributed according to a geographic stratification developed as part of the sampling plan in conjunction with NYS DOH staff. Bidders must submit the Bid Price Cost Proposal Form Part A (Attachment 7) with prices for Year One of this contract:

   - Per completed interview price for a total of 5,500 completed annual BRFSS landline interviews;
   - Per completed interview price for a total of 5,501 or above completed landline interviews;
   - Per completed interview price for 4,500 completed annual BRFSS cell phone interviews;
   - Per completed interview price for a total of 4,501 or above completed cell phone interviews;
   - Per completed interview price for a total of 400 completed Asthma Call Back landline interviews;
   - Per completed interview price for a total of 401 or above completed Asthma Call Back landline interviews;
   - Per completed interview price for up to 350 completed Asthma Call Back cell phone interviews; and
   - Per completed interview price for 351 or above completed Asthma Call Back cell phone interviews.

   See Section 5: Payment, Price Adjustment Clause for price adjustment for annual BRFSS for years two (2) through years five (5).

2. Expanded BRFSS (Part B):

   Option 1: The Expanded (county-level) BRFSS is anticipated to be conducted in 2018 or 2019 and will require additional survey activities (sampling plan development, sample

order and purchase, statistical weighting, development of documentation and technical reports). The completed interviews will be distributed according to a geographic stratification developed as part of the sampling plan in conjunction with NYS DOH staff. Option 1 may be exercised dependent on funding availability and the NYSDOH's needs. The Department does not commit to exercising the option during the life of the contract. Bidders must complete the Bid Price Cost Proposal Form Part B, Option 1 to submit prices for the Expanded BRFSS activities:

- Per completed interview price for up to 11,000 completed supplemental BRFSS landline interviews;
- Per completed interview price for a total of 11,001 or above completed county level BRFSS landline interviews;
- Per completed interview price for a total of 9,000 completed county level BRFSS cell phone interviews; and
- Per completed interview price for a total of 9,001 or above completed county level BRFSS cell phone interviews.

Option 2: An additional Expanded (county-level) BRFSS may be performed in the year 2020 or 2021. The completed interviews will be distributed according to a geographic stratification developed as part of the sampling plan in conjunction with NYS DOH staff. Option 2 may be exercised dependent on funding availability and the NYSDOH's needs. The Department does not commit to exercising the option during the life of the contract. Bidders must complete the Bid Price Cost Proposal Form Part B, Option 2 to submit prices for the Expanded BRFSS activities:

- Per completed interview price for up to 11,000 completed supplemental BRFSS landline interviews;
- Per completed interview price for a total of 11,001 or above completed county level BRFSS landline interviews;
- Per completed interview price for a total of 9,000 completed county level BRFSS cell phone interviews; and
- Per completed interview price for a total of 9,001 or above completed county level BRFSS cell phone interviews.

All bids should be provided using the Bid Price Cost Proposal Form (Attachment 7).

b. Administrative Materials

In addition, the following forms should be submitted with the Bid Price Cost Proposal:

- Three (3) handwritten, signed originals and three (3) copies of the Transmittal Letter (Attachment 6)
- Three (3) signed originals and three (3) copies of the NYS Department of Health Lobbying Form (Attachment 8)
- Three (3) signed originals and three (3) copies of the Vendor Responsibility Attestation (Attachment 10)
- Encouraging Use of New York Businesses in Contract Performance (Attachment 11)

- Three (3) signed originals and three (3) copies of the M/WBE Procurement Forms (Attachment 12)
- Three (3) handwritten, signed originals and three (3) copies of the Cover Page (Attachment 16)
- Reference Submission Form (Attachment 17)

E. Method of Award

Pass/Fail Assessment (Mandatory Requirements)

All proposals will be reviewed by NYSDOH to ensure that minimum criteria are met.

- Proposal package must be received at the address stated in Section E.3, Submission of Proposals, by the date and time specified in the Schedule of Key Events
- Bidder Eligibility (See Section D. 1. Eligible Bidders)
- Bid Price Cost Proposal must include a completed Bid Price Cost Proposal Form (Attachment 7, Part A and Part B).

At the discretion of the Department of Health/HRI, all bids may be rejected. The Evaluation of the bids will include the following considerations:

The Technical Evaluation Committee (TEC) will evaluate and score each bidder's ability to provide the services based on the scoring system described in this RFP. Information from the bid price cost proposal, or evaluation thereof, will not be available to the TEC during their evaluation.

In evaluating each Cost Proposal, the Cost Evaluator will score the Bid Price Form, using the formula described below.

Final selection will be based on the Total Combined Score as follows:

- 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 (70),** and other bidders will receive a proportional score, as calculated using the following formula:

Technical Score = (x/y) x 70, where:

x = raw score of proposal being scored
y = raw score of highest scoring proposal

The costs described under Bid Price in the Detailed Specifications section of this RFP and listed on the Bid Price Cost Proposal Form for Year One.

- The lowest total price will **receive the maximum score (30),** and the other bidders will receive a proportional score using the following formula:

BRFSS Interview Cost Score = (a/b) x 30 where:

a = total cost of lowest cost proposal
b = total cost of proposal being scored

- The bidder's technical score and Cost score will be combined using the following formula:

Technical Score (maximum 70) + Cost Score (maximum 30) =
Total Combined Score = (maximum 100)

The Selection Committee will select the responsive and responsible bidder with the highest Total Combined Score whose proposal reflects the best value. This means that the proposal that best "optimizes quality, cost, and efficiency among responsive and responsible offerers" shall be selected for award (State Finance Law, Article 11, §163(1)(j)).

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 NYSDOH, the Attorney General, and the Office of the State Comptroller. The HRI contract will be approved by NYSDOH and HRI.

In the event of a tie, the determining factor(s) for award, in descending order of importance, will be:

- Lowest cost
- Minority/Women-owned Business Enterprise (MWBE) utilization
- Past experience
- References

F. ADMINISTRATIVE

1. Issuing Agency

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

2. Inquiries

Any questions concerning this solicitation must be directed to:

Diana McFarland
NYSDOH
Bureau of Chronic Disease Evaluation and Research
Empire State Plaza
Corning Tower Building, Room 1084
Albany, NY 12237-0679
diana.mcfarland.@health.ny.gov

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.health.ny.gov/funding/ and HRI's website at:
http://www.healthresearch.org/funding-opportunities
by the date indicated on the Schedule of Key Events.

3. Submission of Proposals

Interested bidders should submit, per Section D. Proposal, three (3) signed originals and three (3) signed copies of their Technical Proposal and two (2) signed originals and two (2) signed copies of the Bid Price Cost Proposal (Attachment 7 Part A and Part B) no later than the time and date listed on the Schedule of Key Events.

Responses to this solicitation should be clearly marked "Behavioral Risk Factor Surveillance System (BRFSS)" and "RFP # 16526" and directed to:

Ian Brissette
NYSDOH
Bureau of Chronic Disease Evaluation and Research
Empire State Plaza
Corning Tower Building, Room 1084
Albany, NY 12237-0679

It is the bidders' responsibility to see that bids are delivered prior to the bid due date and time. Late bids due to delay by the carrier or not received by the Department before the time/date specified in the Schedule of Key Events will not be considered.

- The Lobbying Form should be filled out in its entirety (Attachment 8).The responsible corporate officer for contract negotiation must be listed. This document should be signed by the responsible corporate officer.
- All evidence and documentation requested under Section D. Proposal should be provided at the time the proposal is submitted.

4. THE DEPARTMENT OF HEALTH AND HRI RESERVE THE RIGHT TO:

- Reject any or all proposals received in response to the RFP;
- Withdraw the RFP at any time, at the agency's sole discretion;
- Make an award under the RFP in whole or in part;
- Disqualify any bidder whose conduct and/or proposal fails to conform to the requirements of the RFP;
- Seek clarifications and revisions of proposals;
- Use proposal information obtained through site visits, management interviews and the state's investigation of a bidder's qualifications, experience, ability or financial standing, and any material or information submitted by the bidder in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RFP;
- Prior to the ***bid opening***, amend the RFP specifications to correct errors or oversights, or to supply additional information, as it becomes available;
- Prior to the bid opening, direct bidders to submit proposal modifications addressing subsequent RFP amendments;
- Change any of the scheduled dates;
- Eliminate any mandatory, non-material specifications that cannot be complied with by all of the prospective bidders;
- Waive any requirements that are not material;
- Negotiate with the successful bidder within the scope of the RFP in the best interests of the state;
- Conduct contract negotiations with the next responsible bidder, should the agency be unsuccessful in negotiating with the selected bidder;
- Utilize any and all ideas submitted in the proposals received;
- Unless otherwise specified in the solicitation, every offer is firm and not revocable for a period of 365 days from the bid opening; and,
- Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete

understanding of an offerer's proposal and/or to determine an offerer's compliance with the requirements of the solicitation.

5. Payment

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

- Preferred Method: Email a .pdf copy of your signed voucher to the BSC at: AccountsPayable@ogs.ny.gov with a subject field as follows:

Subject: **Unit ID: 3450263 Contract # TBD**

- Alternate Method: Mail vouchers to BSC at the following U.S. postal address:

NYS Department of Health
Unit ID 3450263
c/o NYS OGS BSC Accounts Payable
Building 5, 5th floor
1220 Washington Ave.
Albany, NY 12226-1900

For State Contract Only: Payment for invoices and/or vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epayments@osc.state.ny.us or by telephone at 518-474-6019. CONTRACTOR acknowledges that it will not receive payment on any invoices and/or vouchers submitted under this Contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9 must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at http://www.osc.state.ny.us/epay.

Completed W-9 forms should be submitted to the following address:

NYS Office of the State Comptroller
Bureau of Accounting Operations
Warrant & Payment Control Unit
110 State Street, 9th Floor
Albany, NY 12236

Payment of such invoices and/or vouchers 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:

For the State contract, vouchers for the monthly payment of completed interviews (not including partial completes), per Section C. Detailed Specifications must be submitted as outlined in the RFP section entitled "5. Payment," which is shown above.

A completed interview is defined according to the standards of the American Association for Public Opinion Research and reflects an interview in which the selected respondent has been asked all questions up to and including the demographic questions which will be used for weighting.

A targeted number of completed interviews for landline and cell phone is established by NYS DOH prior to the start of the data collection for the year. The contractor will be paid the price quoted per completed interview for each survey type and phone type based on the targeted number.

For the annual BRFSS and the Asthma Call-back survey, the payment will be reduced annually by the percentage of completed landline and/or cellphone interviews below the goal number of completed landline and cellphone interviews established at the beginning of the data collection year. For example, if the goal is *4,000* completed surveys but 3,000 interviews are actually completed, *4,000* minus *3,000 completed interviews* equals *1,000 completed interviews below goal:* 1000/4000=25%. Annual payment will be reduced by 25%.

For the Expanded BRFSS, for each Option, payment will be reduced by the percentage of completed landline and/or cellphone interviews below the goal of completed landline and cellphone interviews per each county in New York State. For example, if the county-level goal is 400 but 360 interviews are actually completed in a given county*, 400* minus *360 completed interviews* equals *40 completed interviews below goal*. 40/400 = 10%. Each Option payment for data collection in that county will be reduced by 10%.

The reduction in the annual payment, as determined using the previously mentioned formula, will be recovered from subsequent payments due to the contractor. Starting in month twelve (12) of each contract year, the full amount of the monthly voucher will be withheld and applied to the amount owed the state for the reduction in annual payment until paid in full.

For Option 1 and Option 2, Expanded BRFSS, payment will be made if the department exercises Option 1 and/or Option 2 and the work is performed in accordance with the above completed interview, per Section C. Detailed Specifications and is subject to the above payment reduction if needed. It is at the discretion of the Department and the funding availability to exercise option 1 and/or option 2 for the expanded BRFSS.

Quality assurance reports should be submitted as requested to the BRFSS Coordinator below. Data files should be submitted monthly to:

Mycroft Sowizral, BRFSS Coordinator
Bureau of Chronic Disease Evaluation and Research
1070 Corning Tower
Albany, NY 12237-0679

Price Adjustment for Annual BRFSS: Prices shall remain firm for the first year of the contract period. On each anniversary date of the contract for subsequent years, NYSDOH will increase or decrease each rate the lesser of three percent (3%) or the percent increase or decrease in the Consumer Price Index for all Urban Consumers (CPI-U), All Items (CUUR0000SA0) as published by the U S. Department of Labor, Bureau of Labor Statistics, Washington, D.C. 20212 http://www.bls.gov/data/ for the 12 month-period ending three (3) calendar months prior to the anniversary date of the contract.

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.

For the HRI contract:

Vouchers for the HRI contract should be submitted no later than 30 days after the period for which reimbursement is requested The final voucher must be submitted within 30 days of the close of the budget period. Vouchers received after the 30 days may be processed at the discretion of HRI. Documentation of completion of each of the monthly sampling replicates and submission of quality assurance reports should accompany vouchers. Submit to:

Mycroft Sowizral, BRFSS Coordinator
Bureau of Chronic Disease Evaluation and Research
1070 Corning Tower
Albany, NY 12237-0679

6. Term of Contracts

a. State Contract

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

The anticipated time period of this contract is a five (5) year contract period anticipated to commence on the date specified in the Schedule of Key Events.

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.

b. HRI Contract

The HRI contract resulting from the RFP shall be effective upon the approval of HRI.

The initial annual contract is anticipated to have a time period of October 1, 2016 through March 31, 2022. The total value will depend on the availability of funding from federal grant awards. Annual renewals will be dependent on satisfactory performance of the contractor and subject to the availability of funds.

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 ten (10) business days from date of award or non-award announcement.

8. Protest Procedures

In the event unsuccessful bidders wish to protest the award resulting from this RFP, bidders should follow the protest procedures established by the Office of the State Comptroller (OSC). These procedures can be found in Chapter XI Section 17 of the Guide to Financial Operations (GFO). Available on-line at: http://www.osc.state.ny.us/agencies/guide/MyWebHelp/

9. Vendor Responsibility Questionnaire

New York State Procurement Law requires that state agencies award contracts only to responsible contractors. Contractors 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 ciohelpdesk@osc.state.ny.us. Contractors 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. The winning bidder must also complete and submit the Vendor Responsibility Attestation (Attachment 10).

10. 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.

State Consultant Services Form A

http://www.osc.state.ny.us/agencies/forms/ac3271s.doc

State Consultant Services Form B

http://www.osc.state.ny.us/agencies/forms/ac3272s.doc

11. 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 New York State Commission on Public Integrity 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 New York State Commission on Public Integrity

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 State Commission on Public Integrity regarding procurement lobbying, the 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 New York State Commission on Public Integrity.

12. 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 New York State Enterprise IT Policy NYS-P08-005, "Accessibility Web-based Information and Applications", and New York State Enterprise IT Standard NYS-S08-005, Accessibility of Web-based Information Applications, 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 New York State Enterprise IT Standard NYS-S08-005, 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.

13. 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://its.ny.gov/eiso/breach-notification .

14. 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.

The successful Bidder must file a properly completed Form ST-220-CA with the Department of Health and Form ST-220-TD with the DTF. These requirements must be met before a contract may take effect. Further information can be found at the New York State Department of Taxation and Finance's website, available through this link: http://www.tax.ny.gov/pdf/publications/sales/pub223.pdf.

Forms are available through these links:

- ST-220 CA: http://www.tax.ny.gov/pdf/current_forms/st/st220ca_fill_in.pdf
- ST-220 TD: http://www.tax.ny.gov/pdf/current_forms/st/st220td_fill_in.pdf

15. Piggybacking

New York State Finance Law section 163(10)(e) (see also http://www.ogs.ny.gov/purchase/snt/sflxi.asp) allows the Commissioner of the NYS Office of

General Services to consent to the use of this contract by other New York State Agencies, and other authorized purchasers, subject to conditions and the Contractor's consent.

16. Minority & Woman-Owned Business Enterprise Requirements

Pursuant to New York State Executive Law Article 15-A, the New York State Department of Health ("DOH") recognizes its obligation to promote opportunities for maximum feasible participation of certified minority-and women-owned business enterprises and the employment of minority group members and women in the performance of DOH contracts.

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title "The State of Minority and Women-Owned Business Enterprises: Evidence from New York" ("Disparity Study"). The report found evidence of statistically significant disparities between the level of participation of minority-and women-owned business enterprises in state procurement contracting versus the number of minority-and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority- and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that DOH establish goals for maximum feasible participation of New York State Certified minority- and women – owned business enterprises ("MWBE") and the employment of minority groups members and women in the performance of New York State contracts.

Business Participation Opportunities for MWBEs

For purposes of this solicitation, DOH hereby establishes an overall goal of **30%** for MWBE participation, **15%** for Minority-Owned Business Enterprises ("MBE") participation and **15%** for Women-Owned Business Enterprises ("WBE") participation (based on the current availability of qualified MBEs and WBEs and outreach efforts to certified MWBE firms). A contractor ("Contractor") on the subject contract ("Contract") must document good faith efforts to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract and Contractor agrees that DOH may withhold payment pending receipt of the required MWBE documentation. For guidance on how DOH will determine "good faith efforts," refer to 5 NYCRR §142.8.

The directory of New York State Certified MWBEs can be viewed at: https://ny.newnycontracts.com. The directory is found in the upper right hand side of the webpage under "Search for Certified Firms" and accessed by clicking on the link entitled "MWBE Directory". Engaging with firms found in the directory with like product(s) and/or service(s) is strongly encouraged and all communication efforts and responses should be well documented.

By submitting a bid, a bidder agrees to complete an MWBE Utilization Plan (Attachment 12, Form

#1) of this RFP. DOH will review the submitted MWBE Utilization Plan. If the plan is not accepted, DOH may issue a notice of deficiency. If a notice of deficiency is issued, Bidder agrees that it shall respond to the notice of deficiency within seven (7) business days of receipt. DOH may disqualify a Bidder as being non-responsive under the following circumstances:

a) If a Bidder fails to submit a MWBE Utilization Plan;
b) If a Bidder fails to submit a written remedy to a notice of deficiency;
c) If a Bidder fails to submit a request for waiver (if applicable); or
d) If DOH determines that the Bidder has failed to document good-faith efforts.

The Contractor will be required to attempt to utilize, in good faith, any MBE or WBE identified within its MWBE Utilization Plan, during the performance of the Contract. Requests for a partial or total waiver of established goal requirements made subsequent to Contract Award may be made at any time during the term of the Contract to DOH, but must be made no later than prior to the submission of a request for final payment on the Contract.

The Contractor will be required to submit a Contractor's Quarterly M/WBE Contractor Compliance & Payment Report to the DOH, by the 10th day following each end of quarter over the term of the Contract documenting the progress made toward achievement of the MWBE goals of the Contract.

If the Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such finding will constitute a breach of Contract and DOH may withhold payment from the Contractor as liquidated damages.

Such liquidated damages shall be calculated as an amount equaling the difference between: (1) all sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and (2) all sums actually paid to MWBEs for work performed or materials supplied under the Contract.

New York State certified Minority- and Women-Owned Businesses (M/WBE) may request that their firm's contact information be included on a list of M/WBE firms interested in serving as a subcontractor for this procurement. The listing will be publicly posted on the Department's website for reference by the bidding community. A firm requesting inclusion on this list should send contact information and a copy of its NYS M/WBE certification to diana.mcfarland.@health.ny.gov before the Deadline for Questions as specified in the Schedule of Key Events. Nothing prohibits an M/WBE Vendor from proposing as a prime contractor.

Please Note: Failure to comply with the foregoing requirements may result in a finding of non-responsiveness, non-responsibility and/or a breach of the Contract, leading to the withholding of funds, suspension or termination of the Contract or such other actions or enforcement proceedings as allowed by the Contract.

17. Iran Divestment Act

By submitting a bid in response to this solicitation or by assuming the responsibility of a Contract awarded hereunder, Bidder/Contractor (or any assignee) certifies that it is not on the "Entities Determined To Be Non-Responsive Bidders/Offerers Pursuant to The New York State Iran Divestment Act of 2012" list ("Prohibited Entities List") posted on the OGS website at: http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf and further certifies that it will not utilize on such Contract any subcontractor that is identified on the Prohibited Entities List. Additionally, Bidder/Contractor is advised that should it seek to renew or extend a Contract awarded in response to the solicitation, it must provide the same certification at the time the Contract is renewed or extended.

During the term of the Contract, should the Department of Health receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, the Department of Health will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then the Department of Health shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, seeking compliance, recovering damages, or declaring the Contractor in default.

The Department of Health reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

18. Encouraging Use of New York Businesses in Contract Performance

Public procurements can drive and improve the State's economic engine through promotion of the use of New York businesses by its contractors. New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the state and the nation. In recognition of their economic activity and leadership in doing business in New York State, bidders/proposers for this contract for commodities, services or technology are strongly encouraged and expected to consider New York State businesses in the fulfillment of the requirements of the contract. Such partnering may be as subcontractors, suppliers, protégés or other supporting roles. All bidder's should complete Attachment 11 to indicate their intent to use/not use New York Businesses in the performance of this contract.

19. SAM.gov - Applicant must maintain an active registration in the System for Award Management (SAM) at SAM.gov, and have no exclusions or delinquent federal debt for the life of the contract.

20. Diversity Practices Questionnaire

Diversity practices are the efforts of contractors to include New York State-certified Minority and Women-owned Business Enterprises ("MWBEs") in their business practices. Diversity practices may include past, present, or future actions and policies, and include activities of contractors on

contracts with private entities and governmental units other than the State of New York. Assessing the diversity practices of contractors enables contractors to engage in meaningful, capacity-building collaborations with MWBEs. All bidders should complete Attachment 19, Diversity Practices Questionnaire.

G. APPENDICES

The following will be incorporated as appendices into the state 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 (Lobbying Form-Attachment 8) and all proposal requirements.

- APPENDIX D - General Specifications

- APPENDIX E – Proof of Coverage
  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**:

  - **CE-200**, 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

  - **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

  - **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**:

  - **CE-200,** 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

  - **DB-120.1** – Certificate of Disability Benefits Insurance

  - **DB-155** – Certificate of Disability Benefits Self-Insurance

- Appendix G - Notices

- Appendix M - Participation by Minority Group Members and Women with Respect to State Contracts: Requirements and Procedures

- Appendix X – Modification Agreement Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods

H. TERMS AND CONDITIONS OF HRI CONTRACT

The selected contractor will be required to sign the Consultant Agreement (Attachment 14) and agree to the terms outlined in Appendix A and Appendix C to the Consultant Agreement (Attachment 15).

I. ATTACHMENTS

1. 2016 BRFSS Data Collection Protocol with Disposition Table
2. 2014 BRFSS Asthma Call-back Survey Guidelines
3. 2015 NYS BRFSS Questionnaire (Landline and Cell Phone)
4. BRFSS/ASTHMA Survey Adult Questionnaire-2015
5. BRFSS/ASTHMA Survey Child Questionnaire-2015
6. Transmittal Letter
7. Bid Price Cost Proposal
8. Lobbying Form
9. No Bid Form
10. Vendor Responsibility Attestation
11. Encouraging Use of New York Businesses in Contract Performance
12. M/WBE Procurement Forms
13. Sample Contract Language and Appendices
    - *Appendix A*
    - *Appendix B*
    - *Appendix C*
    - *Appendix D*
    - *Appendix E*
    - *Appendix G*
    - *Appendix M*
    - *Appendix X*
14. HRI Consultant Agreement
15. Appendix A and Appendix C to Health Research Inc. Consultant Agreement
16. Cover Page
17. Reference Submission Form
18. State/HRI Contract Period and Activities
19. Diversity Practices Questionnaire

Attachment 1

2016
BRFSS Data Collection Protocol with Disposition Table

November 3, 2015

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Introduction

In 1984, the Centers for Disease Control and Prevention (CDC) initiated the state-based Behavioral Risk Factor Surveillance System (BRFSS)—a cross-sectional telephone survey that state health departments conduct monthly over landline telephones and, since 2011, cell phones; the states conduct the BRFSS survey with the use of a standardized questionnaire and the technical and methodologic assistance from CDC. BRFSS collects prevalence data among noninstitutionalized adult US residents regarding their risk behaviors and preventive health practices that can affect their health. Respondent data are forwarded to CDC to be aggregated for each state, returned with standard tabulations, and published at year's end by each state. In 2014, over 400,000 interviews were conducted in the states, the District of Columbia, and participating US territories and other geographic areas.

This document provides data collectors with a BRFSS overview and outlines the processes involved with calling, disposition-code assignment, and data submission. This document does not cover details of sampling and weighting, as they are not data-collectors' responsibility. Specific information regarding data quality, response and/or cooperation rates, or calling outcome can be found in the yearly Summary Data Quality Report released with the annual data set.

Find yearly data and support documents here: http://www.cdc.gov/brfss/data_documentation/index.htm.

Details of the data collection process are discussed in regularly scheduled conference calls and at the annual BRFSS meetings/training workshops. BRFSS encourages data collectors to participate in these events, as updating BRFSS data-collection protocol is a collective process that is strengthened when organizations and day-to-day stakeholders provide their input.

The BRFSS Process

The BRFSS questionnaire was developed in collaboration with CDC and public health departments in each of the states, the District of Columbia, and participating territories. Data derived from the questionnaire provide health departments, public health officials, and policy makers with behavioral and health status information that, when combined with mortality and morbidity statistics, guide the development of health-related policies and priorities as well as help decision makers address and assess strategies to promote good health. A finalized version of the questionnaire is sent to the states each year. CDC also provides computer-assisted telephone interviewing (CATI) programming to states, but they may opt to use their own CATI programming software and can refer to the final version of the BRFSS questionnaire as a guide. States may not change the skip patterns or wording of questions in the questionnaire but are free to create state-added questions that can be customized to states' individual needs (see below). In some instances, states may insert state-added questions into the questionnaire--with permission from CDC--when such questions fit into the context of extant topics/sections and do not impede the flow of the interview. Requests should be submitted to the state project officer or the survey methodologist on the Survey Operations Team.

Annual questionnaire construction

The BRFSS questionnaire comprises an **annual standard core**, which includes questions asked of respondents each year; **a biannual rotating core**, which includes questions asked only in even- or odd-numbered years; **optional modules**, which include standardized questions adopted verbatim by the states; and **state-added questions**, which states individually customized. Appendix A provides a **draft** copy of the 2016 BRFSS questionnaire, including modules with skip patterns. Data collectors will note that the 2016 questionnaire includes skip patterns for landline and cell phone interviews that administrators should follow when they are conducting interviews using a sample provided by CDC (see Sampling below).

Standard Core Questions: The portion of the questionnaire that is included each year and must be asked by all states. The core may include questions about emerging or "late-breaking" health issues. After 1 year, these questions are either discontinued or incorporated back into the standard core or become part of the rotating core or optional modules.

Rotating Core Questions: The portion of the questionnaire asked by all states on an every-other-year basis. These questions regularly appear in even- and odd-numbered years.

Optional Modules: Optional modules are sets of standardized questions on various topics that each state may select and include in its questionnaire. Once selected, a module must be used in its entirety and asked of all eligible respondents. If an optional module is modified in any way (e.g., if a question is omitted), then the questions will be treated as state-added questions (see below).

In order to achieve a wide range of data, states may choose to "split" samples in order to give different modules to each smaller group of participants. For example, if a state adopts a questionnaire that is too long to ensure respondent cooperation, a greater number of modules may be used if the state gives different ones to groups of 2,500 or more respondents. Some respondents, therefore, will answer the core questionnaire and one set of modules, while others answer the core questionnaire and a different set of modules. States are required to conduct at least 2,500 interviews for each of the versions of the questionnaire in order to have enough responses for weighting purposes. States create different questionnaire versions when they split modules among respondents. States may adopt up to three versions of the questionnaire, each including the core (with standard and rotating core questions) and a specified number of modules, which will differ by version. States must include modules on both landline and cell phone interviews. Versions must also be included in both samples.

State-added Questions: BRFSS encourages states to add their own extra questions to their questionnaire, so they can gather data on additional topics related to their specific health priorities. All questions included in the BRFSS, with the exception of state-added questions, are cognitively tested prior to inclusion in the questionnaire. It is up to each state to decide whether or not it will cognitively test its state-added questions before use. State-added questions may not be inserted into the text of the core questionnaire or optional modules without approval from BRFSS. States should contact their project officers to request insertion of state-added questions into text that has been approved for use by all states.

The wording of the questions in any part of the BRFSS, with the exception of state-added questions, is determined at the annual BRFSS meeting in March, where BRFSS state coordinators vote to adopt questions submitted by CDC programs. A governing group including state BRFSS coordinators, CDC staff and others known as the BRFSS Working Group, may add questions on emerging issues (such as the H1N1 flu questions added in 2009). After the BRFSS meeting, CDC then designs core components and optional modules and produces data processing layouts, while considering state priorities, potential funding, and other practical aspects. A field test of new portions of the BRFSS questionnaire will be conducted according to the results of voting. Minor changes in question wording and format may be made after the field test. The new BRFSS materials for the next surveillance year are then sent to the states, which may add their own questions that they have designed or acquired. A target of October 1 is set for finalization of the questionnaire for the upcoming year.

Data collectors should have the capacity to make modifications, including addition of questions, during the course of the year. In addition, data collectors must be capable of adjusting screening questions that determine eligibility during the course of the year.

Data Collection

Data collection follows a suggested BRFSS interviewing schedule; all calls for a given survey month should be completed in the same sample month if possible. In some cases samples begun in one month may be completed in the first 7-10 days of the next month. Up to 15 calling attempts may be made for each landline phone number and up to 8 for each cell phone number in the sample, depending on state regulations for calling and outcomes of previous calling attempts. Although states have some flexibility in distribution of calling times, i*n general*, surveys are conducted using the following calling occasions:

- Conduct 20% of landline calling attempts on weekdays (before 5:00 PM)
- Conduct 80% of landline calling attempts on weeknights (after 5:00 PM) and weekends
- Conduct cell phone calling attempts during all three calling occasions (weekday, weeknight, and weekend), with approximately 30% on weekend calling occasions.
- Change schedules to accommodate holidays and special events.
- Make weeknight calls after 5:00 PM.
- Adhere to respondents' requests for specific callback/appointment times whenever possible.

Data collectors must develop and maintain procedures to ensure respondents' confidentiality, assure and document the quality of the interviewing process, and supervise and monitor the interviewers.

Each telephone number in the CDC-provided sample must be assigned a final disposition code to describe the result of calling the number:

- A completed or partially completed interview (see definitions in Appendix B) or
- A determination that:
    - A household was eligible to be included but an interview was not completed or
    - A telephone number was ineligible or could not have its eligibility determined.

The final disposition codes are then used to calculate response rates, cooperation rates, and refusal rates. The distribution of individual disposition codes and the rates of cooperation, refusal, and response are published annually in the Summary Data Quality Reports. BRFSS uses standards set by the American Association of Public Opinion Research (AAPOR) to determine disposition codes and response rates. All BRFSS disposition codes and rules for assigning disposition codes are provided in Appendix B: Disposition Table with Callback Rules. Given the myriad outcomes for assigning specific codes associated with technological barriers, additional guidance is provided in Appendix C: Understanding Coding for Technological/ Telecommunication Barriers. Data collectors must follow the rules for assigning disposition codes and train and monitor interviewers in the use of specific dispositions.

Survey Protocol

BRFSS sets standard protocols for data collection, in order to maintain consistency across states that permits state-to-state data comparison. Data collectors should follow the assignment of disposition codes provided in Appendix B: Disposition Table with Callback Rules. Disposition codes follow the format of 1000-1999 completed/partially completed; 2000-2999 non-completed interviews with eligible respondents/households; 3000-3999 non-completed interviews with unknown eligible persons/households; 4000-4999 ineligible numbers; 5000-5999 interim dispositions. A 2000 level disposition should not be assigned unless the interviewer is certain that both the household and respondent are eligible for the survey. Assigning incorrect disposition codes can lower response rates and efficient use of the sample. The following items are included in the BRFSS survey protocol:

1. All states must include the core questions and introductory scripts without modification. States may choose to add any, all, or none of the optional modules and state-added questions after the core component. Interviewers may not offer information to respondents on the meaning of questions, words, or phrases beyond the interviewer instructions provided by CDC and/or the state BRFSS coordinators. States may not insert state-added questions into the core component or into optional modules without permission. State coordinators should contact their CDC project officers to request the placement of state-added questions into text that has been approved for use by all states.

2. Systematic, unobtrusive electronic monitoring is a routine and integral part of monthly survey procedures for all interviewers. States may also use callback verification procedures to ensure data quality. Unless supervisory monitoring of 10% of all interviews is being routinely conducted, a 5% random sample of each month's interviews must be called back to verify selected responses for quality assurance. Recording calls as part of quality assurance is not part of the BRFSS methodology and recording interviews without respondent knowledge is not legal in all states. Data collectors should remember that cell phone numbers may reach respondents in

any state or country, where laws on recording calls may be different than in the state where the call originated.

3. An eligible household is defined as a housing unit that has a separate entrance, where occupants eat separately from other persons on the property, and that is occupied by its members as their principal or secondary place of residence. The following are non-eligible households: vacation homes not occupied by household members for more than 30 consecutive days per year, group homes, institutions, and (in the landline telephone sample) households in states other than the one conducting the BRFSS questionnaire. Persons in a state's cell phone sample who are residents of other states are eligible for interview. The state contacting the respondent should complete the core questionnaire and then provide the data to CDC for transfer to the appropriate state of the respondents' residence. Since 2012, persons living in college housing have been included as eligible respondents. Although it is rare to contact a college housing resident in the landline sample, this person would also be included as a single adult household. The BRFSS is a self-reported survey. If respondents report that they live in private residences, it is not the role of interviewers to question them. The only instances under which there is discuss of information on whether households qualify as private residences is when respondents initiates the question.

4. Eligible household members include all related adults (aged 18 years or older), unrelated adults, boarders/roomers, live-in au pairs or students and domestic workers who consider the household their home, even though they may not be home at the time of the call. College housing residents are treated as single adult households. Household members do not include adult family members who are currently living elsewhere.

5. Questions should be read verbatim. In many cases introductory phrases are provided which should also be read as written. Interviewer instructions are optional and can be read if the respondent is confused or needs additional information. Items in parentheses in statements are also optional and may be read for clarification. Interviewers should not offer their own interpretation of questions or response options.

6. Proxy interviews are not conducted in the BRFSS. For people interviewed on landline telephones, individual respondents are randomly selected from all adults living in a household and are interviewed in accordance with BRFSS protocol. Household members include all family members, domestic servants, and au pair or live-in students who have resided at the residence for at least 3 months. Cell phone interviews are conducted with respondents who answer the number called and are treated as one-person households.

7. An interview is considered complete if data are collected for all questions which would have normally been asked for any selected respondent. Partially completed interviews are defined as those where the first sections of the interview are completed and the portions of the demographic section which are used for weighting are also asked of the selected respondent in regular order of the questionnaire. For 2016, this would take the respondent through question 8.16. If the respondent does not provide substantive responses for weighting variables (that is, the respondent refuses to answer or responds that he/she does not know), imputed values will be generated and used only to assign weights. **If an interviewer codes a number of responses as**

<u>"don't know" or "refused" just prior to cut off in order to have an interview count as a partial complete, this will be noted by the CDC staff as potential falsification of data.</u>

8. With the exception of verbally abusive respondents, eligible people who initially refuse to be interviewed may be contacted at least one additional time and given the opportunity to be interviewed. Preferably, this second contact will be made by a supervisor or a different interviewer. Some states have regulations on whether refusals should be called again and the manner of the refusal conversion. For example, a period of two days between the initial refusal and second attempt is often standard protocol. Data collectors should contact the state BRFSS coordinator to determine the state's policy on calling back refusals.

9. States are required to give a final disposition for every number in the sample, usually within the same month of the sample. States should complete all calling on each monthly sample within that month. A few states receive and account for all calling on a sample on a quarterly basis rather than a monthly basis. Data collectors should contact the state BRFSS coordinator to verify whether the state is receiving a monthly or quarterly sample from CDC.

10. The BRFSS OMB number and burden statement must appear on the header page of all interviewer forms. The CDC will provide the header with the questionnaire each year. Please note that the interviewers do not need to read any part of the OMB number or burden statement to the respondents unless asked. The entire burden statement does not need to be read if the respondent is simply asking how long the interview will take. If the respondent asks for any information at any time about the authority by which information is being collected, it is imperative that the OMB approval information be available to the interviewer. The interviewer may then cite the OMB control information, which would allow the respondent to review the project plan online.

General callback and disposition coding rules are established by CDC (see Appendix B), and states are encouraged to adhere to them whenever possible. The calling rules are not universally applicable to each state. Data collectors contracted by the states should have the capacity to adhere to the calling rules listed below as well as those to in Appendix B.

1. ***<u>All cell phone numbers must be hand dialed.</u>*** New rulings by the FCC have called into question some previously standard practices of previewing numbers. Data collectors should seek legal advice if they are uncertain whether their practices are in any way contradictory to the new regulations. **Note that the definition of an autodialer has expanded as of June 2015 to include any phone that is connected to another device that can store or redial a data base of numbers. Therefore, at this writing, data collectors should disconnect their phones used to manually dial cell samples from computer systems that have this capability. Refer to current TCPA regulations and interpretations on this issue. This is a fluid interpretation and new regulations may be in place soon. Hand dialing alone is not sufficient to comply with these regulations. Federal surveys are not exempt from the TCPA regulations.**
2. Interviewers should be trained specifically for the BRFSS and retrained each year.

3. If possible, calls made to non-English-speaking households and assigned the interim disposition code of 5330 (household language barrier) should be attempted again with an interviewer who is fluent in the household language (e.g., Spanish).
4. States should maximize calling attempts as outlined in Appendix B. The maximum number of attempts (15 for landline telephone and 8 for cell phone) may be exceeded if formal appointments are made with potential respondents.
5. Calling attempts should allow for a minimum of 6 rings and up to 10 rings if not answered or diverted to answering devices.
6. The maximum number of attempts may be set by the states. CDC recommendations for the minimum number of attempts are 15 for landlines and 8 for cell phones.
7. All numbers must be assigned a final disposition. Data should not be submitted with interim dispositions.
8. Messages left on answering devices/voice mail devices should be left by interviewers. **Messages should never be left by any automated voice devices**. States may have their own standard scripts for messages, describing the reasons for the call and when respondents might expect a return call. Messages can be left after any attempt. It is not recommended that respondents be burdened by repeated messages. States should adopt protocols to leave one or two messages during the calling attempts for a single number during the calling period.

Using the BRFSS Sample

In some instances, states design samples within boundaries of sub-state geographic regions. States may determine that they would like to sample by county, public health district, or other sub-state geography in order to make comparisons of geographic areas with their states. To conduct the BRFSS, states get samples of telephone numbers from CDC. States then review their sampling methodology with a state statistician and CDC to make sure data collection procedures are in place to follow the methodology. States must consult with CDC before making changes to methodology. States must maintain sample phone numbers in files that are separate from responses, in order to maintain standards of respondent confidentiality.

The BRFSS uses two samples: one for landline telephone respondents and one for cell phone respondents. State BRFSS coordinators work with CDC to produce all samples The CDC recommends that the range of completed cell phone interviews be a minimum of 35% to a maximum of 65% of total complete interviews. The 35-65% range of cell phone interviews is set to ensure the geographic distribution of the sample (since landlines samples can be geographically distributed across the state) and to ensure that the sample is demographically representative of the state. Since landline telephones are often shared, household sampling is used in the landline telephone sample. Household sampling requires interviewers to collect information on the number of adults living in a residence and then select randomly from all eligible adults (see questionnaire). Cell phone respondents are treated as single adult households and therefore do not require household sampling. The samples are fully overlapping, so that any eligible person in the landline frame may also be eligible in the cell phone frame. States receive the sample monthly or quarterly, approximately by the 15th. Note that the BRFSS is a sample with replacement. It is possible, therefore, for a single household/respondent to be eligible and appear in a sample more than once within a year. Some states eliminate duplicate ("de-dup") numbers that appear within the same quarter. A state with sub state regions that represent small area is more likely to encounter repeat numbers in the sample. States that wish to send advance

letters should request addresses with their regular landline sample. For states that send advance letters, mailing addresses are appended to landline telephone numbers. Addresses may not be attached to cell phone samples. Data collections should release all replicates (of 30 numbers) in the sample in the first week of each month. The table below provides the format for the landline and cell phone sample files received by the states.

Field Name	**Size**	**Position**	**Format/Values/Explanation**
Phone Number (AREACODS, PREFIXS, SUFFIXS)	22	1-22	9,1-*NNN*-*NNN*-*NNNN*v20161
Geographic Stratum (_GEOSTRS)	3	23-25	First position = 1 for Landline / 2= Cell phone Then States with no geographic strata=01 in each record. Others according to provided information.
Density Stratum (_DENST2S)	1	26	1=Listed number, 2=Not listed one-plus block, 3=Zero block, 9=Not applicable (GU, PR, VI).
Sequence Number (SEQNO)	10	27-36	A unique 10-digit number for a state for a year with year in the first four digits. For example: 2015000001.
Number of Records Selected From Stratum (NRECSELS)	6	37-42	Number of telephone numbers (eligible sampling units) selected from stratum.
Number of Records in Stratum (NRECSTRS)	9	43-51	Number of telephone numbers in the stratum from which sample was selected.
Precall [GENESYS-ID] Status (PRECALLS) Landline sample	1	52	1=To be called, 3=Non-working number, 5=Business phone. (Including GU, PR, VI) 4 = Cellular – PRO-T-S, 6 = Cellular - Interviewer
Precall [Cell-WINS Screening] Status (PRECALLS) Cell phone sample	1	52	1=Active, 3=Inactive, 7=Unknown Status
Replicate Number (SMONTH, REPNUM)	6	53-58	The first two digits, 01-12, represent months, the last four digits a sequential number starting with 0001 each month.
Replicate Depth (REPDEPTH)	2	59-60	A sequential number from 01-30 in each replicate.
State FIPS Code (_STATE)	2	61-62	FIPS code of assigned state.

County FIPS Code (ASGCNTY)	3	63-65	FIPS code of assigned county. Blank=GU, PR, VI.
County FIPS Code of Listed Number (LISTCNTY)	3	66-68	For listed numbers, FIPS code of the county in which number is located. For not listed numbers=999. Blank=GU, PR, VI, and cell phone sample
Number of Landline Assignments in 1K Blocks in Assigned County (NOHHCTY)	4	69-72	Number of Landline Assignments in 1K Blocks that are in assigned county. Blank=GU, PR, VI, and cell phone sample
NXX Type (NXXTYPE)	2	73-74	Blank
Number of Landline Assignments in 100 series bank (BLCKSIZE)	3	75-77	Number of landline assignments in hundred block=000-100. Blank=GU, PR, VI, and cell phone sample
Number of Landline Assignments in 1K Block (LSTHHPRE)	5	78-82	Number of Landline Assignments in 1K Block Blank=GU, PR, VI, and cell phone sample
Estimated Total Households in Prefix (TOTHHPRE)	5	83-87	BLANK
Core Based Statistical Area (CBSACODE)	5	88-92	99999=Not in an MSA. Blank=GU, PR, VI, and cell phone sample
Metropolitan Status Code (MSCODE)	1	93	1=In the center city of an MSA, 2=Outside the center city of an MSA but inside the county containing the center city, 3=Inside a suburban county of the MSA, 4=In an MSA that has no center city, 5=Not in an MSA. Blank=GU, PR, VI.
Rate Center Name (RCNAME) Cell phone only	30	94-123	Rate Center Name (RCNAME)
V&H Coordinate (VNHCOORD)	10	124-133	BLANK
Date Sample Generated (DATESMP)	10	134-143	*mm/dd/yyyy*
Pre-screening Process Used (PRESCREN)	1	144	0= Not screened 1=ID 2=ID Plus 3 = CSS, 4 = Cell
Date Sample Pre-screened (DATESCRN)	10	145-154	*mm/dd/yyyy*

Release Date of Active Prefix Database (PHNRLDAT)	10	155-164	*mm/dd/yyyy* Blank= cell phone sample
Release Date of Listed Phone Number Database (LSTRLDAT)	10	165-174	*mm/dd/yyyy* Blank=GU, PR, VI, and cell phone sample.
CLEC Number (CLEC)	1	175	1=Yes, 2=No. Blank=GU, PR, VI, and cell phone sample.
Replicate designated for inclusion in Multi-Mode Mail Survey and address match status (MSREPMCH) Landline only	1	176	Blank = All States
Time Zone	1	177	Eastern = 7, Central = 6, Mountain = 5, Pacific = 4, Alaska = 3, Hawaii =2 Blank= cell phone sample
Blank	1	178	Blank
Listed in one of the following Databases: InfoUSA, Experian, (DIRLST)	1	179	1=Yes, 2=No. Blank=GU, PR, VI, and cell phone sample.
Secondary Screening Flags	1	180	0/Undetermined/Residential 1/ No Answer 2/ Busy 3/ Fax/Modem 4/ Language Barrier 5/ Privacy Manager 6/ Residential Voice Mail 7/ Residence/Phone Answered 8/Cellular Number 9/Business/Non-Working Blank= cell phone sample
Indication of Address Matching Landline only	1	181	1=Matched 2=Not matched Blank=GU, PR, VI, and cell phone sample
Path variable (PATH) used to help identify which questionnaire is used when there are dual questionnaires. (States may update this variable to use for multiple paths in split samples)	2	182-183	10 = Default Genesys value Landline Survey Sample 20 = Default Genesys value Cell Phone Survey Sample

Note: Monthly files will be sorted by stratum, replicate, and depth. The order of numbers within a replicate will be randomized before assignment of depth numbers. All numeric fields are right aligned and padded with leading zeros. All character fields are left aligned with trailing blanks.

Each phone number is assigned a precall status to indicate whether the number should be called. States may opt to call landline telephone numbers with precall status >1 but are not required to do so. States may also choose not to call landline numbers with precall status =1 which have secondary screening status as fax/modem lines or are listed as "busy" by the precall screener if the number is taken from the unlisted portion of the sample. States are not required to call cell phone sample numbers with an "inactive" precall status, but may choose to do so. States should call all cell phone numbers with active and unknown precall status in the cell phone samples. Given that the precall status indicates the potential for reaching an eligible respondent, calling landline numbers with precall >1 or cell phone numbers with inactive precall status may reduce response rates. States may also use the secondary precall status to assign bilingual interviewers to numbers with language barrier precall assignments, or make extra efforts to reach numbers which have precall status indicating residence/household status.

States that request addresses may send advance letters to those households to alert them to the fact that they will be receiving calls and the nature of the survey. States may include a toll free number for potential respondents to inquire about the BRFSS. Studies have shown that the use of advance letters does improve response rates. However, the proportion of the landline sample that is accurately matched to addresses is declining. Currently about 40-60% of the landline sample is accurately matched to an address. Data collectors should speak to their BRFSS state coordinators about advance letters.

Samples for US territories differ from those from the states. BRFSS coordinators in US territories may deviate from the calling and sampling guidelines to fit the data needs of their jurisdictions. Data collectors should work closely with state BRFSS coordinators to ensure that the sample is properly managed. CDC will provide quarterly sample productivity tables on the upload/download site to alert the state coordinators of any problems with sample management.

Data collectors can track samples and productivity using the YTD Data Quality Reports (DQR) available with assigned logins on the upload site. The following table of contents lists the information available in the YTD Data Quality Reports as of August 2014. Changes in the information provided in the DQRs may change according to the needs of the data collectors and state coordinators.

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Summary Data Quality Reports are also available on the BRFSS website for previous years. States may compare their data productivity to that of other states in the summary reports, but will not have access to the YTD reports from other states.

Data Submission

CDC will provide a data layout file for monthly data submission. The BRFSS provides a data submission website to be used for uploading states' data and monitoring the progress of processing. Access to this site is limited and requires a login accepted by CDC. Details on data submission are included in Appendix D: Uploading BRFSS Data Using OneEdits. Note that 2016 will be the first year that OneEdits software will be used for data submission, so procedures have changed. Data collectors should download and run edit fix programs from the upload site prior to submitting data. Errors in submitted data will delay processing and may result in data sets being returned to states for corrections.

State Pilot Projects Using Protocol Adjustments

At any time during the data collection process, states may make greater efforts to reach respondents than the protocols listed here. These efforts may include increasing the number of attempts, increasing the ring times, calling all numbers in the sample regardless of the precall status or increased interviewer monitoring or training. On occasion states may wish to make adjustments to the data collection protocol in order to test the efficiency of a new procedure. For example, in 2015, one state determined that the "next birthday" method might be a better procedure than random computer selection for the household selection process in the landline

interview. Since this change did not change the statistical probability for selection, the protocol adjustment was approved and the change was made and tested by the state. States, and data collectors who wish to make protocol adjustments must have written approval from CDC in order to make adjustments. State coordinators should contact their project officers and the survey operations team at the Public Health Surveillance Branch of the Division of Population Health with full details of the protocol adjustment that they are seeking.

Appendix A: BRFSS Core Questionnaire (Draft)

2016

Behavioral Risk Factor Surveillance System Questionnaire

******To be inserted later******

October 15, 2015

Appendix B: Disposition Table with Callback Rules

Definitions of terms	
Respondent	An adult who is contacted by an interviewer and who may be eligible for interview.
Calling attempt	An attempt is an effort to reach a potential respondent by dialing a phone number, even if the dialing does not reach or connect with a working phone line.
Complete	An interview in which all questions are complete, including all core and module questions which would be assigned to a selected respondent.
Partial compete	An interview which in which the selected respondent has been asked all questions up to those which will be used for weighting. For the 2016 questionnaire this will include through question 8.16. Questions do not have to be answered substantively to be counted as asked (respondents may have provided answers of “do not know” or refused to answer questions).
Landline telephone	A telephone that is used within a specific location. Includes traditional household telephones, VOIP and internet phones connected to computers in a household.
Cell phone	A mobile device that is not tied to specific location for use and uses cell towers to connect users.
Selected respondent	An adult who is eligible for interview. For the cell telephone sample a selected respondent is an adult associated with the phone number who lives in a private residence or college housing within the US or territories covered by the BRFSS. For the landline telephone sample a selected respondent is the person selected for interview

	during the household enumeration section of the screening questions.
Calling occasions	There are three calling occasions: weekday (before 5:00 pm on a weekday); weeknight (after 5:00 pm on a weekday), and; weekend (any time on Saturday or Sunday).
Personal Cell phone	A cell phone that is used for personal calls. Cell phones that are used for both personal and business calls may be categorized as personal telephones and are eligible for interview. Telephones that are used exclusively as business phones are not personal telephones and, therefore, are not eligible for interview.
Private residence	A non-institutionalized residence in which adults persons aged 18 and over reside at least 30 days per year that has a separate entrance and cooking capabilities. It may also be college housing, such as a dormitory, fraternity or sorority house, campus sponsored housing or college family housing, or international student or visiting faculty housing. Personal RVs may be private residences. Group homes, military barracks, vacation homes that are not lived in for 30 days, or other temporary housing are not private residences. The determination of private residence is primarily made by the respondents. If the respondents indicate that they live in private residences, interviewers do not question their interpretation of their living situations.

Disposition Code	**Description**	**Definition**	**Range of Number of Attempts**	**Callback Rules**

1100	Complete	Assign if selected respondent completes questionnaire.	1-15 attempts (landline) 1-8 attempts (cell phone)	
1200	Partial complete	Assign if selected respondent completes demographic questions that are used for weighting. For the 2016 questionnaire this will include through question 8.16.	1-15 attempts (landline) 1-8 attempts (cell phone)	Selected respondent may be called back to fully complete the interview. Give final disposition on 15th or subsequent call attempt even if there is only one occurrence of a refusal or termination.
2111	Household level refusal (landline telephone only)	Assign for landline telephone only if refusal after confirmation of reaching household telephone line used by adults in correct state but before household selection and core BRFSS Q1 in landline telephone. Refusal can be from any member of the household (note: if refusal by selected respondent use code 2112). Automated messages should not count as refusals.	1-15 attempts (landline) 1-8 attempts (cell phone)	May be assigned after one attempt if hard refusal or special circumstance. Assign after maximum number of attempts and at least one interim disposition of 5111 (household level refusal).
2112	Selected respondent refusal	Assign if refusal by selected respondent before core BRFSS Q1 is answered by landline telephone. Automated messages should not count as refusals. Assign if cell phone respondent refuses after number determined to be personal	1-15 attempts (landline) 1-8 attempts (cell phone)	May be assigned after one attempt if hard refusal or special circumstance. Assign after maximum number of attempts and at least one interim disposition

		phone and respondent confirms living in private residence or college housing.		of 5112 (respondent refusal).
2120	Break off/ termination within questionnaire	Assign if selected respondent has completed portions of Core BRFSS with responses other than “don’t know” or “refused’ and terminates/breaks off prior to demographics section. (NOTE: If respondent completes questionnaire through weighting questions, code 1200.)	1-15 attempts (landline) 1-8 attempts (cell phone)	May be assigned after one attempt if hard refusal or special circumstance. Assign after maximum number of attempts with at least one interim disposition of 5120 (break off/termination).
2210	Selected respondent never available	Assign if selected respondent is never available during sample period. Selected respondent may not have been contacted or contacted and asked to be called later. Includes repeated unsafe location for interview, respondent away during period of interview, respondent not available for appointment. Includes selected respondents who die during interview period.	1-15 attempts (landline) 1-8 attempts (cell phone)	Give final disposition when notified or after at least 5 calling occasions of no more than 3 attempts with at least 3 weekday, 3 weeknight and 3 weekend calls for landline telephone. Cell phone respondents may be called up to 8 times, with at least 2 weekday, 2 weeknight and 2 weekend attempts. Assign after maximum number of calling attempts with at least one interim disposition of 5100

				(appointment), or 5560 (unsafe location).
2220	Household answering device (landline telephone only)	Assign if repeated contact with answering device that confirms residential/non business number (landline telephone only). The answering device gives a message confirming private residence by using the words “home,” “family,” “residence,” or “house” or by using family name in the message (landline telephone only). Due to potential for cell phone answering devices to be out-of-sample and/or not be connected to eligible respondents, do not assign this code to cell phone sample numbers. For cell phone numbers use code 3140 (Answering device, unknown if eligible residence/respondent).	6-15 attempts	Give final disposition after at least 5 calling occasions of no more than 3 attempts with at least 3 weekday, 3 weeknight and 3 weekend calls for landline telephones. Assign after maximum number of calling attempts with at least one interim disposition of 5220 (answering device, confirms residence).
2320	Selected respondent physically or mentally unable to complete interview	Assign if selected respondent is unable to complete interview due to physical or mental impairment. This includes temporary conditions such as bereavement, which will last beyond the interview period.	1-6 attempts	Assign the first time a selected respondent is contacted or is described by someone else as physically or mentally incapable of completing survey or the second time a respondent who is physically or mentally impaired is contacted.

2330	Language barrier, selected respondent	Selected respondent does not speak English or other language for which interviewers are available. (NOTE: If language barriers prevent completion of respondent selection, assign code 3330 (language barrier, physical or mental impairment).	1-6 attempts	Assign the first time a selected respondent is contacted or is described by someone else as not speaking English or other language (i.e. Spanish) for which interviewers are available.
3100	Unknown if eligible	Assign if hang up or call back request without confirming private residence/college housing or age of respondent (landline telephone and cell phone).	1-15 attempts (landline) 1-8 attempts (cell phone)	Give final disposition after second hang-up / call back request / termination or when a first time hang up will not be called back because of hard refusal or special circumstances and **when household eligibility is NOT established**. If the first occurrence is on 15th attempt, give final disposition. Assign after maximum number of attempts with at least one interim disposition of 5050 (hang up, unknown if housing unit).
3130	No answer	Assign if telephone rings normally but no one answers.	6-15 attempts	Give final disposition after at least 5 calling occasions of no more than 3 attempts with at least 3 weekday, 3 weeknight and 3 weekend calls for landline

				telephones. Cell phone respondents may be called up to 8 times, with at least 2 weekday, 2 weeknight and 2 weekend attempts. Assign after maximum number of attempts with plurality of interim dispositions of 5130 (no answer).
3140	Answering device, unknown whether eligible	Assign if a mailbox is full or not yet established. Assign if answering device leaves open the possibility that the telephone number is not a residence or that the respondent is not eligible due to age.	10-15 attempts for landline telephones; up to 8 attempts for cell telephones	Give final disposition after at least 5 calling occasions of no more than 3 attempts with at least 3 weekday, 3 weeknight and 3 weekend calls for landline telephones. Cell phone respondents may be called up to 8 times, with at least 2 weekday, 2 weeknight, and 2 weekend attempts. Assign after maximum number of attempts with plurality of interim dispositions of 5140 (answering device, unknown if eligible residence or respondent).
3150	Telecommunication barrier	Assign if call blocking, call ID requirements or other respondent initiated block device leaves open the possibility of the number	1-6 attempts	Give final disposition after up to 3 calling occasions of no more than 2 attempts with at least 2 weekday, 2

		reaching an eligible household and/or respondent. Assign if call forwarded to other number and there is some potential for reaching household or actual respondent at later time.		weeknight, and 2 weekend calls for landline telephones. Cell phone respondents may be called up to 6 times, with at least 2 weekday, 2 weeknight and 2 weekend attempts. Assign after maximum number of attempts with at least one interim disposition of 5150 (telecommunication barrier) and all others noncontact.
3200	Household, not known if respondent eligible	Assign for landline telephone sample if private residence confirmed without selecting respondent. (NOTE: If contact is made and household eligibility is unknown, use code 3100). Contact with vacation home may apply. Contact with household where residents are away for interview period may apply. Assign for cell phone if contact is made with household resident without determining whether cell phone number and respondent are eligible.	1-15 attempts (landline) 1-8 attempts (cell phone)	Give final disposition after second hang-up/ termination or when a first time hang up will not be called back because of hard refusal or special circumstances and **when respondent eligibility is NOT established**. If the first occurrence is on 15th attempt, give final disposition. Assign after maximum number of attempts with at least one interim disposition of 5050 (hang up, unknown if respondent eligible).

3322	Physical or mental impairment (household level)	Assign if physical or mental impairment prevents determination of private residence or prevents determination of eligibility of household or resident. This is a household level assignment. If selected respondent is physically or mentally impaired, assign 2320 after first attempt.	1-6 attempts	Assign after maximum number of attempts with at least one interim disposition of 5320 (physical or mental impairment).
3330	Language barrier, (household level)	Assign if language barrier prevents determination of private residence or prevents determination of eligibility of household or resident. This is a household level assignment. If selected respondent has language barrier assign 2330 when informed. Information may come from respondent or other household member.	1-6 attempts	Assign after maximum number of attempts with at least one interim disposition of 5330 (household language barrier). Do not assign if there are interviewers within the calling center who could complete the interview in language spoken by household (i.e. Spanish).
3700	On never call list	Assign only if supervisor can determine that respondent/ household is on never call list. Interviewer should not assign based on respondent information. (NOTE: If respondent insists that he/she is on never call list assign household level refusal (2111) or respondent refusal (2112).	No attempt	Assign with confirmation by supervisor. Interviewer should not assign based on respondent information.
4100	Out of sample	Assign if out of state for landline telephone or out of country for cell phone. Assign if indication that	1-15 attempts (landline)	Assigned as soon as sample ineligibility determined. This should

		number reaches vacation home or household members are not living in home during interview period. (NOTE: If contact is made with respondent who indicates that they have been reached at their vacation home where they live for at least 30 consecutive days per year, interview can continue).	1-8 attempts (cell phone)	take priority over other final dispositions.
4200	Fax/data/modem	Assign if call reaches fax or data line without human contact.	1-6 attempts	May be assigned to landline unlisted sample with secondary precall status of fax. May be assigned after one attempt. If states choose to use 6 attempts, give final disposition after recommendation for 3 calling occasions with 2 weekday, 2 weeknight and 2 weekend calls for landline telephones. If states choose to use 6 attempts, cell phone respondents may be called up to 6 times, with recommendations for 2 weekday, 2 weeknight, and 2 weekend attempts. If 6 attempts are used, assign after maximum number of attempts with at least one interim disposition of 5200 (fax/data/modem) and all

				others noncontact with any person.
4300	Nonworking number/ disconnected	Assign if tritone. Assign if operator message of nonworking number. States may choose to assign for temporary nonworking number message on first attempt or after repeated temporary nonworking number messages. Assign if “number changed” message. Assign if correctly dialed number rings to incorrect number. Assign if respondent reports that connection has been made to wrong number. A number that does not accept incoming calls (such as a hospital line only used for outgoing calls)	1-6 attempts. Do not call more than 6 attempts.	May be precall assigned (for both landline and cell phone). May be assigned after one attempt. If states use 6 attempts, give final disposition after recommendation for 3 calling occasions with 2 weekday, 2 weeknight, and 2 weekend calls for landline telephones. Cell phone respondents may be called up to 6 times, with recommendations for 2 weekday, 2 weeknight, and 2 weekend attempts. Assign after maximum number of attempts with at least one interim disposition of 5400 (technological barrier), 5300 (possible nonworking) or 5550 (busy) and all others noncontact.
4400	Technological Barrier	Assign if repeated busy, fast busy or circuit busy messages. Assign if repeated ambiguous operator messages. Assign if repeated poor audio quality. Assign if number repeatedly does not connect.	1-6 attempts. Do not call more than 6 attempts.	May be assigned to landline unlisted sample with secondary precall status of busy. May be assigned after one attempt. Assign as soon as interviewer reaches number resulting in tritone.

		Assign if number reaches a retrieval or connectivity system (such as Skype or OnStar). Assign if cell phone respondent is outside calling area. Assign if respondent is unable to receive calls. DO NOT assign if answering device (which permits leaving messages) is reached.		If states use 6 attempts, give final disposition after recommendation for 3 calling occasions with 2 weekday, 2 weeknight, and 2 weekend calls for landline telephones. Cell phone respondents may be called up to 6 times, with recommendations for 2 weekday, 2 weeknight, and 2 weekend attempts. Assign after maximum number of attempts with interim dispositions of 5200 (fax/data/modem), 5400 (technological barrier), 5300 (possible nonworking) and/or 5550 (busy) and all others noncontact.
4430	Call forwarding / pager	Assign if message indicates number has been forwarded. Assign if number reaches a pager. Assign if connection produces series of beeps. NOTE: Do not select respondents from landline household or location that is different from the original number. Do not enumerate the number of adults at location which is different from original number.	1-6 attempts. Do not call more than 6 attempts.	May be assigned after one attempt. May give final disposition after respondent or automated message informs that the number has been forwarded after multiple attempts. May give final disposition after series of beeps indicates a pager has been reached. If states use 6 attempts, give final disposition after

		However, landline respondent may be interviewed if number has been temporarily forwarded and the respondent is still living at location of original number. Cell phone respondents who have forwarded their numbers may also be interviewed.		recommendation for 3 calling occasions with 2 weekday, 2 weeknight, and 2 weekend calls for landline telephone. Cell phone respondents may be called up to 6 times, with recommendations for 2 weekday, 2 weeknight, and 2 weekend attempts.
4450	Cell phone (landline telephone only)	Assign if landline telephone sample number connects to cell phone or if sample indicates that a number in the landline telephone sample has been ported to a cell phone.	1-15 attempts (landline) 1-8 attempts (cell phone).	Can be precall assigned. Given final disposition when informed. This disposition should take priority over other possible final dispositions for the landline telephone sample. This disposition code should be pre-assigned to precall status code which indicates cell phone in the landline telephone sample.
4460	Landline telephone (cell phone only)	Assign if cell phone sample number connects to a landline telephone.	1-15 attempts (landline) 1-8 attempts (cell phone).	Can be precall assigned. Given final disposition when informed. This disposition should take priority over other possible final dispositions for the cell phone sample.
4500	Non-residence	Assign if business, government, or other organization. For cell phone,	1-15 attempts (landline)	Given final disposition when informed. This disposition should take priority over

		assign if telephone is used exclusively for business purposes.	1-8 attempts (cell phone)	other possible final dispositions. This disposition should be assigned to numbers with a precall status of 5.
4510	Group home	Assign if respondent identifies number as reaching a group home, prison, halfway house, nursing home or hospital. College dormitories, graduate student housing, sorority/fraternity housing, or other college provided housing is not defined as group home. Persons living in college housing are eligible for interview.	1-15 attempts (landline) 1-8 attempts (cell phone)	Given final disposition when informed. This disposition should take priority over other possible final dispositions.
4700	Household, no eligible respondent	Assign if child telephone (landline telephone or cell phone). Assign if landline telephone household without eligible respondent.	1-15 attempts (landline) 1-8 attempts (cell phone)	Given final disposition when informed. This disposition should take priority over other possible final dispositions.
4900	Miscellaneous, non-eligible	Assign for null numbers, special data circumstances only. May be assigned if data are believed by state coordinator or data collection supervisor to be falsified or in error. Notify CDC when this code is used.	1-15 attempts (landline) 1-8 attempts (cell phone)	May be assigned after one attempt. Assign only with supervisor approval.
5050	Unknown whether eligible	Respondent hangs up or refuses before establishing eligibility. The state location question is not needed to establish eligibility for cell phone respondents.		Give interim disposition when this occurs. Call back after an interval of at least one day until maximum call attempts are reached.

5100	Appointment	Respondent asks for an appointment or asked to be called at some other time. Assign if child answers the phone and does not get an adult to come to the phone. Appointments may be formal or informal statements that the respondent is temporarily not able to complete the interview from household members or selected respondent.		Schedule a callback for appropriate time.
5111	Household level refusal (landline telephone only)	Assign for landline telephone only if refusal after confirmation of reaching household phone line used by adults in correct state but before core BRFSS Q1 in landline telephone. Refusal can be from any member of the household (note: if refusal by selected respondent, use code 2112). Automated messages should not count as refusals.		Give interim disposition when this situation occurs. Call back after an interval of at least one day. May assign final disposition of 2111 if hard refusal.
5112	Selected Respondent refusal: hang up or termination	Assign if refusal by selected respondent before Core BRFSS Q1 in landline telephone. Automated messages should not count as refusals. Assign if cell phone respondent refuses after number determined to be personal (nonbusiness) phone and respondent confirms living in		Give interim disposition. Schedule callback for as long as practical for up to two weeks after initial refusal.

		private residence or college housing.		
5120	Break off / termination in questionnaire	Assign after respondent completes through Core BRFSS Q1 with an answer other than “don’t know/not sure” or “refused” but breaks off prior to end of demographic section.		Give interim disposition when this situation occurs. Call back after an interval of at least one day.
5121	Call dropped	Assign for cell phone respondent if call is dropped.		Give interim disposition when this situation occurs. Call back may occur immediately or rescheduled after an interval of one hour.
5130	No answer	Assign if number rings normally without answer.		Give interim disposition when this occurs. Call back after an interval of at least one hour until maximum call attempts are reached.
5140	Answering device, unknown whether eligible	Assign if a mailbox is full or not yet established. Assign if answering device leaves open the possibility that the telephone number is not a residence or that the respondent is not eligible due to age.		Give interim disposition when this occurs. Call back after an interval of at least one hour until maximum call attempts are reached.
5150	Telecommunication barrier	Assign if call blocking, call ID requirements or other respondent initiated block device leaves open the possibility of the number reaching an eligible household		Give interim disposition when this occurs. Call back after an interval of at least one hour until maximum call attempts are reached.

		and/or respondent. Assign if call forwarded to other number and there is some potential for reaching household or actual respondent at later time.		
5200	Fax/data/modem	Assign if number connects to data or fax line without human contact.		States may assign final disposition of 4200 at any attempt, including the first attempt. If states choose to call up to 6 attempts, give interim disposition and schedule callback after an interval of at least one day.
5220	Answering device, confirms residence (landline telephone only)	The answering device gives a message confirming private residence by using the words “home,” “family,” “residence,” or “house” (landline telephone only). Due to potential for cell phone answering devices to be out-of-sample and/or not be connected to eligible respondents, do not assign this code to cell phone sample numbers.		Give interim disposition when this occurs. Call back after an interval of at least one hour until maximum call attempts are reached.
5300	Possible nonworking	Assign if message indicates number might be nonworking. Assign if recorded message indicates number is temporarily out of service. Assign if message indicates telephone number cannot be reached at this time. Assign if recording indicates that the		States may assign final disposition of 4300 at any attempt including the first attempt. If states choose to call up to 6 attempts, give interim disposition and schedule callback after an interval of at least one hour.

		number is for outgoing calls only (such as a hospital line for outgoing calls only).		
5320	Physical or mental impairment	A household respondent or selected respondent is temporarily unable to be interviewed due to physical or mental impairment. NOTE: If selected respondent has permanent physical or mental impairment that renders him/her unable to complete the interview, assign final disposition of 2320 (physical or mental impairment) as soon as informed.		Give interim disposition when this occurs. Call back after an interval of at least one day until maximum call attempts are reached.
5330	Language barrier	Assign if a respondent who is not the selected respondent does not speak English or other language for which an interviewer is available. (NOTE: If selected respondent does not speak English or language for which there is an interviewer available, give final disposition of 2330 as soon as informed.)		Give interim disposition when this occurs. Call back after an interval of at least one day until maximum call attempts are reached.
5400	Technological barrier	Assign if fast busy or circuit busy messages. Assign if ambiguous operator messages. Assign if number reaches a retrieval or connectivity system (such as Skype or Onstar).		States may assign final disposition of 4400 at any attempt. If states choose to call up to 6 attempts, give interim disposition and schedule callback after an interval of at least one day.

		Assign if poor audio quality. Assign if number does not connect. Assign if cell phone respondent is outside calling area. Assign if respondent is unable to receive calls. DO NOT assign if answering device (which permits leaving messages) is reached.		
5550	Busy	Assign if number produces normal busy (not fast busy) signal.		States may assign final disposition of 4400 at any attempt. If states choose to call up to 6 attempts, give interim disposition and schedule callback after an interval of at least one hour.
5560	Unsafe location/ activity for interview	Assign if respondent indicates he/she unable to continue due to safety concerns. May be assigned to numbers in cell phone or landline phone sample.		Give interim disposition when this occurs. Schedule a callback time or call back after an interval of at least one hour until maximum call attempts are reached.
5700	Supervisor attention	Assign if special circumstances require supervisor attention		Assign only for special circumstances.
5900	Null attempt	Assign only with supervisor approval for special data circumstances.		Assign only with supervisor approval for special data circumstances.

Appendix C:
Understanding Coding for Technological / Telecommunication Barriers

Introduction

The Ci3 2015 BRFSS survey programming includes four-digit disposition codes. Disposition code changes resulted from the move toward the standards of the American Association of Public Opinion Research (AAPOR), the increased diversity of types of telephones in the sample, and the rapid changes in telephone usage.

This document provides a quick overview of the differences between Technological Barriers and Telecommunication Barriers, and Phone Circuit Messages and Answering Device Messages. It also provides examples of Phone Circuit messages and Answering Device messages with comments on their proper coding. The number and variety of messages that phone companies use are changing rapidly. The lists provided here are not comprehensive, but they are intended to give an overview of coding for commonly heard messages. This list was developed following discussions with data collectors at the 2013 BRFSS conference, and amended after discussions in 2015.

Definitions of Technological Barriers, Telecommunication Barriers, Phone Circuit Messages and Answering Devices

One challenge with BRFSS disposition codes is the differentiation between a Telecommunication Barrier [5150] and a Technological Barrier. [5400]. The differences between these codes are based on whether the respondent initiates the barrier (Telecommunication Barrier) or the barrier is due to something outside of the control of the respondent (Technological Barrier). Technological Barriers may be due to the carrier or problems in the circuits or with the type of telephone. Technological barriers may also be due to a connection to a system that is not used as a phone, but a connectivity system itself, such as Skpe.

Keep in mind that a Technological Barrier will be coded as ineligible while a Telecommunication Barrier is coded as unknown eligibility. Also remember that clear messages for non-working numbers should be coded as final disposition nonworking number (4300) or possible nonworking number (interim code 5300). Personal answering devices should not be coded as a Technological Barrier.

Telecommunication Barriers vs. Technological Barriers

Technological Barrier (5400 or 4400): A Technological Barrier is either:
a) a telephone # that does not behave like a telephone line but instead acts like some other device (pager, alarm system, etc.); or
b) a NON-connecting telephone line that a telephone owner cannot answer (fast busy, circuit busy, etc.);
c) a retrieval or connectivity system (such as Skype or Onstar).
or
c) a line with an ambiguous phone circuit message.

Telecommunication Barrier (5150 or 3150): A Telecommunication Barrier is a device or service on the end of a telephone line put by the telephone line owner to block incoming calls. This type of barrier includes call blocking devices or requirements for codes prior to connection but does not include personal answering devices (such as voice mail). Telecommunication Barriers result from screening by potential respondents NOT by telephone companies.

Code a result as a telecommunication barrier only when there is assurance that the respondent put the block on the phone line. Otherwise, code the call as a technological barrier.

Interviewers often encounter messages from a phone company, or a phone circuit message. Phone circuit messages are not specific to a potential respondent and DO NOT ALLOW INTERVIEWERS TO LEAVE MESSAGES. Answering devices, on the other hand, do allow for interviewers to leave messages, unless the mailbox is full. Answering devices are set up by respondents or are specific to their telephone numbers. Even if a recorded message is heard on the answering device, it is still specific to that number and should be coded appropriately.

Phone Circuit Messages vs. Answering Devices

Phone Circuit Messages: A phone circuit message is produced by a telephone company. It is not specific to a potential respondent. Phone circuit messages do not permit interviewers to leave messages for potential respondents. Phone circuit messages may result in technological barrier dispositions (5400 or 4400), nonworking number dispositions (5300 or4300) or other ineligible dispositions.

Answering Devices: Answering devices must allow interviewers to leave messages or indicate that a specific mailbox is full. An answering device is specific to a potential respondent, even if it is a recorded message. For example, a recording which indicates that the interviewer has reached a specific number and allows the interviewer to leave a message is an answering device, not a phone circuit message. Answering devices may indicate that the number dialed is a household in the landline telephone sample. Codes for answering devices are 5220/2220 for landline answering devices which are known to be households and 5140 and 3140 when the answering device is in the cell phone sample or when it is not known that the answering device is connected to an eligible household.

Code a result as an answering device only if the interviewer has the potential to leave a message (or if the mailbox is full). Do not code a household answering device for a number in the cellular telephone

Examples of Messages and Coding Suggestions

Sometimes it is difficult to tell if a number is non-working or if there is a technological barrier. If the number is identified as purely non-working (you get an operator message that says it's non-working) then use a non-working disposition code (either final non-working [4300] or possible non-working [5300]). CATI centers should define how strong the message needs to be to decide between final [4300] and possible [5300] non-working. The table below illustrates some common phone circuit messages that have been reported by states in the recent months. We have provided suggested coding for each message. This list is not exhaustive and it is likely that data collectors will continue to hear ambiguous messages in the future. Keep in mind the general rule that technological barriers are outside the control of the respondents, while telecommunication barriers are specifically placed by the respondents to block calls.

Table 1
Common Phone Circuit Messages

Phone Circuit Message	Comment	Suggested Coding
You have reached the (XXX) Telecom voice messaging service. If you have a mailbox on this system and would like to access it now, enter your 10-digit phone number, then press pound.	This is a number to a voicemail service, not a household.	4500--Non-residence
Tritone with and/or without a message	This message indicates that the number may not be a working number.	5300--Possible Non-working 4300--Nonworking
The number you have reached is not in service at this time.	This message indicates that the number may not be a working number.	5300--Possible Non-working 4300--Nonworking
At the subscriber's request, this phone does not accept incoming calls.	Although this may appear to be a block, our experience with this message is that it is a hospital or group home where the phone places outgoing calls only.	5300--Possible Non-working 4300--Nonworking
Welcome to [cell phone carrier]. The number you have dialed is unassigned.	This message indicates that the number may not be a working number.	5300--Possible Non-working 4300--Nonworking
We're sorry; your call cannot be completed as dialed. If you feel you have reached this recording in error, please check the area code and the number and try your call again.	This message indicates that the number may not be a working number.	5300--Possible Non-working 4300--Nonworking

We're sorry. Your call cannot be completed as dialed. Please check the number and dial again or call your operator to help you.	This message indicates that the number may not be a working number.	5300--Possible Non-working 4300--Nonworking
The number you are trying to call is not reachable.	This message indicates that the number may not be a working number.	5300--Possible Non-working 4300--Nonworking
Your call has been connected to a vacant number series. Please check the number and dial again or call an operator to assist you.	This message indicates that the number may not be a working number.	5300--Possible Non-working 4300-Nonworking
The number you dialed is not a working number. Please check the number and dial again.	This message indicates that the number may not be a working number.	5300--Possible Non-working 4300--Nonworking
The number or code you have dialed is incorrect. Please check the number or code and try again.	This message indicates that the number may not be a working number.	5300--Possible Non-working 4300--Nonworking
The mobile customer you have dialed has turned the unit off or is outside its service area.	Note that this message indicates that the call may not be blocked by the respondent but by the lack of phone coverage; therefore, this message still may be coded as a technological barrier.	5400--Technological Barrier 4400--Technological Barrier
The subscriber you have dialed is not available or has traveled outside the coverage area. Please try you call again later.	Note that this message indicates that the call may not be blocked by the respondent but by the lack of phone coverage. Therefore this message still may be coded as a technological barrier.	5400--Technological Barrier 4400--Technological Barrier
The person you are calling cannot accept calls at this time. We're sorry for any inconvenience this may cause.	The potential respondent could not answer this call, even if he/she wanted to; therefore, it is a technological barrier.	5400--Technological Barrier 4400--Technological Barrier
The mobile number you dialed is unavailable. Please try your call again later.	The potential respondent could not answer this call, even if he/she wanted to therefore it is a technological barrier.	5400--Technological Barrier 4400--Technological Barrier
Welcome to (cell phone carrier). The wireless customer you called is not available at this time. Please try your call again later.	The potential respondent could not answer this call, even if he/she wanted to; therefore, it is a technological barrier.	5400--Technological Barrier 4400-Technological Barrier
The person you are trying to reach is not accepting calls at this time. Please try your call again later.	The potential respondent could not answer this call, even if	5400--Technological Barrier 4400--Technological Barrier

	he/she wanted to therefore it is a technological barrier.	
The subscriber is off line. Please call again later.	The potential respondent could not answer this call, even if he/she wanted to; therefore, it is a technological barrier.	5400--Technological Barrier 4400--Technological Barrier
The person you have called is not available right now. Please try again later.	The potential respondent could not answer this call, even if he/she wanted to therefore it is a technological barrier.	5400--Technological Barrier 4400- Technological Barrier
The party you are calling is currently unavailable.	The potential respondent could not answer this call, even if he/she wanted to; therefore, it is a technological barrier.	5400--Technological Barrier 4400--Technological Barrier
The person you have dialed is not able to receive calls at this time.	The potential respondent could not answer this call, even if he/she wanted to; therefore, it is a technological barrier.	5400--Technological Barrier 4400- Technological Barrier
The (cell phone carrier) number you dialed does not subscribe to voicemail services.	This appears to be a working number without voicemail set up.	5130--No Answer 3130--No Answer
The number you have reached has not yet set up voicemail services.	This appears to be a working number without voicemail set up.	5130--No Answer
The mobile customer you have dialed has turned the unit off.	Because this is a clear message that the call has been blocked by an action of the respondent, it is a telecommunication barrier.	5150--Telecommunication Barrier 3150--Telecommunication Barrier
Please enter your PIN to be connected.	Because this is a clear message that the call has been blocked by an action of the respondent, it is a telecommunication barrier	5150--Telecommunication Barrier 3150--Telecommunication Barrier

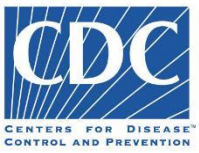
An answering device is differentiated from a phone circuit message in that it offers the interviewers the possibility to leave a message. In some cases, the answering device indicates that the number dialed has reached a residence. In other cases, messages from answering devices are less specific or seem to indicate that the answering device is attached to a business. Care should be taken to ensure that coding from answering device messages is accurate. Moreover, messages from cell phone sample answering devices are coded differently in some cases than are messages from landline sample answering devices. As in the past, assigning a disposition code for a message from an answering device before the household selection is complete will cause a prompt to be displayed. This prompt asks if the message includes "home," "house," "family," "residence" or a family name. It is important to answer this question correctly.

The table below explains the coding for the four answering device codes.

Table 2 Assigning Codes for Answering Devices		
Message	Comment	Code
The message indicates that the interviewer has reached a household number in the landline telephone sample. The message may include the word "residence" "home" "family" "household" or list the parents' and children's names.	Use this code only for the landline telephone sample. Due to potential for cell phone answering devices to be out-of-sample, do not use this disposition code for cell phone sample numbers.	2220--HH Answering device 5220--HH Answering device
The message does not indicate that the number is a household in the landline telephone sample. For cell phone sample numbers use this code on all answering devices where you can leave a message.	Assign if answering device permits the interviewer to leave a message, without indication of whether the number is connected to a household or business. Assign if answering device is reached on the cell phone sample.	3140--Answering device, unknown whether eligible 5140--Answering device, unknown whether eligible
The answering device indicates that the mailbox is full without indication of household status in the landline telephone sample number. Use this code for all cell phone answering devices where the mailbox is full.	Even though the interviewer cannot leave a message on this call, there is still potential for leaving a message on this device. Follow rules for household status on landline telephone devices.	2220--HH Answering device (LL only) 5220-HH Answering device (LL only) 3140-Answering device, unknown whether eligible 5140- Answering device, unknown whether eligible

Appendix D: Uploading BRFSS Data Using OneEdits

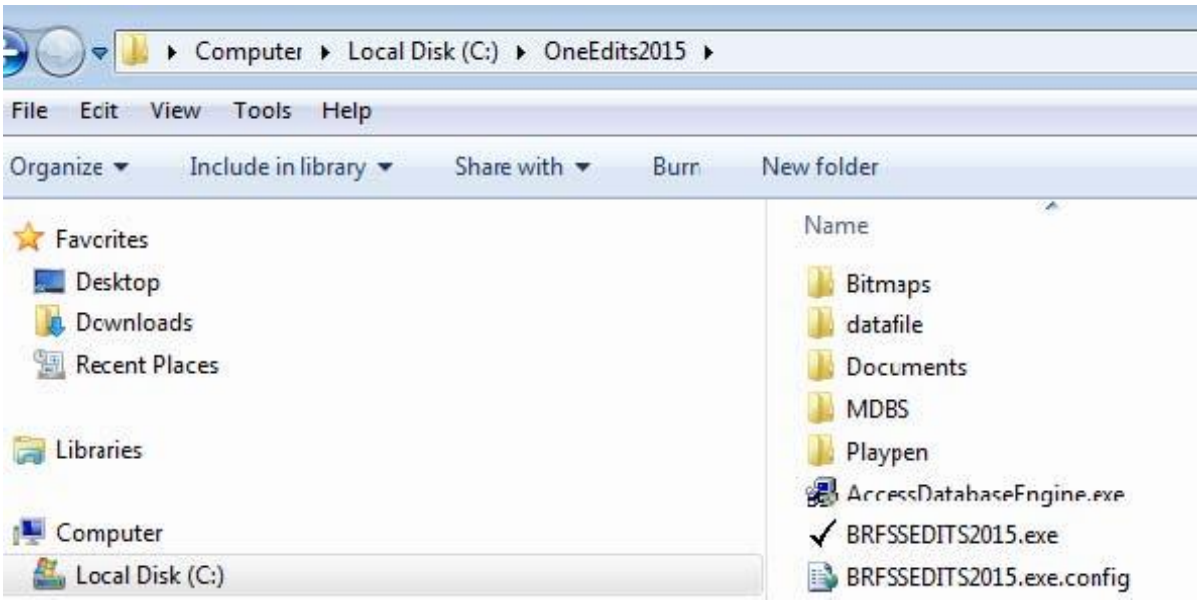
Using OneEdits 2015



New Features of OneEdits2015

- Landline and Cell Phone survey in one software
- Includes a feature that allows ‘Resume Editing’
- Allows Users to “Hide Errors”
  - Help in temporarily suppressing errors (avoid crowding) to focus on other problems
  - Can be reactivated
- Global field value replacement
  - Value of a particular field across the dataset can be replaced in one action
- Appropriate error messages
  - Allows users to fix problems at their end

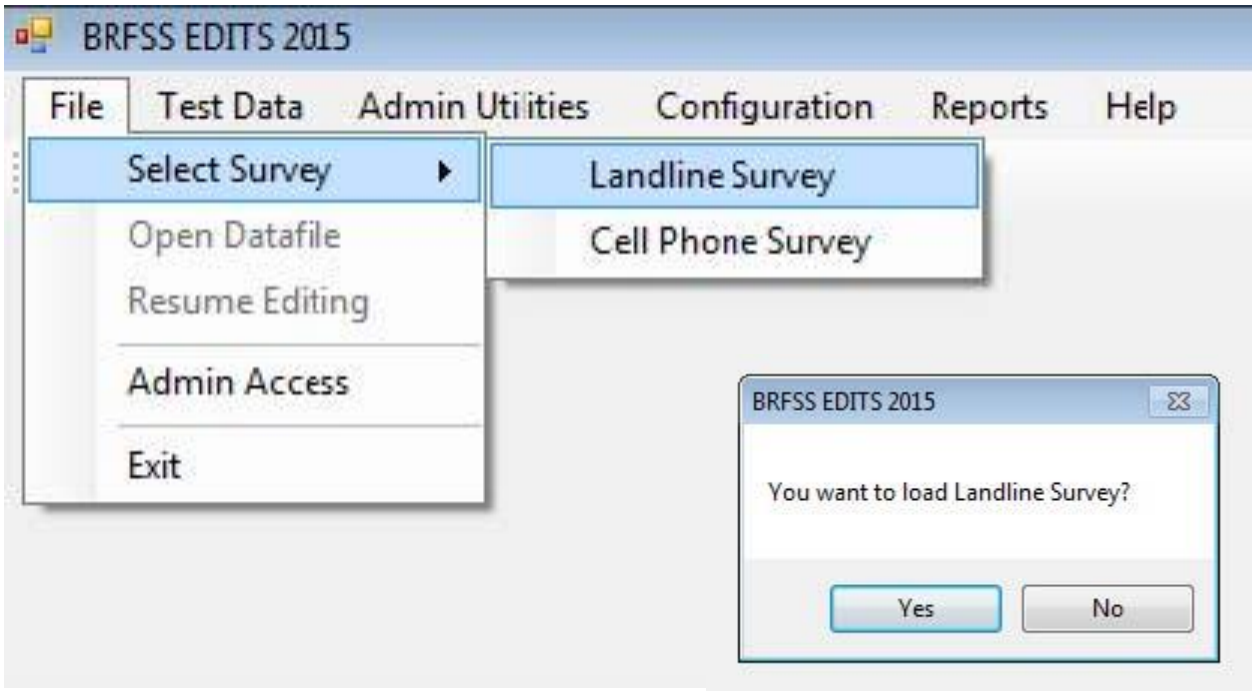
Default Folder Structure



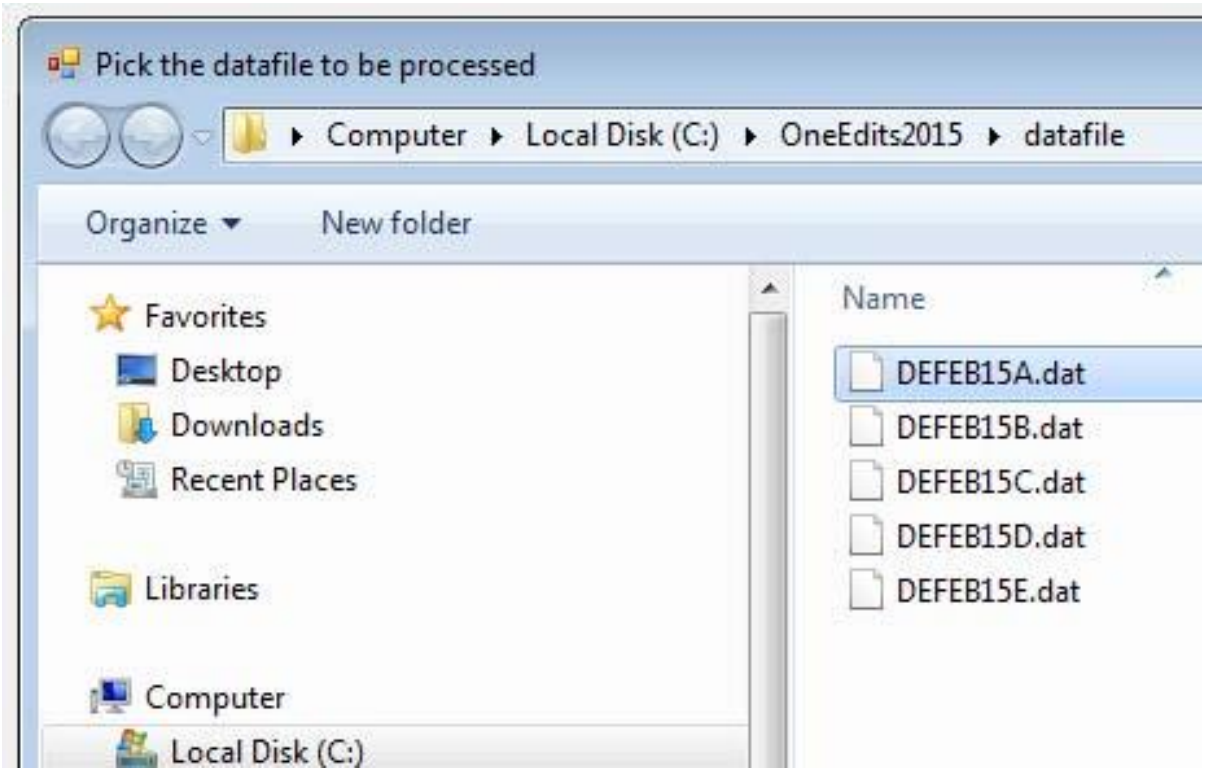
Datafile– Keep original .dat file

Playpen – OneEdits keeps duplicate file there and make changes there

Select Survey



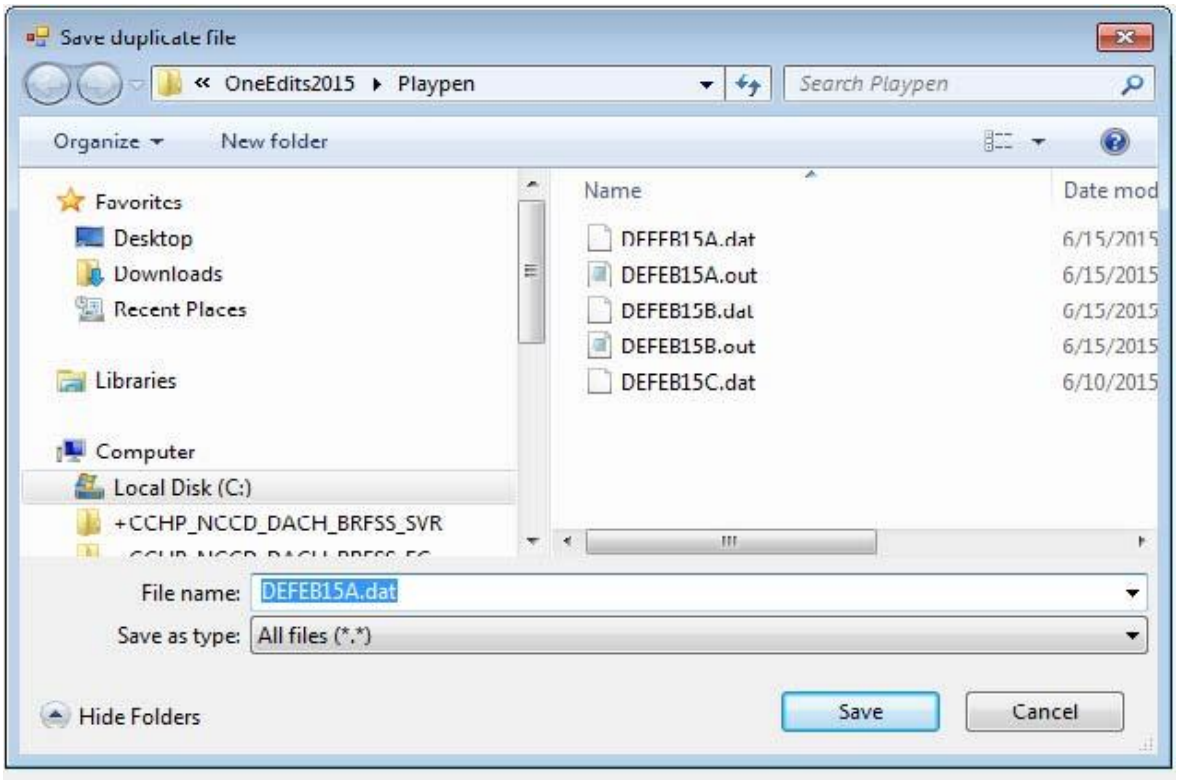
Select data file



Select file from Datafile folder

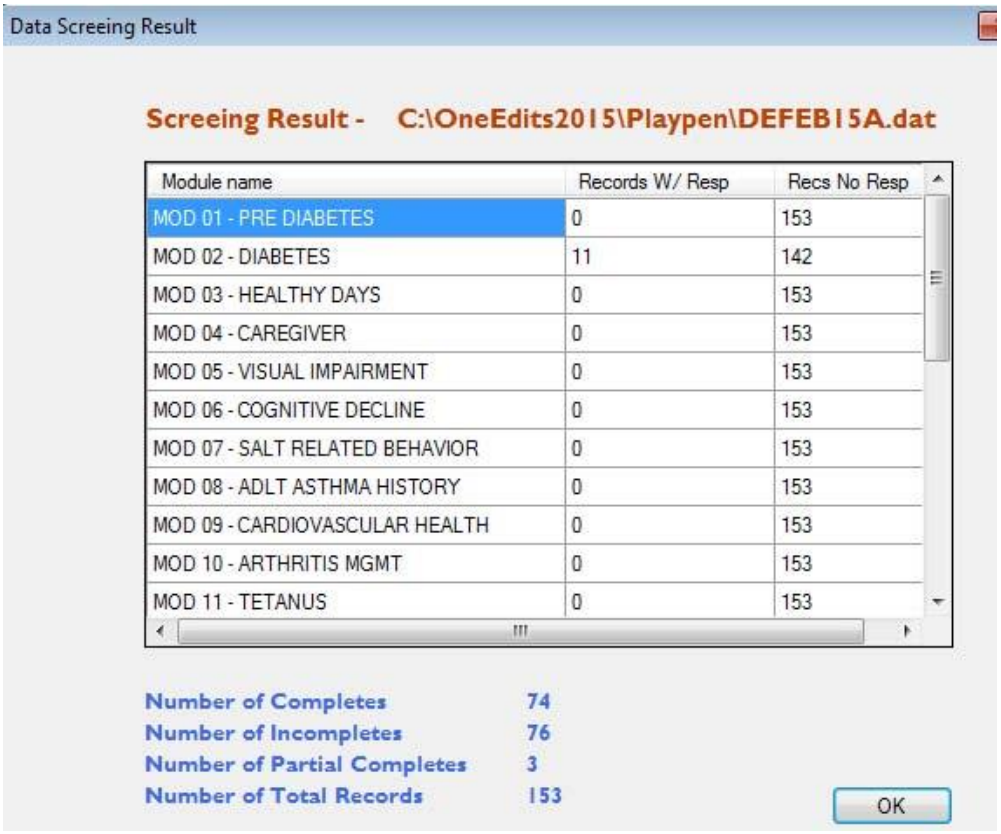
Save selected data file….

Save selected file in playpen folder. Keep filename same as original file.



Screening Results ….

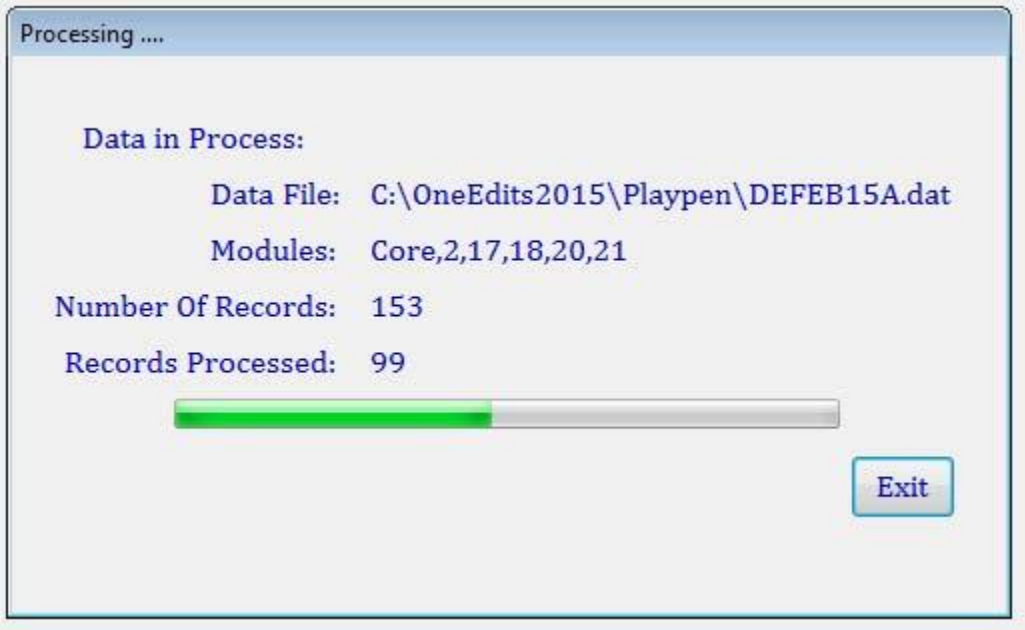
Basic screening run results, good place to verify if selected modules have data.



Screening Results ….

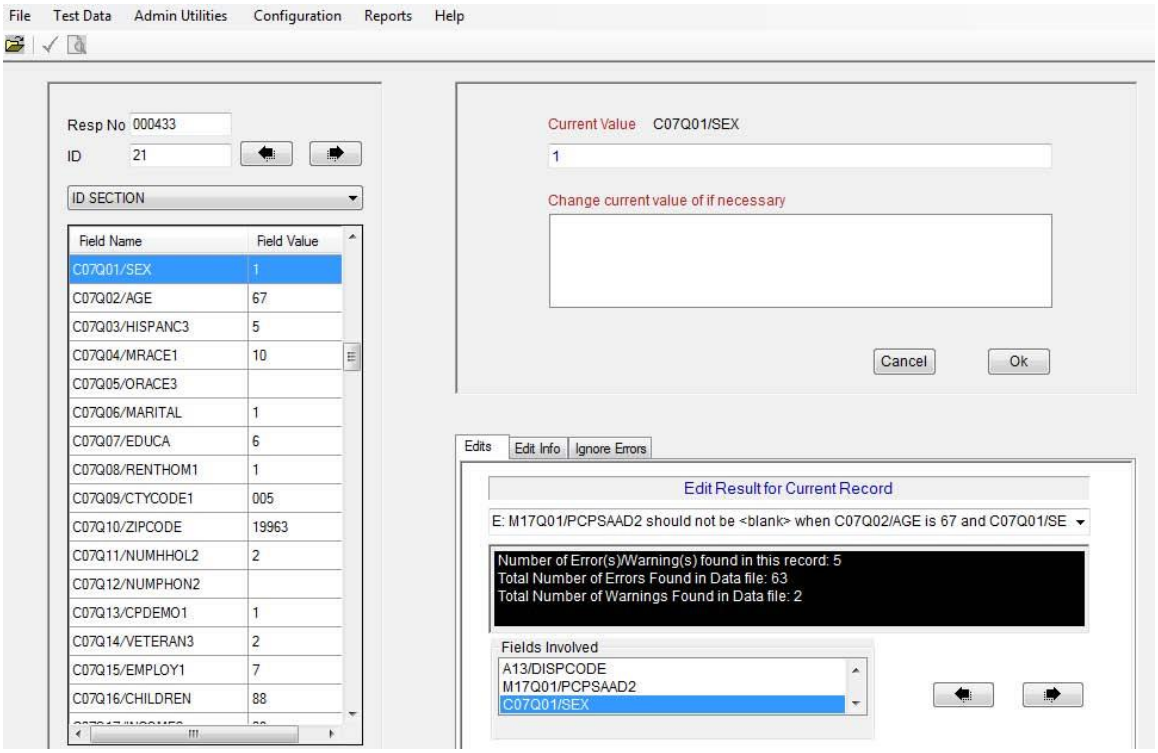
Test Dataset - > Run Edits menu would run edits on selected dataset.

Good place to review modules being run and see if that matches with what state intended to collect.



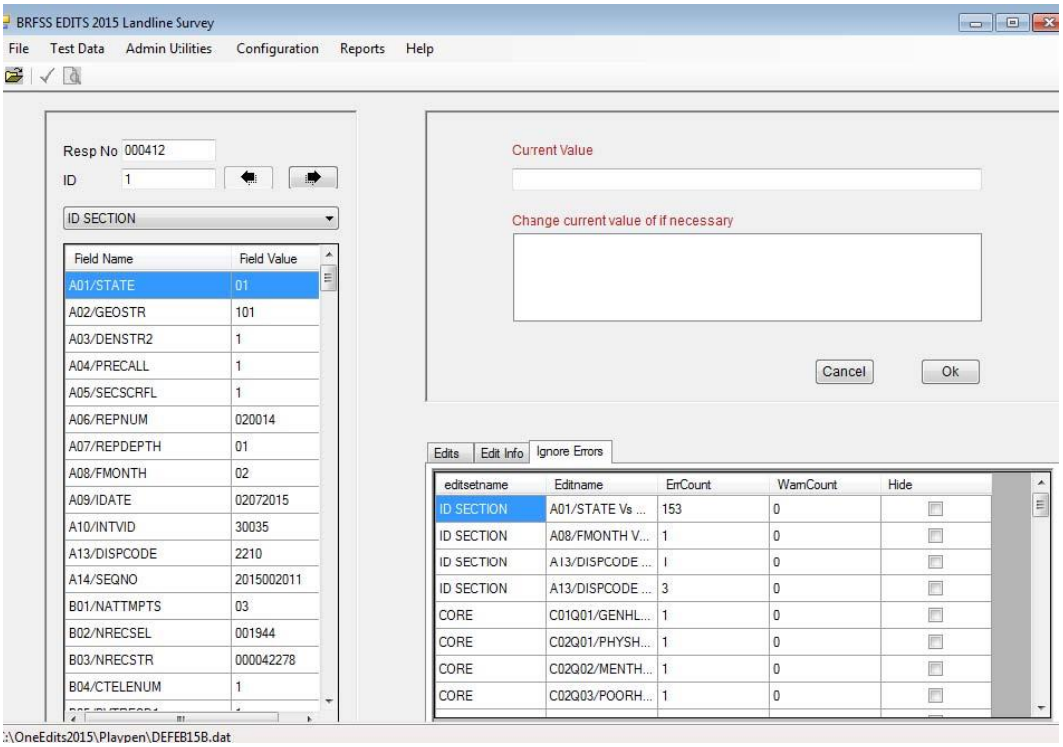
Edits Result ….

Test Dataset - > View Data menu would show edits run results. Data can be modified here in real time.



Ignore Errors….

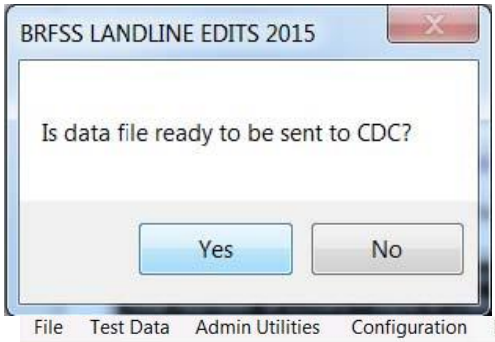
This is where repeating errors can be suppressed temporarily to focus on other errors.

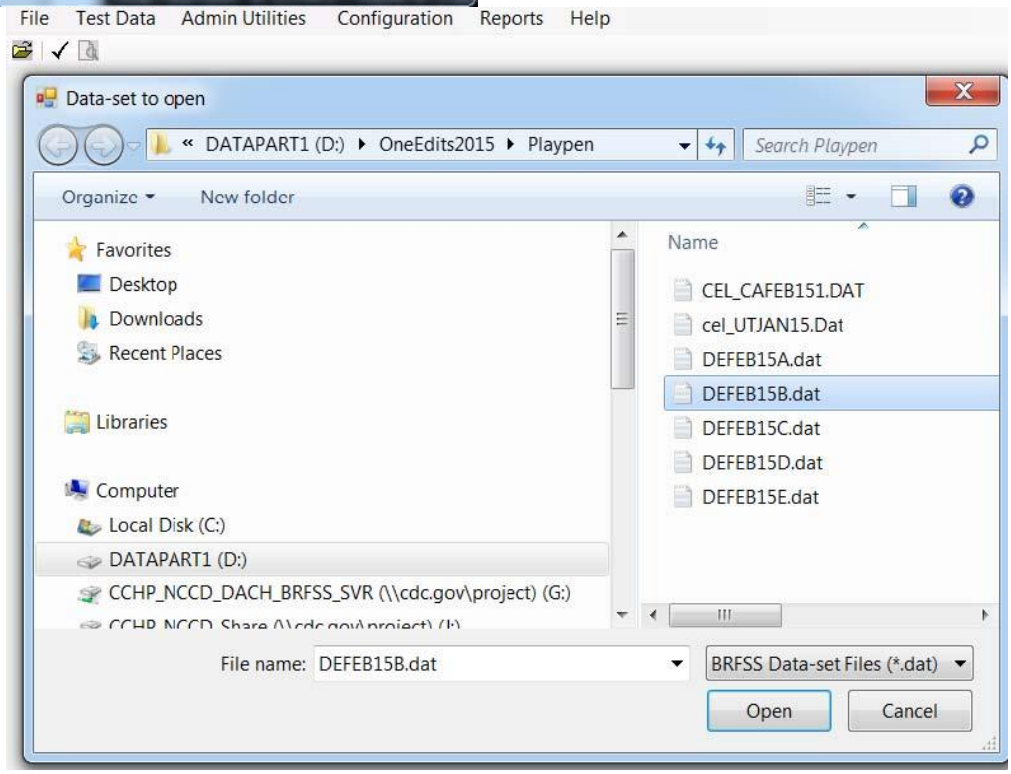


Resume Edits….

Select ‘No’ while quitting application if user wants to resume editing in future.

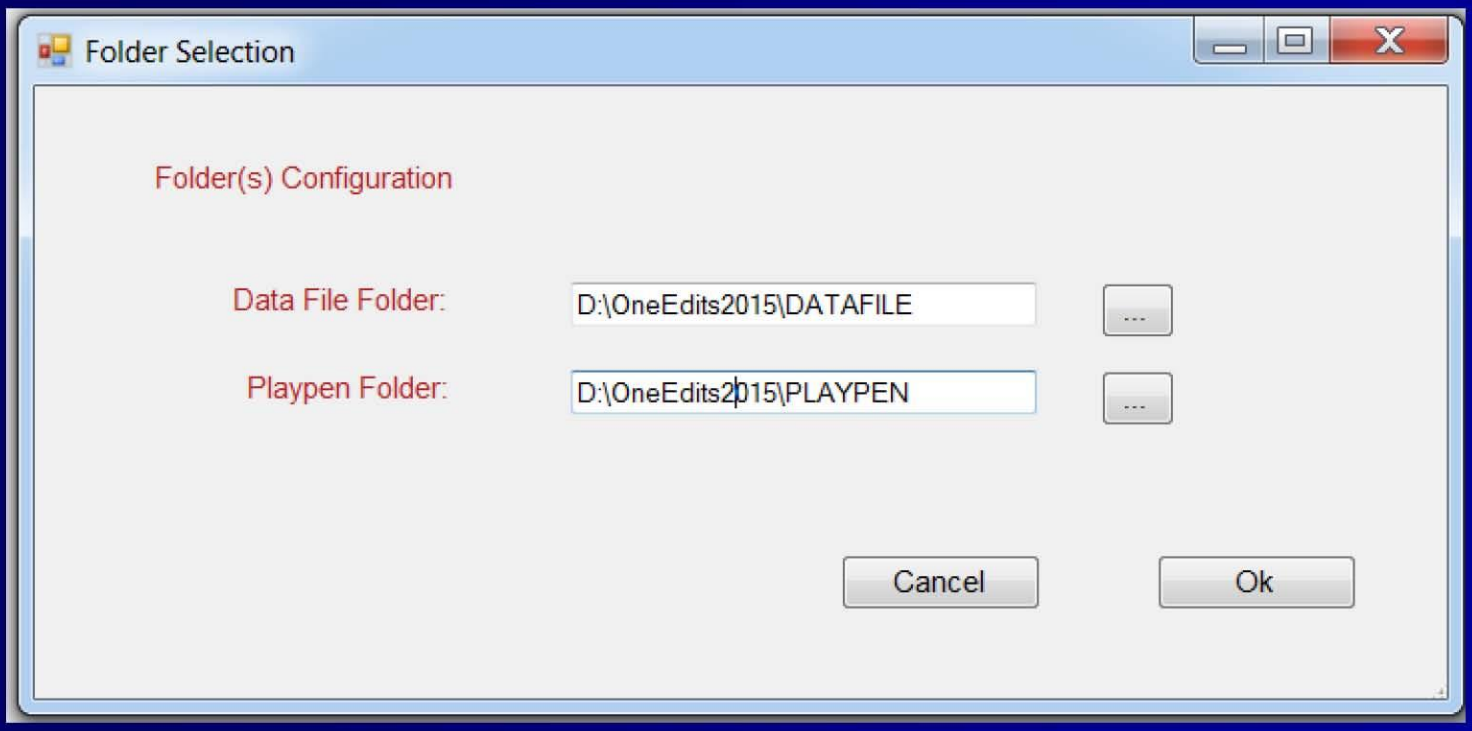
File - > Select Survey and File - > Resume Editing would allow resumption of editing.





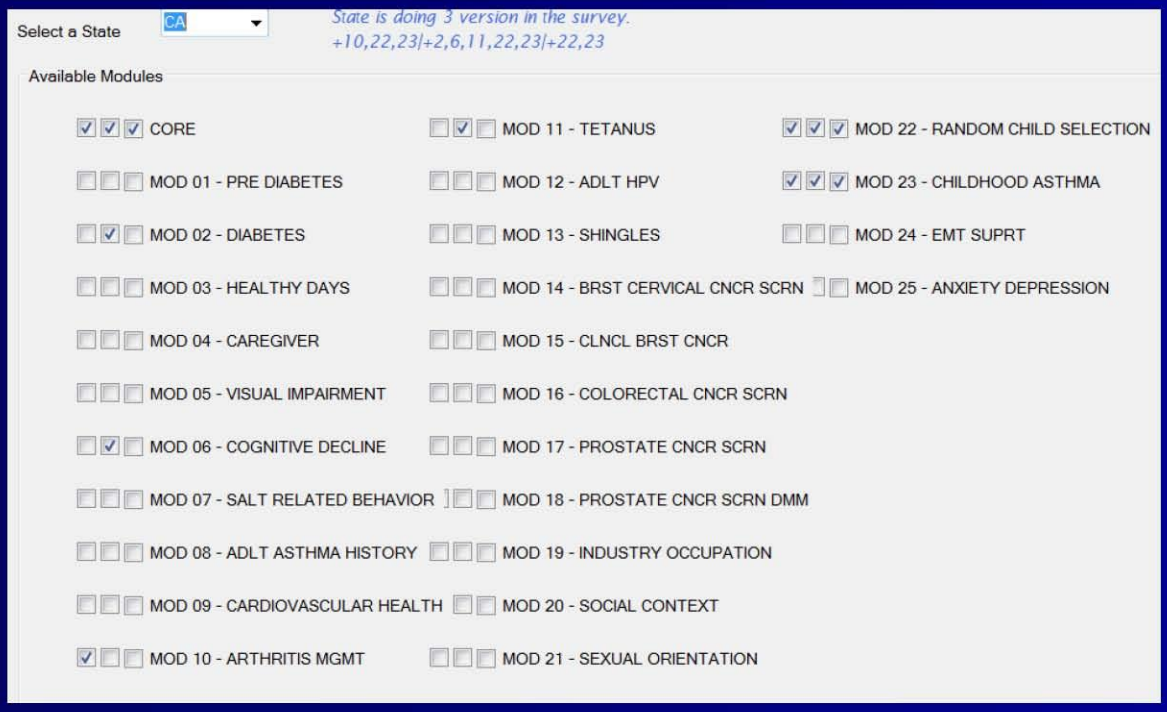
Folder Selection….

File - > Select Survey and Configuration



- File -> Select Survey and Configuration-> Folder Selection would allow users to change folders related to Data file and Playpen locations.
- User can point these locations to network drive if one wish to.

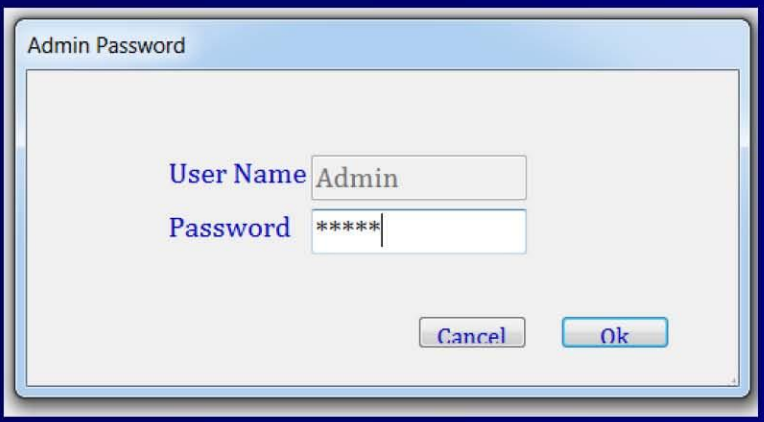
Module Selection….

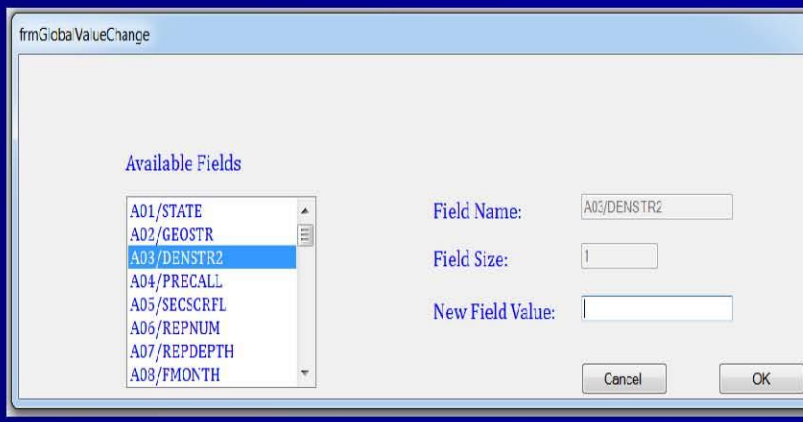


- File -> Select Survey and Configuration-> Module Selection would allow users to change modules being collected for states doing split version.
- No need to provide module list for states not doing dual survey.

Global field value change

File - > Select Survey, File - > Admin Access, Admin





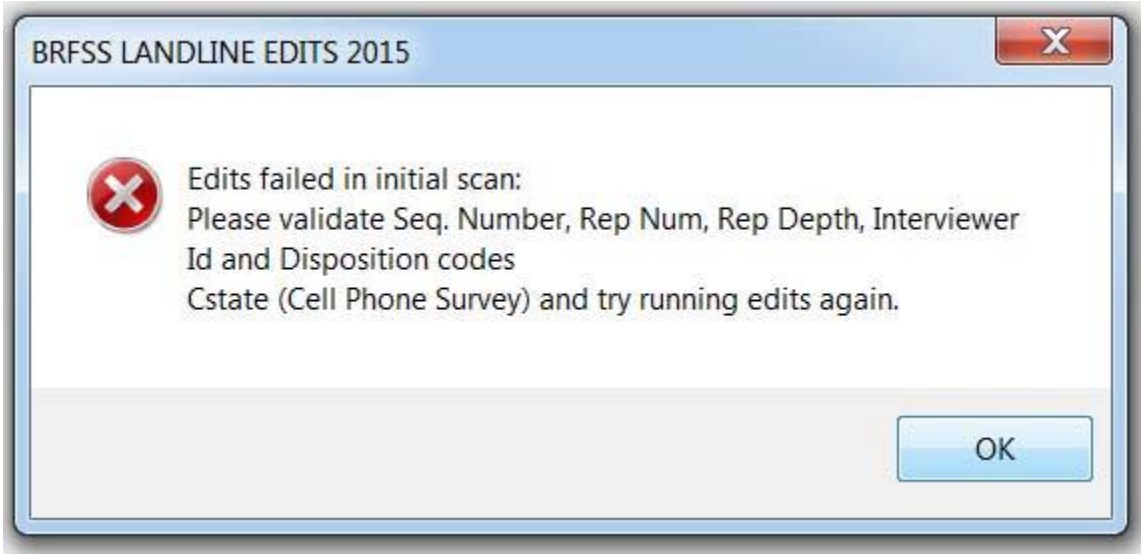
- File -> Select Survey, File -> Admin Access, Admin Utilities -> Global field value change would allow users to change value of a field across records in data file.

Reports …

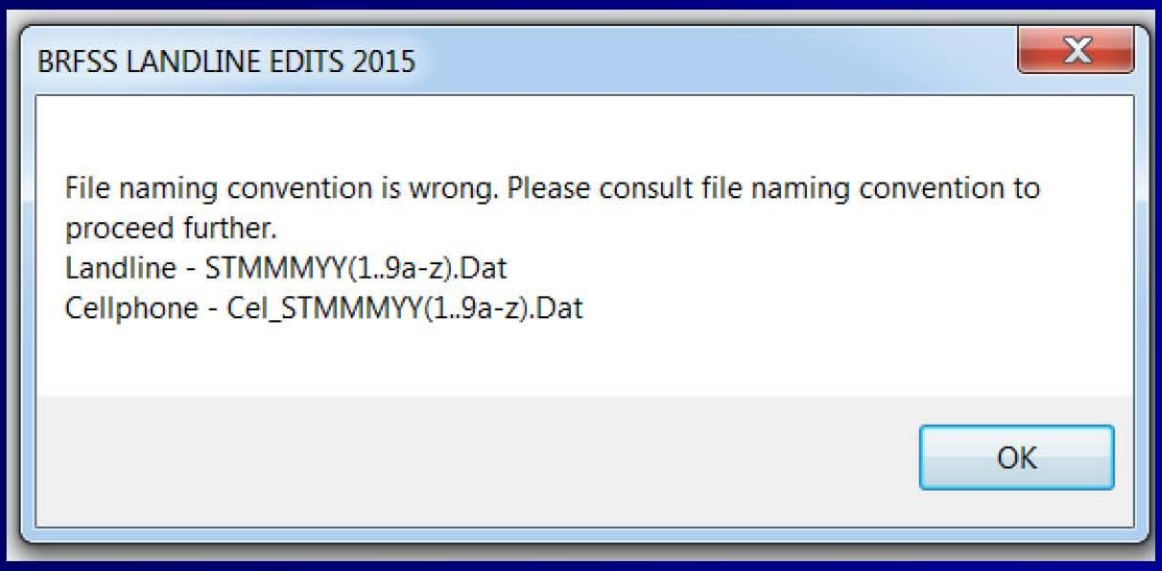
- Screening Report
  - Report shows modules presence in the dataset along with number of complete, partial complete
- Summary Report
  - Report shows summary of errors generated during edits run grouped by edit names
- Complete Report
  - Report shows detailed error messages along with screeing and summary part of it

Error Messages

This message will show up if selected data file has missing data for any one of the fields mentioned in error message.

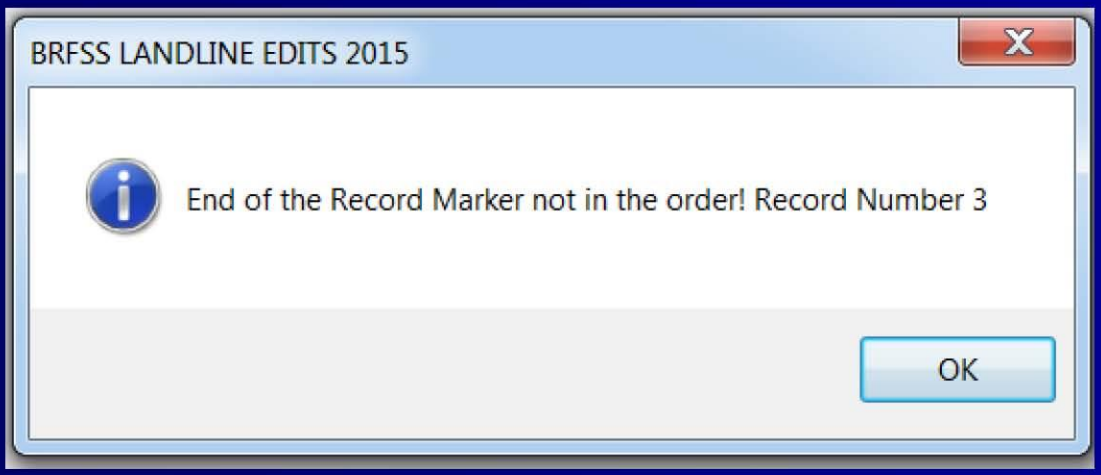


Error Messages



- This message will show up if data file selected does not follow file naming convention.
- User may inadvertently select cell phone survey data file when he/she is in landline survey session.

Error Messages



- This message will show up if data file selected does not follow record layout.
- Missing EOR marker (‘1’) at the end of any record will prompt this error message.

As with any software, there may be unexpected errors.

If you continue to experience problems with OneEdits, please contact Ajay Sharma

AUS6@cdc.gov or Bill Garvin WSG1@cdc.gov.

Attachment 2
2014 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 modules; Random Child Selection and Childhood Asthma Prevalence) 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 to be 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. However, the parent/guardian of the child can transfer the interview to the Most Knowledgeable Person (MKP) and grant this person permission to conduct the interview.**

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 (DBS) 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 new BRFSS exemption email for the 2014 BRFSS is provided in Appendix B, with an expiration date of 10/20/16. DBS will forward a copy of the updated IRB Exemption once it is received (which should be sometime in October, 2016).

5. Because both the adult and child questionnaires were pre-tested and administered in three states during 2005, administered to 25 states in 2006, and 35 states in 2007, 37 states in 2008, 37 states in 2009 and 40 states in 2010 and has been running consecutively for nine years, therefore we will not be requiring a pretest of the 2014 questionnaires. However, states can do a pretest, it's just not required. CA and PR provide a Spanish translation of each instrument. New states should test their CATI someway if they are not using one of the contractors currently conducting the Asthma Call-back.

6. The Callback Survey does encourage and support calls made via cellular phones. Due to the complexity of the data-swapping process, the survey will not be supporting this record swapping technique. Therefore, please call cellular respondents that have been identified as being from your state. Please follow BRFSS' cellular calling rules.

7. Data collection for the call-back survey should begin by February 1, 2014. Interviews should be conducted within two weeks of the BRFSS interview completion date. Conducting the Asthma interview earlier than 2-weeks limit is preferred. If the respondent is willing an immediate callback survey can be conducted. *If an immediate callback is conducted please help us to track this by entering a "2" in column 983 of the 2014 Adult Data Submission Layout or column 1004 of the 2014 Child Data Submission Layout.*

8. Data will be submitted to the BRFSS Upload/Download Website under the heading of Special Surveys. The following schedule should be used to submit your data: (earlier submissions are fine if data collection is completed earlier)

- March 1, 2014
- April 2, 2014
- July 2, 2014
- September 3, 2014
- October 3, 2014
- December 3, 2014
- February 25, 2015

Quarterly Submissions:

- April 2, 2014 (January, February, March)
- July 2, 2014 (April, May, June)
- October 3, 2014 (July, August, September)
- February 25, 2015 (October, November, December, plus all remaining data)

Note: You can submit your data earlier!

Proposed filenames for 2014 (UPDATED 5/5/2014)

```
AFA_    [Asthma Landline Adults]        e.g. AFA_ORAPR14x.DAT
AFC_    [Asthma Landline Children]      e.g. AFC_ORAPR14x.DAT
AFA_    [Asthma Cellphone Adults]       e.g. AFA_ORAPR14x_CEL.DAT
AFC_    [Asthma Cellphone Children]     e.g. AFC_ORAPR14x_CEL.DAT
```

Please submit files in the following format:

AFA_SSMMMYY.DAT for the asthma follow-up of adults (AFA)

AFC_SSMMMYY.DAT for the asthma follow-up of children (AFC)

SS represents the two character state abbreviation, **MMM** the three character month abbreviation (the last month interviews were conducted, and **YY** as the last two digits of the year. These files should be uploaded to the BRFSS website, under the **Special Surveys** link, and the **Submit Files** portal.

SS: State two letters initials

MMM: ***latest month three letters initials;*** If you send the data quarterly; ex: File with January, February, March should be named AFA_MI**MAR**14.DAT

YY: Year

12: For 2014 DATA

z: ONE LETTER(A-M) OR NUMER(1-9) FOR DIFFERENT VERSIONs (use with updated versions of a previous data file).

For states that will be completing their December 2014 data collection sample in January 2015, please name this file **AFA_GADEC14.DAT, using the sample's month and year.**

9. 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

10. A case should be considered as a partial complete (disposition code 1200) 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 2100) 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).

11. PC Edits programs for the adults and children datasets will be provided by DBS. This is expected to be available at end of the first quarter of the 2014 processing year.

12. DBS 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.

Appendix A

2014 BRFSS Asthma Call-back
Recommended Permission Script

"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 <STATE>. 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

Can I please have either (your/your child's) first name or initials so we will know who to ask for when we call back?

_____ Enter first name or initials

Appendix B

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Disease Control and Prevention (CDC)

Memorandum

October 18, 2013

Barbara R. DeCausey, MPH, MBA
Chief, Human Research Protection Office

HRPO Approval of Continuation of Protocol #2988.0, "Behavioral Risk Factor Surveillance System (BRFSS)"

Carol Pierannunzi, PhD
NCCDPHP/DPHP

The CDC Human Research Protection Office has received your submission for continuing review of exempt protocol #2988.0, "Behavioral Risk Factor Surveillance System (BRFSS)."

I find that this research activity remains exempt under 45 CFR 46.101(b)(2). Changes to this protocol may not be implemented until they are reviewed and determined to be consistent with the exemption categories. You will be asked in three years at **10/20/2016** to confirm that no changes have occurred in the protocol or the related science that would affect the ethical appropriateness of the research or this exemption. Please be advised that the investigators remain responsible for appropriate human research protections even for research that is exempt from regulations for protecting human subjects.

If you have any questions, please contact your National Center Human Subjects Contact or the CDC Human Research Protection Office at (404) 639-7570 (or by e-mail at Human Subjects Review - OD on the global CDC global address list or at huma@cdc.gov).

cc:
Joan Redmond Leonard

Attachment 3

2015

New York State
Behavioral Risk Factor Surveillance System
Questionnaire

December 29, 2014

2015 Questionnaire

Table of Contents

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?

READ ONLY IF NECESSARY: "By private residence, we mean someplace like a house or apartment."

Yes **[Go to state of residence]**
No **[Go to college housing]**

No, business phone only

If "No, business phone only".

Thank you very much but we are only interviewing persons on residential phones lines at this time.

STOP

College Housing

Do you live in college housing?

READ ONLY IF NECESSARY: "By college housing we mean dormitory, graduate student or visiting faculty housing, or other housing arrangement provided by a college or university."

Yes **[Go to state of residence]**
No

If "No",

Thank you very much, but we are only interviewing persons who live in a private residence or college housing at this time. STOP

State of Residence

Do you reside in ____(state)____?

Yes **[Go to Cellular Phone]**
No

If "No"

Thank you very much, but we are only interviewing persons who live in the state of _____at this time. STOP

Cellular Phone

Is this a cellular telephone?

Interviewer NOTE: Telephone service over the internet counts as landline service (includes Vonage, Magic Jack and other home-based phone services).

Read only if necessary: "By cellular (or cell) 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 by land line telephones and for private residences or college housing. **STOP**

No

CATI NOTE: IF (College Housing = Yes) continue; otherwise go to Adult Random Selection
Adult

Are you 18 years of age or older?

1 Yes, respondent is male [Go to Page 6]
2 Yes, respondent is female [Go to Page 6]
3 No

If "No",

Thank you very much, but we are only interviewing persons aged 18 or older at this time. **STOP**

Adult Random Selection

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 6.**

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 7.

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 your 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 about the survey, please call **(give appropriate state telephone number)**.

Section 1: Health Status

1.1 Would you say that in general your health is— (90)

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? (91–92)

Number of days
88 None
77 Don't know/Not sure
99 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?

(93–94)

		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?

(95-96)

		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, government plans such as Medicare, or Indian Health Service?

(97)

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?"

(98)

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?

(99)

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.

(100)

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

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

Section 4: Hypertension Awareness

4.1 Have you EVER been told by a doctor, nurse, or other health professional that you have high blood pressure?

(101)

Read only if necessary: By "other health professional" we mean a nurse practitioner, a physician's assistant, or some other licensed health professional.

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]**

4.2 Are you currently taking medicine for your high blood pressure?

(102)

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

Section 5: Cholesterol Awareness

5.1 Blood cholesterol is a fatty substance found in the blood. Have you EVER had your blood cholesterol checked?

(103)

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

5.2 About how long has it been since you last had your blood cholesterol checked?

(104)

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

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

(105)

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

Section 6: Chronic Health Conditions

Now I would like to ask you some questions about general health conditions.

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."

6.1 (Ever told) you that you had a heart attack also called a myocardial infarction? (106)

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

6.2 (Ever told) you had angina or coronary heart disease? (107)

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

6.3 (Ever told) you had a stroke? (108)

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

6.4 (Ever told) you had asthma? (109)

1 Yes
2 No **[Go to Q6.6]**
7 Don't know/Not sure **[Go to Q6.6]**
9 Refused **[Go to Q6.6]**

6.5 Do you still have asthma? (110)

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

6.6 (Ever told) you had skin cancer?

(111)

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

6.7 (Ever told) you had any other types of cancer?

(112)

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

6.8 (Ever told) you have Chronic Obstructive Pulmonary Disease or COPD, emphysema or chronic bronchitis?

(113)

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

6.9 (Ever told) you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?

(114)

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)

6.10 (Ever told) you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?

(115)

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

6.11 (Ever told) you have kidney disease? Do NOT include kidney stones, bladder infection or incontinence.

INTERVIEWER NOTE: Incontinence is not being able to control urine flow.

(116)

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

6.12 (Ever told) you have diabetes? (117)

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

CATI NOTE: If Q6.12 = 1 (Yes), go to next question. If any other response to Q6.12, go to Pre-Diabetes Optional Module (if used). Otherwise, go to next section.

6.13 How old were you when you were told you have diabetes?

(118-119)

_ _ Code age in years **[97 = 97 and older]**
9 8 Don't know/Not sure
9 9 Refused

CATI NOTE: Go to Diabetes Optional Module (if used). Otherwise, go to next section.

Section 7: Demographics

7.1 Indicate sex of respondent. **Ask only if necessary.** (120)

1 Male
2 Female

7.2 What is your age? (121-122)

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

7.3 Are you Hispanic, Latino/a, or Spanish origin? (123-126)

If yes, ask: Are you…

Interviewer NOTE: *One or more categories may be selected.*

1 Mexican, Mexican American, Chicano/a
2 Puerto Rican
3 Cuban
4 Another Hispanic, Latino/a, or Spanish origin

Do not read:

5 No
7 Don't know/Not sure
9 Refused

7.4 Which one or more of the following would you say is your race? (127-154)

Interviewer NOTE: Select all that apply.

Interviewer NOTE: 40 (Asian) or 50 (Pacific Islander) is selected read and code subcategories underneath major heading.

Please read:

10 White

20 Black or African American

30 American Indian or Alaska Native

40 Asian

41 Asian Indian
42 Chinese
43 Filipino
44 Japanese
45 Korean
46 Vietnamese
47 Other Asian

50 Pacific Islander

51 Native Hawaiian
52 Guamanian or Chamorro
53 Samoan
54 Other Pacific Islander

Do not read:

60 Other
88 No additional choices
77 Don't know/Not sure
99 Refused

CATI NOTE: If more than one response to Q7.4; continue. Otherwise, go to Q7.6.

7.5 Which one of these groups would you say best represents your race?

Interviewer NOTE: If 40 (Asian) or 50 (Pacific Islander) is selected read and code subcategory underneath major heading.

(155-156)

~~**10 White**~~

20 Black or African American

30 American Indian or Alaska Native

40 Asian

41 Asian Indian
42 Chinese
43 Filipino
44 Japanese
45 Korean
46 Vietnamese
47 Other Asian

50 Pacific Islander

51 Native Hawaiian
52 Guamanian or Chamorro
53 Samoan
54 Other Pacific Islander

Do not read:

60 Other
77 Don't know/Not sure
99 Refused

7.6 Are you…?

(157)

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

7.7 What is the highest grade or year of school you completed?

(158)

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

7.8 Do you own or rent your home?

(159)

1 Own
2 Rent
3 Other arrangement
7 Don't know/Not sure
9 Refused

INTERVIEWER NOTE: "Other arrangement" may include group home, staying with friends or family without paying rent.

NOTE: Home is defined as the place where you live most of the time/the majority of the year.

INTERVIEWER NOTE: We ask this question in order to compare health indicators among people with different housing situations.

7.9 What county do you live in? (160-162)

_ _ _	ANSI County Code (formerly FIPS county code)
7 7 7	Don't know/Not sure
9 9 9	Refused

7.10 What is the ZIP Code where you live? (163-167)

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

CATI NOTE: If cellular telephone interview skip to 7.14 (QSTVER GE 20)

7.11 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. (168)

1	Yes	
2	No	**[Go to Q7.13]**
7	Don't know/Not sure	**[Go to Q7.13]**
9	Refused	**[Go to Q7.13]**

7.12 How many of these telephone numbers are residential numbers? (169)

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

7.13 Do you have a cell phone for personal use? Please include cell phones used for both business and personal use. (170)

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

7.14 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?

INTERVIEWER NOTE: Active duty does not include training for the Reserves or National Guard, but DOES include activation, for example, for the Persian Gulf War.
(171)

1 Yes
2 No

Do not read:

7 Don't know/Not sure
9 Refused

7.15 Are you currently…?
(172)

Please read:

1 Employed for wages
2 Self-employed
3 Out of work for 1 year or more
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

7.16 How many children less than 18 years of age live in your household?
(173-174)

Number of children
88 None
99 Refused

7.17 Is your annual household income from all sources— (175-176)

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

7.18 Have you used the internet in the past 30 days? (177)

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

7.19 About how much do you weigh without shoes?

(178-181)

NOTE: If respondent answers in metrics, put "9" in column 178.

Round fractions up

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

7.20 About how tall are you without shoes?

(182-185)

NOTE: If respondent answers in metrics, put "9" in column 182.

Round fractions down

_ _ **/** _ _ Height
(f t / inches/meters/centimeters)
7 7/ 7 7 Don't know/Not sure
9 9/ 9 9 Refused

If male, go to Q7.22; If female respondent is 45 years old or older, go to Q7.22

7.21 To your knowledge, are you now pregnant?

(186)

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

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

7.22 Are you limited in any way in any activities because of physical, mental, or emotional problems?

(187)

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

7.23 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? (188)

NOTE: Include occasional use or use in certain circumstances.

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

7.24 Are you blind or do you have serious difficulty seeing, even when wearing glasses? (189)

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

7.25 Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (190)

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

7.26 Do you have serious difficulty walking or climbing stairs? (191)

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

7.27 Do you have difficulty dressing or bathing? (192)

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

7.28 Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (193)

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

Section 8: Tobacco Use

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

(194)

NOTE: 5 packs = 100 cigarettes

1	Yes	
2	No	**[Go to Q8.5]**
7	Don't know/Not sure	**[Go to Q8.5]**
9	Refused	**[Go to Q8.5]**

INTERVIEWER NOTE: "For cigarettes, do not include: electronic cigarettes (e-cigarettes, NJOY, Bluetip), herbal cigarettes, cigars, cigarillos, little cigars, pipes, bidis, kreteks, water pipes (hookahs), or marijuana."

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

(195)

1	Every day	
2	Some days	
3	Not at all	**[Go to Q8.4]**
7	Don't know/Not sure	**[Go to Q8.5]**
9	Refused	**[Go to Q8.5]**

8.3 During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

(196)

1	Yes	**[Go to Q8.5]**
2	No	**[Go to Q8.5]**
7	Don't know / Not sure	**[Go to Q8.5]**
9	Refused	**[Go to Q8.5]**

8.4 How long has it been since you last smoked a cigarette, even one or two puffs?

(197-198)

0 1	Within the past month (less than 1 month ago)
0 2	Within the past 3 months (1 month but less than 3 months ago)
0 3	Within the past 6 months (3 months but less than 6 months ago)
0 4	Within the past year (6 months but less than 1 year ago)
0 5	Within the past 5 years (1 year but less than 5 years ago)
0 6	Within the past 10 years (5 years but less than 10 years ago)
0 7	10 years or more
0 8	Never smoked regularly
7 7	Don't know/Not sure

9 9 Refused

8.5 Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?

Snus (rhymes with 'goose')

NOTE: Snus (Swedish for snuff) is a moist smokeless tobacco, usually sold in small pouches that are placed under the lip against the gum.

(199)

1 Every day
2 Some days
3 Not at all

Do not read:

7 Don't know/Not sure
9 Refused

Section 9: Alcohol Consumption

9.1 During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?

(200-202)

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	**[Go to next section]**
9 9 9	Refused	**[Go to next section]**

9.2 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?

(203-204)

NOTE: A 40 ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks.

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

9.3 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?
(205-206)

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

9.4 During the past 30 days, what is the largest number of drinks you had on any occasion?
(207-208)

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

Section 10: Fruits and Vegetables

These next questions are about the fruits and vegetables **you** ate or drank during the past 30 days. Please think about all forms of fruits and vegetables including cooked or raw, fresh, frozen or canned. Please think about all meals, snacks, and food consumed at home and away from home.
I will be asking how often **you** ate or drank each one: for example, once a day, twice a week, three times a month, and so forth.

INTERVIEWER NOTE: If respondent responds less than once per month, put "0" times per month. If respondent gives a number without a time frame, ask: "Was that per day, week, or month?"

10.1 During the past month, how many times per day, week or month did you drink 100% PURE fruit juices? Do not include fruit-flavored drinks with added sugar or fruit juice you made at home and added sugar to. Only include 100% juice.
(209-211)

1 _ _	Per day
2 _ _	Per week
3 _ _	Per month
5 5 5	Never
7 7 7	Don't know/Not sure
9 9 9	Refused

INTERVIEWER NOTE: Do not include fruit drinks with added sugar or other added sweeteners like Kool-Aid, Hi-C, lemonade, cranberry cocktail, Tampico, Sunny Delight, Snapple, Fruitopia, Gatorade, Power-Ade, or yogurt drinks.
Do not include fruit juice drinks that provide 100% daily vitamin C but include added sugar.

Do not include vegetable juices such as tomato and V8 if respondent provides but include in "other vegetables" question 10.6.

DO include 100% pure juices including orange, mango, papaya, pineapple, apple, grape (white or red), or grapefruit. Only count cranberry juice if the R perception is that it is 100% juice with no sugar or artificial sweetener added. 100% juice blends such as orange-pineapple, orange-tangerine, cranberry-grape are also acceptable as are fruit-vegetable 100% blends. 100% pure juice from concentrate (i.e., reconstituted) is counted.

10.2 During the past month, not counting juice, how many times per day, week, or month did you eat fruit? Count fresh, frozen, or canned fruit.

(212-214)

1 _ _ Per day
2 _ _ Per week
3 _ _ Per month
5 5 5 Never
7 7 7 Don't know/Not sure
9 9 9 Refused

Read only if necessary: "Your best guess is fine. Include apples, bananas, applesauce, oranges, grape fruit, fruit salad, watermelon, cantaloupe or musk melon, papaya, lychees, star fruit, pomegranates, mangos, grapes, and berries such as blueberries and strawberries."
INTERVIEWER NOTE: Do not count fruit jam, jelly, or fruit preserves.

Do not include dried fruit in ready-to-eat cereals.

Do include dried raisins, cran-raisins if respondent tells you - *but due to their small serving size they are not included in the prompt.*

Do include cut up fresh, frozen, or canned fruit added to yogurt, cereal, jello, and other meal items.

Include culturally and geographically appropriate fruits that are not mentioned (e.g. genip, soursop, sugar apple, figs, tamarind, bread fruit, sea grapes, carambola, longans, lychees, akee, rambutan, etc.).

10.3 During the past month, how many times per day, week, or month did you eat cooked or canned beans, such as refried, baked, black, garbanzo beans, beans in soup, soybeans, edamame, tofu or lentils. Do NOT include long green beans.

(215-217)

1 _ _ Per day
2 _ _ Per week
3 _ _ Per month
5 5 5 Never
7 7 7 Don't know/Not sure
9 9 9 Refused

Read only if necessary: "Include round or oval beans or peas such as navy, pinto, split peas, cow peas, hummus, lentils, soy beans and tofu. Do NOT include long green beans such as string beans, broad or winged beans, or pole beans."

INTERVIEWER NOTE: Include soybeans also called edamame, TOFU (BEAN CURD MADE FROM SOYBEANS), kidney, pinto, hummus, lentils, black, black-eyed peas, cow peas, lima beans and

white beans.
Include bean burgers including garden burgers and veggie burgers.

Include falafel and tempeh.

10.4 During the past month, how many times per day, week, or month did you eat dark green vegetables for example broccoli or dark leafy greens including romaine, chard, collard greens or spinach?

(218-220)

1 _ _ Per day
2 _ _ Per week
3 _ _ Per month
5 5 5 Never
7 7 7 Don't know/Not sure
9 9 9 Refused

INTERVIEWER NOTE: Each time a vegetable is eaten it counts as one time.

INTERVIEWER NOTE: Include all raw leafy green salads including spinach, mesclun, romaine lettuce, bok choy, dark green leafy lettuce, dandelions, komatsuna, watercress, and arugula.

Do not include iceberg (head) lettuce if specifically told type of lettuce. Include all cooked greens including kale, collard greens, choys, turnip greens, mustard greens.

10.5 During the past month, how many times per day, week, or month did you eat orange-colored vegetables such as sweet potatoes, pumpkin, winter squash, or carrots?

(221-223)

1 _ _ Per day
2 _ _ Per week
3 _ _ Per month
5 5 5 Never
7 7 7 Don't know/Not sure
9 9 9 Refused

Read only if needed: "Winter squash have hard, thick skins and deep yellow to orange flesh. They include acorn, buttercup, and spaghetti squash."

FOR INTERVIEWER: Include all forms of carrots including long or baby-cut.

Include carrot-slaw (e.g. shredded carrots with or without other vegetables or fruit).

Include all forms of sweet potatoes including baked, mashed, casserole, pie, or sweet potatoes fries.

Include all hard-winter squash varieties including acorn, autumn cup, banana, butternut, buttercup, delicate, hubbard, kabocha (Also known as an Ebisu, Delica, Hoka, Hokkaido, or Japanese Pumpkin; blue kuri), and spaghetti squash. Include all forms including soup.

Include pumpkin, including pumpkin soup and pie. Do not include pumpkin bars, cake, bread or other grain-based desert-type food containing pumpkin (i.e. similar to banana bars, zucchini bars we do not include).

10.6 Not counting what you just told me about, during the past month, about how many times per day, week, or month did you eat OTHER vegetables? Examples of other vegetables include tomatoes, tomato juice or V-8 juice, corn, eggplant, peas, lettuce, cabbage, and white potatoes that are not fried such as baked or mashed potatoes.

(224-226)

1 _ _	Per day
2 _ _	Per week
3 _ _	Per month
5 5 5	Never
7 7 7	Don't know/Not sure
9 9 9	Refused

Read only if needed: "Do not count vegetables you have already counted and do not include fried potatoes."

INTERVIEWER NOTE: Include corn, peas, tomatoes, okra, beets, cauliflower, bean sprouts, avocado, cucumber, onions, peppers (red, green, yellow, orange); all cabbage including American-style cole-slaw; mushrooms, snow peas, snap peas, broad beans, string, wax-, or pole-beans.

Include any form of the vegetable (raw, cooked, canned, or frozen).

Do include tomato juice if respondent did not count in fruit juice.

Include culturally and geographically appropriate vegetables that are not mentioned (e.g. daikon, jicama, oriental cucumber, etc.).

Do not include rice or other grains.

Do not include products consumed usually as condiments including ketchup, catsup, salsa, chutney, relish.

Section 11: Exercise (Physical Activity)

The next few questions are about exercise, recreation, or physical activities other than your regular job duties.

INTERVIEWER INSTRUCTION: If respondent does not have a "regular job duty" or is retired, they may count the physical activity or exercise they spend the most time doing in a regular month.

11.1 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?

(227)

1	Yes	
2	No	**[Go to Q11.8]**
7	Don't know/Not sure	**[Go to Q11.8]**
9	Refused	**[Go to Q11.8]**

11.2. What type of physical activity or exercise did you spend the most time doing during the past month?

(228-229)

_ _	(Specify)	**[See Physical Activity Coding List]**
7 7	Don't know/Not sure	**[Go to Q11.8]**
9 9	Refused	**[Go to Q11.8]**

INTERVIEWER INSTRUCTION: If the respondent's activity is not included in the Physical Activity Coding List, choose the option listed as "Other ".

11.3 How many times per week or per month did you take part in this activity during the past month?

(230-232)

1_ _	Times per week
2_ _	Times per month
7 7 7	Don't know/Not sure
9 9 9	Refused

11.4 And when you took part in this activity, for how many minutes or hours did you usually keep at it?

(233-235)

_:_ _	Hours and minutes
7 7 7	Don't know/Not sure
9 9 9	Refused

11.5 What other type of physical activity gave you the next most exercise during the past month?

(236-237)

_ _	(Specify)	**[See Physical Activity Coding List]**
8 8	No other activity	**[Go to Q11.8]**
7 7	Don't know/Not sure	**[Go to Q11.8]**
9 9	Refused	**[Go to Q11.8]**

INTERVIEWER INSTRUCTION: If the respondent's activity is not included in the Coding Physical Activity List, choose the option listed as "Other".

11.6 How many times per week or per month did you take part in this activity during the past month?

(238-240)

1_ _	Times per week
2_ _	Times per month
7 7 7	Don't know/Not sure
9 9 9	Refused

11.7 And when you took part in this activity, for how many minutes or hours did you usually keep at it?

(241-243)

_:_ _	Hours and minutes
7 7 7	Don't know/Not sure
9 9 9	Refused

11.8 During the past month, how many times per week or per month did you do physical activities or exercises to STRENGTHEN your muscles? Do NOT count aerobic activities like walking, running, or bicycling. Count activities using your own body weight like yoga, sit-ups or push-ups and those using weight machines, free weights, or elastic bands.

(244-246)

1_ _	Times per week
2_ _	Times per month
8 8 8	Never
7 7 7	Don't know/Not sure
9 9 9	Refused

Section 12: Arthritis Burden

If Q6.9 = 1 (yes) then continue, else go to next section.

Next, I will ask you about your arthritis.

Arthritis can cause symptoms like pain, aching, or stiffness in or around a joint.

12.1 Are you now limited in any way in any of your usual activities because of arthritis or joint symptoms? (247)

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

INTERVIEWER INSTRUCTION: If a question arises about medications or treatment, then the interviewer should say: "Please answer the question based on your current experience, regardless of whether you are taking any medication or treatment."

INTERVIEWER NOTE: Q12.2 should be asked of all respondents regardless of employment. status.

12.2 In this next question, we are referring to work for pay. Do arthritis or joint symptoms now affect whether you work, the type of work you do, or the amount of work you do? (248)

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

INTERVIEWER INSTRUCTION: If respondent gives an answer to each issue (whether respondent works, type of work, or amount of work), then if any issue is "yes" mark the overall response as "yes."

If a question arises about medications or treatment, then the interviewer should say: "Please answer the question based on your current experience, regardless of whether you are taking any medication or treatment."

12.3 During the past 30 days, to what extent has your arthritis or joint symptoms interfered with your normal social activities, such as going shopping, to the movies, or to religious or social gatherings? (249)
Please read [1-3]:

1 A lot
2 A little
3 Not at all

Do not read:

7 Don't know/Not sure
9 Refused

INTERVIEWER INSTRUCTION: If a question arises about medications or treatment, then the interviewer should say: "Please answer the question based on your current experience, regardless of whether you are taking any medication or treatment."

12.4 Please think about the past 30 days, keeping in mind all of your joint pain or aching and whether or not you have taken medication. DURING THE PAST 30 DAYS, how bad was your joint pain ON AVERAGE? *Please answer on a scale of 0 to 10 where 0 is no pain or aching and 10 is pain or aching as bad as it can be*.

(250-251)

_ _	Enter number [00-10]
7 7	Don't know/Not sure
9 9	Refused

Section 13: Seatbelt Use

13.1 How often do you use seat belts when you drive or ride in a car? Would you say—

(252)

Please read:

1	Always
2	Nearly always
3	Sometimes
4	Seldom
5	Never

Do not read:

7	Don't know/Not sure
8	Never drive or ride in a car
9	Refused

Section 14: Immunization

Now I will ask you questions about the flu vaccine. There are two ways to get the flu vaccine, one is a shot in the arm and the other is a spray, mist, or drop in the nose called FluMist™.

14.1 During the past 12 months, have you had either a flu shot or a flu vaccine that was sprayed in your nose?

(253)

READ IF NECESSARY:
A new flu shot came out in 2011 that injects vaccine into the skin with a very small needle. It is called Fluzone Intradermal vaccine. This is also considered a flu shot.

1	Yes	
2	No	**[Go to Q14.4]**
7	Don't know/Not sure	**[Go to Q14.4]**
9	Refused	**[Go to Q14.4]**

14.2 During what month and year did you receive your most recent flu shot injected into your arm or flu vaccine that was sprayed in your nose?

(254-259)

_ _ / _ _ _ _	Month / Year
7 7 / 7 7 7 7	Don't know/Not sure
9 9 / 9 9 9 9	Refused

14.3 At what kind of place did you get your last flu shot/vaccine?

(260-261)

Note: Read only if necessary

0 1	A doctor's office or health maintenance organization (HMO)
0 2	A health department
0 3	Another type of clinic or health center (Example: a community health center)
0 4	A senior, recreation, or community center
0 5	A store (Examples: supermarket, drug store)
0 6	A hospital (Example: inpatient)
0 7	An emergency room
0 8	Workplace
0 9	Some other kind of place
1 0	Received vaccination in Canada/Mexico (Volunteered – Do not read)
1 1	A school
7 7	Don't know/Not sure **(*Probe:* "How would you describe the place where you went to get your most recent flu vaccine?"**

Do not read:

9 9	Refused

14.4 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?

(262)

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

Section 15: HIV/AIDS

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.

15.1 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.

(263)

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

15.2 Not including blood donations, in what month and year was your last HIV test?

(264-269)

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 / Not sure

15.3 Where did you have your last HIV test — at a private doctor or HMO office, at a counseling and testing site, at an emergency room, as an inpatient in a hospital, at a clinic, in a jail or prison, at a drug treatment facility, at home, or somewhere else?

(270-271)

0 1	Private doctor or HMO office
0 2	Counseling and testing site
0 9	Emergency room
0 3	Hospital inpatient
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

Transition to Modules and State-Added Questions

Please read:

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

Optional Modules

Module 1B: Pre-Diabetes

NOTE: Only asked of those not responding "Yes" (code = 1) to Core Q6.12 (Diabetes awareness question).

1. Have you had a test for high blood sugar or diabetes within the past three years?

(287)

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

CATI NOTE: If Core Q6.12 = 4 (No, pre-diabetes or borderline diabetes); answer Q2 "Yes" (code = 1).

2. Have you ever been told by a doctor or other health professional that you have pre-diabetes or borderline diabetes?

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

(288)

1 Yes
2 Yes, during pregnancy
3 No
7 Don't know / Not sure
9 Refused

Module 2B: Diabetes (asked in Core)

CATI note: To be asked following Core Q6.13; if response to Q6.12 is "Yes" (code = 1)

1. Are you now taking insulin?

(289)

1 Yes
2 No
9 Refused

2. About how often do you check your blood for glucose or sugar? Include times when checked by a family member or friend, but do NOT include times when checked by a health professional.

(290-292)

1 _ _	Times per day
2 _ _	Times per week
3 _ _	Times per month
4 _ _	Times per year
8 8 8	Never
7 7 7	Don't know/Not sure
9 9 9	Refused

Interviewer Note: If the respondent uses a continuous glucose monitoring system (a sensor inserted under the skin to check glucose levels continuously), fill in '98 times per day.'

3. About how often do you check your feet for any sores or irritations? Include times when checked by a family member or friend, but do NOT include times when checked by a health professional.

(293-295)

1 _ _	Times per day
2 _ _	Times per week
3 _ _	Times per month
4 _ _	Times per year
5 5 5	No feet
8 8 8	Never
7 7 7	Don't know/Not sure
9 9 9	Refused

4. About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes?

(296-297)

_ _	Number of times **[76 = 76 or more]**
8 8	None
7 7	Don't know/Not sure
9 9	Refused

5. 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"?

(298-299)

_ _	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

CATI NOTE: If Q3 = 555 (No feet), go to Q7.

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

(300-301)

_ _ Number of times **[76 = 76 or more]**
8 8 None
7 7 Don't know/Not sure
9 9 Refused

7. 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.

(302)

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

8. Has a doctor ever told you that diabetes has affected your eyes or that you had retinopathy?

(303)

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

9. Have you ever taken a course or class in how to manage your diabetes yourself?

(304)

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

Module 4B: Caregiver

People may provide regular care or assistance to a friend or family member who has a health problem or disability.

1. During the past 30 days, did you provide regular care or assistance to a friend or family member who has a health problem or disability? (313)

INTERVIEWER INSTRUCTIONS: If caregiving recipient has died in the past 30 days, say "I'm so sorry to hear of your loss." and skip to the next module.

1. Yes
2. No **[Go to Question 9]**
7. Don't know/Not sure **[Go to Question 9]**
8. Caregiving recipient died in past 30 days **[Go to next module]**

9. Refused **[Go to Question 9]**

2. What is his or her relationship to you? For example is he or she your (mother or daughter or father or son)?

INTERVIEWER NOTE: If more than one person, say: "Please refer to the person to whom you are giving the most care."

(314-315)

[DO NOT READ; CODE RESPONSE USING THESE CATEGORIES]

01 Mother
02 Father
03 Mother-in-law
04 Father-in-law
05 Child
06 Husband
07 Wife
08 Same-sex partner
09 Brother or brother-in-law
10 Sister or sister-in-law
11 Grandmother
12 Grandfather
13 Grandchild
14 Other relative
15 Non-relative/Family friend

77 Don't know/Not sure
99 Refused

3. For how long have you provided care for that person? Would you say… (316)

1 Less than 30 days
2 1 month to less than 6 months
3 6 months to less than 2 years
4 2 years to less than 5 years
5 More than 5 years

7 Don't know/Not sure
9 Refused

4. In an average week, how many hours do you provide care or assistance? Would you say… (317)

1 Up to 8 hours per week
2 9 to 19 hours per week
3 20 to 39 hours per week
4 40 hours or more

7 Don't know/Not sure
9 Refused

5. What is the main health problem, long-term illness, or disability that the person you care for has? (318-319)

IF NECESSARY: Please tell me which one of these conditions would you say is the *major* problem?

[DO NOT READ: RECORD ONE RESPONSE]

1 Arthritis/Rheumatism
2 Asthma
3 Cancer
4 Chronic respiratory conditions such as Emphysema or COPD
5 Dementia and other Cognitive Impairment Disorders
6 Developmental Disabilities such as Autism, Down's Syndrome, and Spina Bifida
7 Diabetes
8 Heart Disease, Hypertension
9 Human Immunodeficiency Virus Infection (HIV)
10 Mental Illnesses, such as Anxiety, Depression, or Schizophrenia
11 Other organ failure or diseases such as kidney or liver problems
12 Substance Abuse or Addiction Disorders
13 Other

77 Don't know/Not sure
99 Refused

6. In the past 30 days, did you provide care for this person by… (320)

…managing personal care such as giving medications, feeding, dressing, or bathing?

1 Yes
2 No

7 Don't know/Not sure
9 Refused

7. In the past 30 days, did you provide care for this person by… (321)

…managing household tasks such as cleaning, managing money, or preparing meals?

1 Yes
2 No

7 Don't know/Not sure
9 Refused

8. Of the following support services, which one do you MOST need, that you are not currently getting? (322)

[INTERVIEWER NOTE: IF RESPONDENT ASKS WHAT RESPITE CARE IS]: Respite care means short-term or long-term breaks for people who provide care.

[READ OPTIONS 1 – 6]
1 Classes about giving care, such as giving medications
2 Help in getting access to services
3 Support groups
4 Individual counseling to help cope with giving care
5 Respite care
6 You don't need any of these support services

[DO NOT READ]

7 Don't Know /Not Sure
9 Refused

[If Q1 = 1 or 8, GO TO NEXT MODULE]

9. In the next 2 years, do you expect to provide care or assistance to a friend or family member who has a health problem or disability? (323)

1 Yes
2 No

7 Don't know/Not sure
9 Refused

Module 6B: Cognitive Decline

CATI Note: If respondent is 45 years of age or older continue, else go to next module

Introduction: The next few questions ask about difficulties in thinking or remembering that can make a big difference in everyday activities. This does not refer to occasionally forgetting your keys or the name of someone you recently met, which is normal. This refers to confusion or memory loss that is happening more often or getting worse, such as forgetting how to do things you've always done or forgetting things that you would normally know. We want to know how these difficulties impact you.

1. During the past 12 months, have you experienced confusion or memory loss that is happening more often or is getting worse? (334)

1 Yes
2 No **[Go to next module]**

7 Don't know/Not sure **[Go to Q2]**
9 Refuse **[Go to next module]**

2. During the past 12 months, as a result of confusion or memory loss, how often have you given up day-to-day household activities or chores you used to do, such as cooking, cleaning, taking medications, driving, or paying bills? (335)

Please read:

1 Always
2 Usually
3 Sometimes
4 Rarely
5 Never

7 Don't know/Not sure
9 Refused

3. As a result of confusion or memory loss, how often do you need assistance with these day-to-day activities? (336)

Please read:

1 Always
2 Usually
3 Sometimes
4 Rarely **[Go to Q5]**

5	Never	**[Go to Q5]**
7	Don't know/Not sure	**[Go to Q5]**
9	Refused	**[Go to Q5]**

CATI NOTE: If Q3 = 1, 2, or 3, continue. If Q3 = 4, 5, 7, or 9 go to Q5.

4. When you need help with these day-to-day activities, how often are you able to get the help that you need? (337)

Please read:

1 Always
2 Usually
3 Sometimes
4 Rarely
5 Never

7 Don't know/Not sure
9 Refused

5. During the past 12 months, how often has confusion or memory loss interfered with your ability to work, volunteer, or engage in social activities outside the home? (338)

Please read:

1 Always
2 Usually
3 Sometimes
4 Rarely
5 Never

7 Don't know/Not sure
9 Refused

6. Have you or anyone else discussed your confusion or memory loss with a health care professional? (339)

1 Yes
2 No

7 Don't know/Not sure
9 Refused

Module 10B: Arthritis Management

CATI NOTE: If Core Q6.9 = 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**?

(368)

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?

(369)

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?

(370)

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?

(371)

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

Module 16B: Colorectal Cancer Screening

CATI NOTE: If respondent is ≤ 49 years of age, go to next section.

The next questions are about colorectal cancer screening.

1. A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. Have you ever had this test using a home kit?

(386)

1	Yes	
2	No	**[Go to Q3]**
7	Don't know/Not sure	**[Go to Q3]**
9	Refused	**[Go to Q3]**

2. How long has it been since you had your last blood stool test using a home kit?

(387)

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 3 years (2 years but less than 3 years ago)
4	Within the past 5 years (3 years but less than 5 years ago)
5	5 or more years ago

Do not read:

7	Don't know/Not sure
9	Refused

3. Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had either of these exams?

(388)

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

4. For a SIGMOIDOSCOPY, a flexible tube is inserted into the rectum to look for problems. A COLONOSCOPY is similar, but uses a longer tube, and you are usually given medication through a needle in your arm to make you sleepy and told to have someone else drive you home after the test. Was your MOST RECENT exam a sigmoidoscopy or a colonoscopy?

(389)

1	Sigmoidoscopy
2	Colonoscopy
7	Don't know/Not sure
9	Refused

5. How long has it been since you had your last sigmoidoscopy or colonoscopy?

(390)

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 3 years (2 years but less than 3 years ago)
4 Within the past 5 years (3 years but less than 5 years ago)
5 Within the past 10 years (5 years but less than 10 years ago)
6 10 or more years ago

Do not read:

7 Don't know/Not sure
9 Refused

Module 19A: Industry and Occupation (asked in Core)

CATI Note: Ask after Core Q7.15.

If Core Q7.15 = 1 or 4 (Employed for wages or out of work for less than 1 year) or 2 (Self-employed), continue else go to next module.

Now I am going to ask you about your work.

If Core Q7.15 = 1 (Employed for wages) or 2 (Self-employed) ask,

1. What kind of work do you do? (for example, registered nurse, janitor, cashier, auto mechanic)

(402-501)

INTERVIEWER NOTE: If respondent is unclear, ask "What is your job title?"

INTERVIEWER NOTE: If respondent has more than one job then ask, "What is your main job?"

[Record answer] _____
99 Refused

Or

If Core Q7.15 = 4 (Out of work for less than 1 year) ask,

What kind of work did you do? (for example, registered nurse, janitor, cashier, auto mechanic) (429-453)

INTERVIEWER NOTE: If respondent is unclear, ask "What was your job title?"

INTERVIEWER NOTE: If respondent had more than one job then ask, "What was your main job?"

[Record answer] _____
99 Refused

If Core Q7.15 = 1 (Employed for wages) or 2 (Self-employed) ask,

2. What kind of business or industry do you work in? (for example, hospital, elementary school, clothing manufacturing, restaurant)

(502-601)

[Record answer] _____
99 Refused

Or

If Core Q7.15 = 4 (Out of work for less than 1 year) ask,

What kind of business or industry did you work in? (for example, hospital, elementary school, clothing manufacturing, restaurant)

[Record answer] _____
99 Refused

Module 21AB: Sexual Orientation and Gender Identity

The next two questions are about sexual orientation and gender identity.

INTERVIEWER NOTE: We ask this question in order to better understand the health and health care needs of people with different sexual orientations.

INTERVIEWER NOTE: Please say the number before the text response. Respondent can answer with either the number or the text/word.

1. Do you consider yourself to be:

(610)

Please read:

1 1 Straight
2 2 Lesbian or gay
3 3 Bisexual

Do not read:

4 Other
7 Don't know/Not sure
9 Refused

2. Do you consider yourself to be transgender? (611)

If yes, ask "Do you consider yourself to be **1**. male-to-female, **2**. female-to-male, or **3.** gender non-conforming?

INTERVIEWER NOTE: Please say the number before the "yes" text response. Respondent can answer with either the number or the text/word.

1 Yes, Transgender, male-to-female
2 Yes, Transgender, female to male
3 Yes, Transgender, gender nonconforming
4 No

7 Don't know/Not sure
9 Refused

INTERVIEWER NOTE: If asked about definition of transgender:

Some people describe themselves as transgender when they experience a different gender identity from their sex at birth. For example, a person born into a male body, but who feels female or lives as a woman would be transgender. Some transgender people change their physical appearance so that it matches their internal gender identity. Some transgender people take hormones and some have surgery. A transgender person may be of any sexual orientation – straight, gay, lesbian, or bisexual.

INTERVIEWER NOTE: If asked about definition of gender non-conforming:

Some people think of themselves as gender **non-conforming** when they do not identify only as a man or only as a woman.

Module 22A: Random Child Selection

CATI NOTE: If Core Q7.16 = 88, or 99 (No children under age 18 in the household, or Refused), go to next module.

If Core Q7.16 = 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 Q7.16 is >1 and Core Q7.16 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?

(612-617)

_ _/_ _ _ _	Code month and year
7 7/ 7 7 7 7	Don't know/Not sure
9 9/ 9 9 9 9	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?

(618)

1 Boy
2 Girl
9 Refused

3. Is the child Hispanic, Latino/a, or Spanish origin?

(619-622)

If yes, ask: Are they…

Interviewer NOTE: ***One or more categories may be selected***

1 Mexican, Mexican American, Chicano/a
2 Puerto Rican
3 Cuban
4 Another Hispanic, Latino/a, or Spanish origin

Do not read:

5 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?

(623-652)

(Select all that apply)

Interviewer NOTE: If 40 (Asian) or 50 (Pacific Islander) is selected read and code subcategories underneath major heading.

10 White

20 Black or African American

30 American Indian or Alaska Native

40 Asian

41 Asian Indian
42 Chinese
43 Filipino
44 Japanese
45 Korean
46 Vietnamese
47 Other Asian

50 Pacific Islander

51 Native Hawaiian
52 Guamanian or Chamorro
53 Samoan
54 Other Pacific Islander

Do not read:

60 Other
88 No additional choices
77 Don't know/Not sure
99 Refused

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

(653-654)

Interviewer NOTE: If 40 (Asian) or 50 (Pacific Islander) is selected read and code subcategories underneath major heading.

10 White

20 Black or African American

30 American Indian or Alaska Native

40 Asian

41 Asian Indian
42 Chinese
43 Filipino
44 Japanese

45 Korean
46 Vietnamese
47 Other Asian

50 Pacific Islander

51 Native Hawaiian
52 Guamanian or Chamorro
53 Samoan
54 Other Pacific Islander

Do not read:

60 Other
77 Don't know/Not sure
99 Refused

6. How are you related to the child?

(655)

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 23A: Childhood Asthma Prevalence

CATI NOTE: If response to Core Q7.16 = 88 (None) or 99 (Refused), go to next module.

The next two questions are about the "Xth" **[CATI: please fill in correct number]** child.

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

(656)

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?

(657)

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

NY State-Added Modules

NY State-Added Module 1A: Asthma Call-Back

If response to Core Q6.4=1 (Adult lifetime=yes) or M21Q01=1 (childhood lifetime=yes) then continue. Otherwise, skip to next module.

1. "We would like to call 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, initials or nickname 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 Q01 = 1:

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

_____ Enter name/initials/nickname (CATI only)

7 Don't know/Not sure
9 Refused

Which person in the household was selected as the focus of the asthma call-back? ()

1 Adult
2 Child

If Q01 = 1 and child selected:

3. Can I please have the child's first name, initials or nickname so we will know which child to ask about when we call back?

_____ Enter name/initials/nickname (CATI only)

7 Don't know/Not sure
9 Refused

4. Are you the parent or guardian in the household who knows the most about (child)'s asthma?

()

1 Yes **[Go to Q06]**
2 No
7 Don't know/Not sure
9 Refused

5. You said someone else was more knowledgeable about the child's asthma. Can I please have this adult's first name, initials or nickname so we will know who to ask for when we call back regarding your child.

_____ Enter name/initials/nickname (CATI only)

7 Don't know/Not sure
9 Refused

IF Q04 = 1:

6. What is a good time to call you back? For example, evenings, days or weekends?

IF Q04 = 2:

6. What is a good time to call back and speak with (OthName)? For example, evenings, days or weekends?

_____ Time (CATI only)

7 Don't know/Not sure
9 Refused

NY State-Added Module 2AB: Health Care Access

If Core question Q3.1 (has health care coverage) = 1 (Yes) then continue, else go to Q3.

1. Do you have Medicare?

(281)

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

Note: Medicare is a coverage plan for people age 65 or over and for certain disabled people.

2. What is the primary source of your health care coverage? Is it… (282-283)

Please Read

01 A plan purchased through an employer or union **(includes plans purchased through another person's employer)**
02 A plan that you or another family member buys on your own
03 Medicare
04 Medicaid or other state program
05 TRICARE (formerly CHAMPUS), VA, or Military
06 Alaska Native, Indian Health Service, Tribal Health Services
Or
07 Some other source
08 None (no coverage)

Do not read:

77 Don't know/Not sure

99 Refused

INTERVIEWER NOTE: If the respondent is unclear on what is meant by "primary" source, ask which type of health care coverage do they use to pay for most of their medical care.

INTERVIEWER NOTE: If the respondent indicates that they purchased health insurance through the Health Insurance Marketplace ("NYState of Health: The Official Plan marketplace"), ask:
"was it a private health insurance plan purchased on your own or by a family member (private) or did you receive Medicaid (state plan)?"
If purchased on their own (or by a family member), select 02, if Medicaid select 04.

3. Other than cost, there are many other reasons people delay getting needed medical care.

Have you delayed getting needed medical care for any of the following reasons in the past 12 months? Select the most important reason. (284)

Please read

1 You couldn't get through on the telephone.
2 You couldn't get an appointment soon enough.
3 Once you got there, you had to wait too long to see the doctor.
4 The (clinic/doctor's) office wasn't open when you got there.
5 You didn't have transportation.

Do not read:

6 Other _____ (specify) (285-309)

8 No, I did not delay getting medical care/did not need medical care
7 Don't know/Not sure
9 Refused

CATI NOTE: If Core Q3.1 = 1 (Has Health Care Coverage=Yes) continue, else go to Q4b.

4a. In the PAST 12 MONTHS was there any time when you did NOT have ANY health insurance or coverage?

(310)

1	Yes	**[Go to Q5]**
2	No	**[Go to Q5]**
7	Don't know/Not sure	**[Go to Q5]**
9	Refused	**[Go to Q5]**

CATI Note: If Core Q3.1 = 2, 7, or 9 (Has Health Care Coverage=No, Don't know/Not sure, Refused) continue, else go to Q5.

4b. About how long has it been since you last had health care coverage?

(311)

1	6 months or less
2	More than 6 months, but not more than 1 year ago
3	More than 1 year, but not more than 3 years ago
4	More than 3 years
5	Never
7	Don't know/Not sure
9	Refused

5. How many times have you been to a doctor, nurse, or other health professional in the past 12 months?

(312-313)

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

6. Was there a time in the past 12 months when you did not take your medication as prescribed because of cost? Do not include over-the-counter (OTC) medication. (314)

1	Yes
2	No

Do not read:

3	No medication was prescribed.
7	Don't know/Not sure
9	Refused

7. In general, how satisfied are you with the health care you received? Would you say—

Please read: (315)

1	Very satisfied

2 Somewhat satisfied
3 Not at all satisfied

Do not read:

8 Not applicable
7 Don't know/Not sure
9 Refused

8. Do you currently have any health care bills that are being paid off over time? (316)

INTERVIEWER NOTE:
This could include medical bills being paid off with a credit card, through personal loans, or bill paying arrangements with hospitals or other providers. The bills can be from earlier years as well as this year.

INTERVIEWER NOTE: Health care bills can include medical, dental, physical therapy and/or chiropractic cost.

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

NY State-Added Module 3A: Workers Compensation Coverage

If Q7.15 = 5 (A Homemaker), 6 (A Student), 7 (Retired), or 8 (Unable to work), then go to Q1.
If Q7.15 = 1 (Employed for wages), 2 (Self-employed), or 4 (Out of work for less than 1 year), then go to Q2.
If Q7.15 = 3 (Out of work for 1 year or more) or 9 (Refused), then go to the next module.

1. 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 Next Module**
7 Don't know/Not sure. **Go to Next Module**
9 Refused. **Go to Next Module**

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

2. During the past 12 months, were you injured seriously enough at your job that you received medical treatment from a doctor, nurse or other health care professional?

1 Yes
2 No **Go to Next Module**
7 Don't know/Not Sure **Go to Next Module**

9 Refused **Go to Next Module**

3. How many days after your work-related injury were you able to return to work? Include weekends and scheduled days off or vacation?

Read only if necessary:

1 Next day
2 One or two
3 Three or four
4 Five
5 Six
6 Seven or more
7 Don't know/Not sure
9 Refused

For your most recent work-related injury, who paid for your medical treatment? Choose all that apply. **Interviewer NOTE: Select all that apply.**

Please read:
1 Workers' compensation or the State Insurance Fund
2 Worker's compensation claim was filed, but it's still pending
3 Your own health insurance or health coverage plan
4 You or your family; out of pocket – excluding co-pays
5 Your employer WITHOUT a workers' compensation claim
6 Other source (SPECIFY) _____

Do not read these responses
8 No one paid; no treatment
7 Don't know/Not sure
9 Refused

5. Was your employer aware of the work-related injury??

1 Yes
2 No

Do not read these responses
7 Don't know/Not sure
9 Refused

NY State-Added Module 4A: Mental Illness and Stigma

Now, I am going to ask you some questions about how you have been feeling lately.

1. About how often during the past 30 days did you feel **nervous** — would you say **all** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?

(418)

1 All
2 Most
3 Some
4 A little
5 None
7 Don't know/Not sure
9 Refused

2. During the past 30 days, about how often did you feel **hopeless** — **all** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?

(419)

1 All
2 Most
3 Some
4 A little
5 None
7 Don't know/Not sure
9 Refused

3. During the past 30 days, about how often did you feel **restless** or **fidgety**?

[If necessary: all, most, some, a little, or none of the time?]

(420)

1 All
2 Most
3 Some
4 A little
5 None
7 Don't know/Not sure
9 Refused

4. During the past 30 days**,** about how often did you feel **so depressed** that nothing could cheer you up?

[If necessary: all, most, some, a little, or none of the time?]

(421)

1 All
2 Most
3 Some
4 A little
5 None
7 Don't know/Not sure
9 Refused

5. During the past 30 days, about how often did you feel that **everything was an effort**?

Note: If respondent asks what does "everything was an effort" means; say, "Whatever it means to you"

[If necessary: all, most, some, a little, or none of the time?]

(422)

1 All
2 Most
3 Some
4 A little
5 None
7 Don't know/Not sure
9 Refused

6. During the past 30 days, about how often did you feel **worthless**?

[If necessary: all, most, some, a little, or none of the time?]

(423)

1 All
2 Most
3 Some
4 A little
5 None
7 Don't know/Not sure
9 Refused

7. During the past 30 days, for about how many days did a mental health condition or emotional problem **keep you from doing** your work or other usual activities?

(424-425)

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

INTERVIEWER NOTE: If asked, **"usual activities"** includes housework, self-care, care giving, volunteer work, attending school, studies, or recreation.

8. Are you now taking medicine or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?

(426)

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

These next questions ask about peoples' attitudes toward mental illness and its treatment.

9. Treatment can help people with mental illness lead normal lives. Do you –**agree** slightly or strongly, or **disagree** slightly or strongly?

(427)

Read only if necessary:

1 Agree strongly
2 Agree slightly
3 Neither agree nor disagree
4 Disagree slightly
5 Disagree strongly

Do not read:

7 Don't know/Not sure
9 Refused

10. People are generally caring and sympathetic to people with mental illness. Do you – **agree** slightly or strongly, or **disagree** slightly or strongly?

(428)

Read only if necessary:

1 Agree strongly
2 Agree slightly
3 Neither agree nor disagree
4 Disagree slightly
5 Disagree strongly

Do not read:

7 Don't know/Not sure
8 Refused

INTERVIEWER NOTE: If asked for the purpose of Q9 or Q10: say: "answers to these questions will be used by health planners to help understand public attitudes about mental illness and its treatment and to help guide health education programs".

NY State-Added Module 5A: Sugar Drinks

Now I would like to ask you some questions about sugary beverages.

1. During the past 30 days, how often did you drink regular soda or pop that contains sugar? Do not include diet soda or diet pop.

()

Please read:
You can answer times per day, week, or month: for example, twice a day, once a week, and so forth.

1 _ _ Times per day
2 _ _ Times per week
3 _ _ Times per month

Do not read:

8 8 8 None
7 7 7 Don't know/Not sure
9 9 9 Refused

2. During the past 30 days, how often did you drink sugar-sweetened fruit drinks (such as Kool-Aid and lemonade), sweet tea, and sports or energy drinks (such as Gatorade and Red Bull)? Do not include 100% fruit juice, diet drinks, or artificially sweetened drinks.

()

Please read: You can answer times per day, week, or month: for example, twice a day, once a week, and so forth.

1 _ _ Times per day
2 _ _ Times per week
3 _ _ Times per month

Do not read:

8 8 8 None
7 7 7 Don't know/Not sure
9 9 9 Refused

NY State-Added Module 6A: Hepatitis Testing Law

1. Have you heard of hepatitis C?

()

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

Interviewer note: *Hepatitis C is an infectious disease affecting the liver, caused by the hepatitis C virus (HCV). It is spread by blood-to-blood contact. It should not be confused with hepatitis A or hepatitis B both of which you can be vaccinated for.*

2. Have you ever been tested for hepatitis C (HCV)? Do not count tests you may have had as part of a blood donation.

()

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

3. Not including blood donations, in what month and year was your last HCV test?

()

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

Next, I am going to ask you some questions about your recent medical care visits and whether you have been offered a hepatitis C (HCV) test in various settings.

4. In the past 12 months, have you received medical care at an inpatient unit of a hospital?
()

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

5. Were you offered an HCV test while receiving care at an inpatient unit of a hospital?
()

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

6. Did you accept the HCV test that was offered by a medical care provider at the inpatient unit of a hospital?
()

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

Interviewer note: *Question 7 is referencing* ***primary care*** *providers which include: Physicians, physician assistants, and nurse practitioners practicing in any the following specialties in hospitals, hospital outpatient clinics, community health centers, or private single/group practices:*

- *Family medicine*
- *General pediatrics*
- *Internal medicine*
- *Obstetrics or gynecology*

Providers ***not*** *considered to be primary care include physicians, physician assistants and nurse practitioners in the following specialties:*

- *Allergy and Immunology*
- *Anesthesiology*
- *Dermatology*
- *Cardiology*
- *Endocrinology*
- *Gastroenterology*
- *Oncology and Hematology*
- *Hospice and Palliative Medicine*
- *Nephrology*
- *Pulmonary Disease*
- *Rheumatology*
- *Neurology*
- *Neurosurgery*

- *Ophthalmology*
- *Orthopedic Surgery*
- *Otolaryngology (E.N.T.)*
- *Psychiatry*
- *Radiology*
- *Surgery*
- *Urology*

Other non-primary care providers include:

- *Alternative therapists (e.g., acupuncturists, herbalists)*
- *Audiologists*
- *Dentists and orthodontists*
- *Nurses, nurse anesthetists and nurses aides*
- *Podiatrists*
- *Therapists (occupational, physical, radiation, recreational, respiratory, speech-language, exercise)*

7. In the past 12 months, have you received medical care from a primary care provider?

()

1	Yes	
2	No	[STOP, go to the next module]
7	Don't know/Not sure	[STOP, go to the next module]
9	Refused	[STOP, go to the next module]

8. Were you offered an HCV test by your primary care provider?

()

1	Yes	
2	No	[STOP, go to the next module]
7	Don't know/Not sure	[STOP, go to the next module]
9	Refused	[STOP, go to the next module]

9. Did you accept the HCV test that was offered by your primary care provider?

()

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

NY State-Added Module 7A: Participation in Chronic Disease Self-Management

CATI NOTE: If Core Q6.1 or Q 6.2 or Q6.3 or Q6.4 or Q6.7 or Q6.8 or Q6.9 or Q6.11 or Q6.12 = 1 (Yes), continue. Otherwise, go to next module.

CATI note: To be asked of respondents who answered "yes" to any of the core/rotating core questions that ask if the respondent has been diagnosed with a chronic illness; otherwise skip to next section.

o Diabetes
o Heart Attack
o Angina/Coronary Heart Disease
o Stroke
o Asthma
o Arthritis
o Cancer (other than skin cancer)
o Chronic Obstructive Pulmonary Disease (COPD)
o Chronic Kidney Disease

The next question is about chronic illnesses, these are illnesses that last for more than 3 months, for example, asthma, diabetes, arthritis and heart disease.

1. You said that a medical professional has told you that you have or have had **[CATI NOTE: fill in illnesses from previous questions – heart attack, diabetes, asthma, stroke…].** During the last 12 months, have you taken a course or class to teach you about how to manage problems related to (this/these) chronic illness(es)?" ()

Interviewer notes: A course or class is defined as *6 weeks or more (in person or online)*

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

NY State-Added Module 8B: Participation in Life-style Change Program

1. Have you ever attended a lifestyle change program, such as the diabetes Prevention Program, in order to improve your health or prevent diabetes?

()

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

NY State-Added Module 9B: Oral Health

1. How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.

()

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
8 Never
9 Refused

2. How many of your permanent teeth have been removed because of tooth decay or gum disease? Include teeth lost to infection, but do not include teeth lost for other reasons, such as injury or orthodontics.

NOTE: If wisdom teeth are removed because of tooth decay or gum disease, they should be included in the count for lost teeth.

()

1 1 to 5
2 6 or more but not all
3 All
8 None
7 Don't know/Not sure
9 Refused

NY State-Added Module 10B: Hearing Disability

1. Do you have serious difficulty hearing or are you deaf?

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

NY State-Added Module 11B: Access to Fruits and Vegetables

1. When you or someone in your household shops for fresh fruits or vegetables, do you buy them in your community or neighborhood?

1 Yes, in my community or neighborhood **[Go to next module]**
2 No, someplace else
7 Don't know/Not sure **[Go to next module]**
9 Refused **[Go to next module]**

2. What is the main reason you or someone in your household does not buy fresh fruits and vegetables in your community or neighborhood?

Read only if necessary:

01 No stores in my community or neighborhood
02 Stores in my community or neighborhood have poor quality fruits and vegetables
03 Stores in my community or neighborhood are too expensive
04 Stores in my community or neighborhood have poor quality service
05 I feel uncomfortable in stores in my community or neighborhood
06 Don't cook

07 Don't eat fresh fruits or vegetables
08 Other (SPECIFY) _____
77 Don't know/Not sure
99 Refused

NY State-Added Module 12B: Social Context

Now, I am going to ask you about several factors that can affect a person's health.

If Core Q7.8 = 1 or 2 (own or rent) continue, else go to Q2.

1. How often in the past 12 months would you say you were worried or stressed about having enough money to pay your rent/mortgage? Would you say ---

Please read:

1 Always
2 Usually
3 Sometimes
4 Rarely
5 Never

Do not read:

8 Not applicable
7 Don't know/Not sure
9 Refused

2. How often in the past 12 months would you say you were worried or stressed about having enough money to buy nutritious meals? Would you say ---

Please read:

1 Always
2 Usually
3 Sometimes
4 Rarely
5 Never

Do not read:

8 Not applicable
7 Don't know/Not sure
9 Refused

Closing Statement

Closing Statement

Please read:

That was my last question. Everyone's answers will be combined to help us provide information about the health practices of people in New York State. Thank you very much for your time and cooperation.

Activity List for Common Leisure Activities (To be used for Section 11: Physical Activity)

Code Description (Physical Activity, Questions 11.2 and 11.5 above)

0 1 Active Gaming Devices (Wii Fit, Dance Dance revolution)
0 2 Aerobics video or class
0 3 Backpacking
0 4 Badminton
0 5 Basketball
0 6 Bicycling machine exercise
0 7 Bicycling
0 8 Boating (Canoeing, rowing, kayaking, sailing for pleasure or camping)
0 9 Bowling
1 0 Boxing
1 1 Calisthenics
1 2 Canoeing/rowing in competition
1 3 Carpentry
1 4 Dancing-ballet, ballroom, Latin, hip hop, Zumba, etc.
1 5 Elliptical/EFX machine exercise
1 6 Fishing from river bank or boat
1 7 Frisbee
1 8 Gardening (spading, weeding, digging, filling)
1 9 Golf (with motorized cart)
2 0 Golf (without motorized cart)
2 1 Handball
2 2 Hiking – cross-country
2 3 Hockey
2 4 Horseback riding
2 5 Hunting large game – deer, elk
2 6 Hunting small game – quail
2 7 Inline Skating
2 8 Jogging
2 9 Lacrosse
3 0 Mountain climbing
3 1 Mowing lawn
3 2 Paddleball
3 3 Painting/papering house
3 4 Pilates
3 5 Racquetball
3 6 Raking lawn
3 7 Running
3 8 Rock Climbing
3 9 Rope skipping
4 0 Rowing machine exercise
4 1 Rugby
4 2 Scuba diving
4 3 Skateboarding
4 4 Skating – ice or roller
4 5 Sledding, tobogganing
4 6 Snorkeling
4 7 Snow blowing
4 8 Snow shoveling by hand
4 9 Snow skiing
5 0 Snowshoeing
5 1 Soccer
5 2 Softball/Baseball
5 3 Squash
5 4 Stair climbing/Stair master
5 5 Stream fishing in waders
5 6 Surfing
5 7 Swimming
5 8 Swimming in laps
5 9 Table tennis
6 0 Tai Chi
6 1 Tennis
6 2 Touch football
6 3 Volleyball
6 4 Walking
6 6 Waterskiing
6 7 Weight lifting
6 8 Wrestling
6 9 Yoga

7 1 Childcare
7 2 Farm/Ranch Work (caring for livestock, stacking hay, etc.)
7 3 Household Activities (vacuuming, dusting, home repair, etc.)
7 4 Karate/Martial Arts
7 5 Upper Body Cycle (wheelchair sports, ergometer, etc.)
7 6 Yard work (cutting/gathering wood, trimming hedges etc.)

9 8 Other_____
9 9 Refused

Attachment 4

NOTE: The only changes made were in the for 2013 medication lists

BRFSS/ASTHMA SURVEY
ADULT QUESTIONNAIRE - 2015
CATI SPECIFICATIONS

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

MISDIAGNOSIS NOTE: If, during the survey, the interviewer discovers that the respondent never really had asthma because it was a misdiagnosis, then assign disposition code "470 Respondent was misdiagnosed; never had asthma" as a final code and terminate the interview.

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 {STATE NAME} 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 {STATE NAME} 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.

{Read the statement below ONLY if you're conducting the survey via a cellphone}
Is this a safe time to talk with you now or are you driving? **(STATES HAVE THE OPTION OF INCLUDING THIS TEXT HERE OR AT THE END OF THE SURVEY INTRO BELOW.)**

1.1 Are you {sample person's name}?

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

1.2 May I speak with {sample person's name}?

1. Yes (go to 1.4 when sample person comes to phone)
2. No
   If not available set time for return call in 1.3

1.3 Enter time/date for return call _____

1.4 Hello, my name is _____. I'm calling on behalf of the {STATE NAME} 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 {STATE NAME} 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) **(Respondent did not agree with previously BRFSS recorded asthma status so double 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?

1. **Yes [continue to EVER_ASTH (2.1)]**
2. **No**
   a. **Correct person is available and can come to phone [return to question 1.1]**
   b. **Correct person is not available [return to question 1.3 to set call date/time]**
   c. **Correct person unknown, interview ends [disposition code 4306 is assigned]**

EVER_ASTH (2.1) **I would like to repeat the questions from the previous survey now to make sure you qualify for this study.**

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 you 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 before going to section 3:

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)
(9) REFUSED (GO TO TERMINATE)

TERMINATE:
Upon survey termination, READ:

Those are all the questions I have. I'd like to thank you on behalf of the {STATE NAME} 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

Note: Disposition code is automatically assigned here by CATI as "**2211** Sel. Resp. ref. combine ans." Selected Respondent refused combining responses with BRFSS" and the survey will end. This disposition code will only be needed if the optional question PERMISS (2.3) is asked.

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 YEAR OLD]

_____(ENTER AGE IN YEARS)
[RANGE CHECK: 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**

(1) Within the past 12 months
(2) 1-5 years ago
(3) 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

Section 4. History of Asthma (Symptoms & Episodes in past year)

IF LAST SYMPTOMS (LASTSYMP 3.5) WERE WITHIN THE PAST 3 MONTHS (1, 2 OR 3) CONTINUE. IF LAST SYMPTOMS (LASTSYMP 3.5) WERE 3 MONTHS TO 1 YEAR AGO (4), SKIP TO EPISODE INTRODUCTION (EPIS_INT - BETWEEN 4.4 AND 4.5); IF LAST SYMPTOMS (LASTSYMP 3.5) WERE 1-5+ YEARS AGO (05, 06 OR 07), SKIP TO SECTION 5; IF NEVER HAD SYMPTOMS (88), SKIP TO SECTION 5, IF DK/REF (77, 99) 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
(30) EVERY DAY (Added 1/24/08)

(77) DON'T KNOW
(99) REFUSED

SYMPFREE (4.4) **During the <u>past two weeks</u>, 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 (3.5) = 4) PICK UP HERE, SYMPTOMS WITHIN THE PAST 3 MONTHS PLUS DK AND REFUSED (LASTSYMP (3.5) = 1, 2, 3, 77, 99) CONTINUE HERE AS WELL**

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
(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 <u>three months</u>, 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

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 (5.01) 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 (5.02) 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" (88) OR "MORE THAN ONE YEAR AGO" (05, 06 or 07) TO SEEING A DOCTOR ABOUT ASTHMA (LAST_MD (3.3)), TAKING ASTHMA MEDICATION (LAST_MED (3.4)), AND SHOWING SYMPTOMS OF ASTHMA (LASTSYMP (3.5)), SKIP TO SECTION 6]

The best known value for whether or not the adult "still has asthma" is used in the skip below. It can be the previously answered BRFSS core value or the answer to CUR_ASTH (2.2) if this question is asked in this call back survey If the respondent confirms in the "Informed Consent" question that the previously answered BRFSS core (BRFSS 9.2) value is correct then the value from the BRFSS core question (BRFSS 9.2) is used. If the respondent does not agree with the previous BRFSS core value in "Informed Consent" then the question REPEAT (2.0) was asked (REPEAT = 1) then the value for CUR_ASTH (2.2) "Do you still have asthma?" is used.

IF respondent agrees 1 (Yes) with "Informed Consent":

IF BRFSS core value for 9.2, "Do you still have asthma?" = 2 (No), 7 (DK), or 9 (Refused)
AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) AND
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) AND
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO Section 6; otherwise continue with Section 5.

The above "if" statement can also be restated in different words as:

IF BRFSS core value for 9.2, "Do you still have asthma?" = 2 (No), 7 (DK), or 9 (Refused)
AND
((LAST_MD = 4) OR
(LAST_MED = 1, 2, 3 or 4) OR
(LASTSYMP = 1, 2, 3 or 4)
THEN Continue with Section 5 otherwise skip to Section 6)

IF BRFSS core value for 9.2, "Do you still have asthma?" = 1 (Yes) continue with Section 5.

IF respondent DOES NOT agree 2 (No) with "Informed Consent" REPEAT = 1:

IF CUR_ASTH (2.2) = 2 (No), 7 (DK), or 9 (Refused) AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) AND
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) AND
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO Section 6; otherwise continue with Section 5.

The above "if" statement can also be restated in different words as:

IF* CUR_ASTH (2.2) *= 2 (No), 7 (DK), or 9 (Refused) AND
((LAST_MD = 4) OR
(LAST_MED = 1, 2, 3 or 4) OR
(LASTSYMP = 1, 2, 3 or 4)
THEN Continue with Section 5; otherwise skip to Section 6)

IF CUR_ASTH (2.2) = 1 (Yes) continue with section 5.

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, 888, 999)] [Verify any entry >50]

(888) NONE (Skip back to 5.2)
(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"]

[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 ≥ 5 AND ≤ 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]

[CATI CHECK: IF RESPONSE TO 5.5 IS "YES" AND RESPONDENT SAYS NONE OR ZERO TO 5.6A ALLOW LOOPING BACK TO CORRECT 5.5 TO "NO"]

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. This should not be coded yes if the respondent only received a pamphlet or instructions to view a website or video since the question clearly states "talk with you".]

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_DAYS30 (5.9) **During just the past 30 days, 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?

[HELP SCREEN: Health professional includes doctors, nurses, physician assistants, nurse practitioners, and health educators]

(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?

[HELP SCREEN: Health professional includes doctors, nurses, physician assistants, nurse practitioners, and health educators]

(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?

[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_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) **A dehumidifier is a small, portable appliance which removes moisture from the air.**

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.

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 (cannabis, 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 = 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.
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_MED3 (8.7) **[when Respondent returns to phone:] Do you have all the medications?**

[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 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)

For the following inhalers the respondent can choose up to eight medications; however, each medication can only be used once (in the past, errors such as 030303 were submitted in the data file). When 66 (Other) is selected as a response, the series of questions ILP03 (8.13) to ILP10 (8.19) is not asked for that response. (typo corrected)

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.]

Note: The top ten items (in bold below) should be highlighted in the CATI system if possible

so they can be found more easily.

	Medication	Pronunciation
01	**Advair** (+ A. Diskus)	**ăd**-vâr (or **add**-vair)
02	Aerobid	â-**rō**'bĭd (or **air**-row-bid)
03	**Albuterol** (+ A. sulfate or salbutamol)	ăl'-**bu**'ter-ōl (or al-**BYOO**-ter-ole) săl-byū'tə-môl'
04	Alupent	**al**-u-pent
43	Alvesco (+ Ciclesonide)	**al**-ves-co
40	Asmanex (twisthaler)	**as**-m*uh*-neks **twist**-hey-ler
05	**Atrovent**	At-ro-vent
06	**Azmacort**	**az**-ma-cort
07	Beclomethasone dipropionate	bek"lo-**meth**'ah-son dī' **pro'**pe-o-nāt (or be-kloe-**meth**-a-sone)
08	Beclovent	be' klo-vent" (or **be**-klo-vent)
09	Bitolterol	bi-tōl'ter-ōl (or bye-**tole**-ter-ole)
~~10~~	~~Brethaire~~ Discontinued - Delete	~~**breth-air**~~
11	Budesonide	byoo-**des**-oh-nide
12	**Combivent**	**com**-bi-vent
13	Cromolyn	**kro**'mŏ-lin (or **KROE**-moe-lin)
44	Dulera	**do**-lair-a
14	**Flovent**	**flow**-vent
15	Flovent Rotadisk	**flow**-vent **row**-ta-disk
16	Flunisolide	floo-**nis**'o-līd (or floo-**NISS**-oh-lide)
17	Fluticasone	flue-**TICK**-uh-zone
34	Foradil	*FOUR-a-dil*
35	Formoterol	for moh' te rol
~~18~~	~~Intal~~ Discontinued - Delete	~~**in-tel**~~
19	Ipratropium Bromide	ĭp-rah-**tro**'pe-um bro'mīd (or ip-ra-**TROE**-pee-um)
37	Levalbuterol tartrate	**lev-al-BYOU-ter-ohl**
20	Maxair	**măk**-sâr
21	Metaproteronol	met"ah-pro-**ter'**ĕ-nōl (or met-a-proe-**TER**-e-nole)
39	Mometasone furoate	**moe-MET-a-sone**
22	Nedocromil	ne-DOK-roe-mil
23	Pirbuterol	pēr-**bu**'ter-ōl (or peer-**BYOO**-ter-ole)
41	Pro-Air HFA	**proh-air HFA**
24	**Proventil**	pro"**ven**-til' (or pro-**vent**-il)
25	**Pulmicort Flexhaler**	**pul**-ma-cort **flex**-hail-er
36	**QVAR**	**q** -vâr (or q-vair)
03	Salbutamol (or Albuterol)	săl-byū'tə-môl'
26	Salmeterol	sal-ME-te-role
27	**Serevent**	**Sair**-a-vent
42	Symbicort	**sim**-b*uh*-kohrt
28	Terbutaline (+ T. sulfate)	ter-**bu'**tah-lēn (or ter-**BYOO**-ta-leen)
~~29~~	~~Tilade~~ Discontinued - Delete	~~**tie-laid**~~
30	Tornalate	**tor**-na-late
31	Triamcinolone acetonide	tri"am-**sin**'o-lōn as"ĕ-tō-nīd' (or trye-am-**SIN**-oh-lone)
32	Vanceril	**van**-sir-il
33	Ventolin	**vent**-o-lin
38	Xopenex HFA	*ZOH-pen-ecks*
66	Other, Please Specify	**[SKIP TO OTH_I1]**

[IF RESPONDENT SELECTS ANY ANSWER <66, SKIP TO ILP03]

(88) NO PRESCRIPTION INHALERS **[SKIP TO PILLS]**

(77) DON'T KNOW **[SKIP TO PILLS]**
(99) REFUSED **[SKIP TO PILLS]**

[100 ALPHANUMERIC CHARACTER LIMIT FOR 66]

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.

CATI programmers note that the text for 66 (other) should be checked to make sure one of the medication names above was not entered. If the medication entered is on the list above, then an error message should be shown.

[LOOP BACK TO ILP03 AS NECESSARY TO ADMINSTER QUESTIONS ILP03 THRU ILP10 FOR EACH MEDICINE 01 – 44 REPORTED IN INH_MEDS, BUT NOT FOR 66 (OTHER).]

[FOR FILL [MEDICINE FROM INH_MEDS SERIES] FOR QUESTIONS ILP03 THROUGH ILP10]

SKIP before ILP03
IF [MEDICINE FROM INH_MEDS SERIES] IS ADVAIR (01) OR FLOVENT ROTADISK (15) OR MOMETASONE FUROATE (39) OR ASMANEX (40) OR FORADIL (34) OR MAXAIR (20) OR PULMICORT (25) OR SEREVENT (27) OR SYMBICORT (42) 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 dry powder inhaler or disk inhaler, not a canister inhaler
(4) Medication has a built-in spacer/does not need a spacer

(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 or dry powder) and 4 (built in spacer) are primarily intended for medications Beclomethosone (7) Beclovent (08), Budesonide (11) and QVAR (36), which are known to come in disk or breathe activated inhalers (which do not use a spacer). However, new medications may come on the market that will need either category, so 3 or 4 can be used for other medications as well.]

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

ILP08 (8.18) **How many times per day or per week do you use [MEDICINE FROM INH_MEDS SERIES]**?

3 _ _ Times per DAY **[RANGE CHECK: (>10)]**
4 _ _ Times per WEEK **[RANGE CHECK: (>75)]**
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

[RANGE CHECK: 301-399, 401-499, 555, 666, 777, 999]

[ASK ILP10 ONLY IF INH_MEDS = 3, 4, 9, 10, 20, 21, 23, 24, 28, 30, 33, 37, 38, 41 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) **For the following pills, the respondent can choose up to five medications; however, each medication can only be used once (in the past, errors such as 232723 were submitted in the data file).**

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.]

Note: The top ten items (in bold below) should be highlighted in the CATI system if possible so they can be found more easily.

	Medication	Pronunciation
01	**Accolate**	**ac**-o-late
02	Aerolate	**air**-o-late
03	**Albuterol**	ăl'-**bu**'ter-ōl (or al-**BYOO-**ter-all)
04	Alupent	**al-**u-pent
49	Brethine	**breth-een**
05	Choledyl (oxtriphylline)	**ko**-led-il
07	Deltasone	**del**-ta-sone
08	Elixophyllin	e-licks-**o**-fil-in
11	Medrol	**Med**-rol
12	Metaprel	**Met**-a-prell
13	Metaproteronol	met"ah-pro-**ter**'ĕ-nōl (or met-a-proe-**TER**-e-nole)
14	Methylpredinisolone	meth-ill-pred-**niss**-oh-lone (or meth-il-pred-**NIS**-oh-lone)
15	**Montelukast**	mont-e-**lu**-cast
17	Pediapred	Pee-**dee**-a-pred
18	**Prednisolone**	pred-NISS-oh-lone
19	**Prednisone**	PRED-ni-sone
21	Proventil	pro-**ven**-til
23	Respid	**res**-pid
24	**Singulair**	**sing**-u-lair
25	Slo-phyllin	**slow**- fil-in
26	Slo-bid	**slow**-bid
48	Terbutaline (+ T. sulfate)	ter byoo' ta leen
28	Theo-24	**thee**-o-24
30	Theochron	**thee** -o-kron
31	Theoclear	**thee**-o-clear
32	**Theodur**	**thee**-o-dur
33	**Theo-Dur**	**thee**-o-dur
35	**Theophylline**	thee-**OFF**-i-lin
37	Theospan	**thee**-o-span
40	T-Phyl	**t**-fil
42	**Uniphyl**	**u**-ni-fil
43	Ventolin	**vent**-o-lin
44	Volmax	**vole**-max
45	Zafirlukast	za-**FIR**-loo-kast
46	Zileuton	zye-**loo**-ton
47	Zyflo Filmtab	**zye**-flow **film** tab
66	Other, please specify	**[SKIP TO OTH_P1]**

[IF RESPONDENT SELECTS ANY ANSWER FROM 01-49 SKIP TO PILL01]

(88) NO PILLS **[SKIP TO SYRUP]**

(77) DON'T KNOW **[SKIP TO SYRUP]**
(99) REFUSED **[SKIP TO SYRUP]**

[100 ALPHANUMERIC CHARACTER LIMIT FOR 66]

OTH_P1

ENTER OTHER MEDICATION IN TEXT FIELD
IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.

CATI programmers note that the text for 66 (other) should be checked to make sure one of the medication names above was not entered. If the medication entered is on the list above, then an error message should be shown.

[REPEAT QUESTION PILL01 AS NECESSARY FOR EACH PILL 01-49 REPORTED IN PILLS_MD, BUT NOT FOR 66 (OTHER).]

FOR FILL [MEDICATION LISTED IN PILLS_MD] FOR QUESTION PILL01]

PILL01 (8.22) **In the past 3 months, did you take [MEDICATION LISTED IN PILLS_MD] on a regular schedule every day?**

(1) YES
(2) NO

(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) **For the following syrups the respondent can choose up to four medications; however, each medication can only be used once (in the past, errors such as 020202 were submitted in the data file).**

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	Pronunciation
01	Aerolate	**air**-o-late
02	Albuterol	ăl'-**bu**'ter-ōl (or al-BYOO-ter-ole)
03	Alupent	**al**-u-pent
04	Metaproteronol	met"ah-pro-**ter**'ĕ-nōl (or met-a-proe-TER-e-nole)
05	Prednisolone	pred-NISS-oh-lone
06	Prelone	**pre**-loan
07	Proventil	Pro-**ven**-til
08	Slo-Phyllin	**slow**-fil-in
09	Theophyllin	thee-OFF-i-lin
10	Ventolin	**vent**-o-lin
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]**

[100 ALPHANUMERIC CHARACTER LIMIT FOR 66]

OTH_S1

ENTER OTHER MEDICATION.
IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.

CATI programmers note that the text for 66 (other) should be checked to make sure one of the medication names above was not entered. If the medication entered is on the list above, then an error message should be shown.

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) AT HOME
(1) YES (2) NO (7) DK (9) REF

(8.26b) AT A DOCTOR'S OFFICE
(1) YES (2) NO (7) DK (9) REF

(8.26c) IN AN EMERGENCY ROOM
(1) YES (2) NO (7) DK (9) REF

(8.26d) AT WORK OR AT SCHOOL
(1) YES (2) NO (7) DK (9) REF

(8.26e) AT ANY OTHER PLACE
(1) YES (2) NO (7) DK (9) REF

NEB_ID (8.27) **For the following nebulizers, the respondent can chose up to five medications; however, each medication can only be used once (in the past, errors such as 0101 were submitted in the data file).**

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	Pronunciation
01	Albuterol	ăl'-**bu'**ter-ōl (or al-BYOO-ter-ole)
02	Alupent	**al**-u-pent
03	Atrovent	at-ro-vent
04	Bitolterol	bi-tōl'ter-ōl (or bye-**tole**-ter-ole)
05	Budesonide	byoo-**des**-oh-nide
17	Combivent Inhalation solution	**com**-bi-vent
06	Cromolyn	**kro**'mŏ-lin (or KROE-moe-lin)
07	DuoNeb	DUE-ow-neb
08	Intal	**in**-tel
09	Ipratroprium bromide	ĭp-rah-**tro**'pe-um bro'mīd (or ip-ra-**TROE**-pee-um)
10	Levalbuterol	lev al byoo' ter ol
11	Metaproteronol	met"ah-pro-**ter'**ĕ-nōl (or met-a-proe-TER-e-nole)
18	Perforomist (Formoterol)	per-**form**-ist
12	Proventil	pro-**ven**-til
13	Pulmicort	**pul**-ma-cort
14	Tornalate	**tor**-na-late
15	Ventolin	**vent**-o-lin
16	Xopenex	*ZOH-pen-ecks*
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

[100 ALPHANUMERIC CHARACTER LIMIT FOR 66]
ENTER OTHER MEDICATION
IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.

CATI programmers note that the text for 66 (other) should be checked to make sure one of the medication names above was not entered. If the medication entered is on the list above, then an error message should be shown.

[LOOP BACK TO NEB01 AS NECESSARY TO ADMINISTER QUESTIONS NEB01 THROUGH NEB03 FOR EACH MEDICINE 01 THROUGH 18 (NEB_01 to NEB_18) REPORTED IN NEB_ID, BUT NOT FOR 66 (OTHER).]

FOR FILL [MEDICATION LISTED IN NEB_ID] FOR QUESTION NEB01 to NEB03]

NEB01 (8.28) In the past 3 months, did you take [MEDICINE FROM NEB_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

NEB02 (8.29) In the past 3 months, did you take [MEDICINE FROM NEB_MEDS SERIES] on a regular schedule everyday?

(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED

NEB03 (8.30) How many times per day or per week do you use [MEDICINE FROM NEB_MEDS SERIES]?

3__ __ DAYS
4__ __ WEEKS

(555) NEVER
(666) LESS OFTEN THAN ONCE A WEEK

(777) DON'T KNOW / NOT SURE
(999) REFUSED

Section 9. Cost of Care

The best known value for whether or not the adult "still has asthma" is used in the skip below. It can be the previously answered BRFSS core value or the answer to CUR_ASTH (2.2) if this question is asked in this call back survey If the respondent confirms in the "Informed Consent" question that the previously answered BRFSS core (BRFSS 9.2) value is correct then the value from the BRFSS core question (BRFSS 9.2) is used. If the respondent does not agree with the previous BRFSS core value in "Informed Consent" then the question REPEAT (2.0) was asked (REPEAT = 1) then the value for CUR_ASTH (2.2) "Do you still have asthma?" is used.

IF respondent agrees 1 (Yes) with "Informed Consent":

IF BRFSS core value for 9.2, "Do you still have asthma?" = 2 (No), 7 (DK), or 9 (Refused)
AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO Section 10; otherwise continue with Section 9

IF BRFSS core value for 9.2 "Do you still have asthma?" = 1 (Yes), then continue with section 9.

IF respondent DOES NOT agree 2 (No) with "Informed Consent" REPEAT = 1:

IF CUR_ASTH (2.2) = 2 (No), 7 (DK), or 9 (Refused)
AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO Section 10; otherwise continue with Section 9

IF CUR_ASTH (2.2) = 1 (Yes) then continue with section 9.

ASMDCOST (9.1) **Was there a time in the past 12 months when you needed to see your primary care doctor <u>for your asthma</u> 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 <u>for asthma care</u> 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 <u>for your asthma</u> 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 in the workplace that affect asthma. 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 35+ hours per week.]

(1) EMPLOYED FULL-TIME **[SKIP TO WORKENV5 (10.4)]**
(2) EMPLOYED PART-TIME **[SKIP TO WORKENV5 (10.4)]**
(3) NOT EMPLOYED

(7) DON'T KNOW **[SKIP TO EMPL_EVER1 (10.3)]**
(9) REFUSED **[SKIP TO EMPL_EVER1 (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_EVER1 (10.3) **Have you ever been employed?**

[INTERVIEWER: Code self employed as "YES".]

(1) YES **[SKIP TO WORKENV7 (10.6)]**
(2) NO **[SKIP TO SECTION 11]**

(7) DON'T KNOW **[SKIP TO SECTION 11]**
(9) REFUSED **[SKIP TO SECTION 11]**

The best known value for whether or not the adult "still has asthma" is used in the skip below. It can be the previously answered BRFSS core value or the answer to CUR_ASTH (2.2) if this question is asked in this call back survey If the respondent confirms in the "Informed Consent" question that the previously answered BRFSS core (BRFSS 9.2) value is correct then the value from the BRFSS core question (BRFSS 9.2) is used. If the respondent does not agree with the previous BRFSS core value in "Informed Consent" then the question REPEAT (2.0) was asked (REPEAT = 1) then the value for CUR_ASTH (2.2) "Do you still have asthma?" is used.

IF respondent agrees 1 (Yes) with "Informed Consent":

IF BRFSS core value for 9.2, "Do you still have asthma?" = 2 (No), 7 (DK), or 9 (Refused)
AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO skip to 10.5; otherwise continue with 10.4

IF BRFSS core value for 9.2, "Do you still have asthma?" = 1 (Yes) then continue with question 10.4.

IF respondent DOES NOT agree 2 (No) with "Informed Consent" REPEAT = 1:

IF CUR_ASTH (2.2) = 2 (No), 7 (DK), or 9 (Refused)
AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO skip to 10.5; otherwise continue with 10.4

IF CUR_ASTH (2.2) = 1 (Yes) continue with question 10.4.

WORKENV5 (10.4) **Things in the workplace such as chemicals, smoke, dust or mold can make asthma symptoms worse in people who already HAVE asthma or can actually CAUSE asthma in people who have never had asthma before.**

Are your asthma symptoms MADE WORSE by things like chemicals, smoke, dust or mold in your CURRENT job?

(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED

[HELP SCREEN: "Some examples of things in the workplace that may cause asthma or make asthma symptoms worse include: flour dust in a bakery, normal dust in an office, smoke from a manufacturing process, smoke from a co-worker's cigarette, cleaning chemicals in a hospital, mold in a basement classroom, a co-worker's perfume, or mice in a research laboratory."]

WORKENV6 (10.5) **Was your asthma first CAUSED by things like chemicals, smoke, dust or mold in your CURRENT job?**

(1) YES **[SKIP TO WORKTALK (10.9)]**
(2) NO

(7) DON'T KNOW
(9) REFUSED

[HELP SCREEN: "Some examples of things in the workplace that may cause asthma or make asthma symptoms worse include: flour dust in a bakery, normal dust in an office, smoke from a manufacturing process, smoke from a co-worker's cigarette, cleaning chemicals in a hospital, mold in a basement classroom, a co-worker's perfume, or mice in a research laboratory."]

WORKENV7 (10.6) **[READ THIS INTRO TO 10.6 ONLY IF EMP_EVER1 (10.3) = 1 (yes); OTHERWISE SKIP INTRO AND JUST READ THE QUESTION]**
Things in the workplace such as chemicals, smoke, dust or mold can make asthma symptoms worse in people who already HAVE asthma or can actually CAUSE asthma in people who have never had asthma before.

Were your asthma symptoms MADE WORSE by things like chemicals, smoke, dust or mold in any PREVIOUS job you ever had?

(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED

[HELP SCREEN: "Some examples of things in the workplace that may cause asthma or make asthma symptoms worse include: flour dust in a bakery, normal dust in an office, smoke from a manufacturing process, smoke from a co-worker's cigarette, cleaning chemicals in a hospital, mold in a basement classroom, a co-worker's perfume, or mice in a research laboratory."]

WORKENV8 (10.7) **Was your asthma first CAUSED by things like chemicals, smoke, dust or mold in any PREVIOUS job you ever had?**

(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED

[HELP SCREEN: "Some examples of things in the workplace that may cause asthma or make asthma symptoms worse include: flour dust in a bakery, normal dust in an office, smoke from a manufacturing process, smoke from a co-worker's cigarette, cleaning chemicals in a hospital, mold in a basement classroom, a co-worker's perfume, or mice in a research laboratory."]

SKIP BEFORE 10.8 **[ASK 10.8 ONLY IF:**
WORKENV7 (10.6) = 1 (YES) OR
WORKENV8 (10.7) = 1 (YES)
OTHERWISE SKIP TO WORKTALK (10.9)]

WORKQUIT1 (10.8) **Did you ever lose or quit a job because things in the workplace, like chemicals, smoke, dust or mold, caused your asthma or made your asthma symptoms worse?**

(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED

[INTERVIEWER: RESPONDENTS WHO WERE FIRED BECAUSE THINGS IN THE WORKPLACE AFFECTED THEIR ASTHMA SHOULD BE CODED AS "YES".]

WORKTALK (10.9) **Did you and a doctor or other health professional ever DISCUSS whether your asthma could have been caused by, or your symptoms made worse by, any job you ever had?**

(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED

WORKSEN3 (10.10) **Have you ever been TOLD BY a doctor or other health professional that your asthma was caused by, or your symptoms made worse by, any job you ever had?**

(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED

WORKSEN4 (10.11) **Have YOU ever TOLD a doctor or other health professional that your asthma was caused by, or your symptoms made worse by, 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
(9) REFUSED

Section 12. Complimentary and Alternative Therapy

The best known value for whether or not the adult "still has asthma" is used in the skip below. It can be the previously answered BRFSS core value or the answer to CUR_ASTH (2.2) if this question is asked in this call back survey If the respondent confirms in the "Informed Consent" question that the previously answered BRFSS core (BRFSS 9.2) value is correct then the value from the BRFSS core question (BRFSS 9.2) is used. If the respondent does not agree with the previous BRFSS core value in "Informed Consent" then the question REPEAT (2.0) was asked (REPEAT = 1) then the value for CUR_ASTH (2.2) "Do you still have asthma?" is used.

IF respondent agrees 1 (Yes) with "Informed Consent":

IF BRFSS core value for 9.2, "Do you still have asthma?" = 2 (No), 7 (DK), or 9 (Refused)
AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO skip to CWEND; otherwise continue with section 12

IF BRFSS core value for 9.2, "Do you still have asthma?" = 1 (Yes) continue with section 12.

IF respondent DOES NOT agree 2 (No) with "Informed Consent" REPEAT = 1:

IF CUR_ASTH (2.2) = 2 (No), 7 (DK), or 9 (Refused)
AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO skip to CWEND; otherwise continue with section 12

IF CUR_ASTH (2.2) = 1 (Yes) continue with section 12.

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 <u>in the past 12 months</u>. 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 phasing 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?**

(1)	YES	
(2)	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]

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 {STATE NAME} 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**.

Appendix A:
Coding Notes and Pronunciation Guide

Coding Notes:

1) MISDIAGNOSIS NOTE: If, during the survey, the interviewer discovers that the respondent never really had asthma because it was a misdiagnosis, then assign disposition code "**4471 R**esp. was misdiagnosed; never had asthma" as a final code and terminate the interview.

2) BACKCODE SYMPFREE (4.4) TO 14 IF LASTSYMP (3.5) = 88 (never) or = 04, 05, 06, or 07 OR IF SYMP_30D = 88. THIS WILL BE DONE BY BSB.

3) CATI Programmer's note: For the Other in the medications (in INH_MEDS, PILLS_MD, SYRUP_ID or NEB_ID. If "Other" has one of the following misspellings then a menu choice should have been made. Code for this and correct:

Medication	Common misspelling in "Other"
Zyrtec	Zertec, Zertek or Zerteck
Allegra	Alegra, Allegra or Allegra D
Claritin	Cleraton, Cleritin or Claritin D
Singulair	Singular, Cingulair or Cingular
Xopenex	Zopanox or Zopenex
Advair Diskus	Advair or Diskus
Albuterol	Aluterol Sulfate
Maxair	Maxair Autohaler

Pronunciation Guide:

The following is a pronunciation guide. The top ten medications are shown bolded. Audio files are available from the BRFSS coordinators' upload/download site.

INH_MEDS

	Medication	Pronunciation
01	**Advair**	**ăd**-vâr (or **add**-vair)
02	Aerobid	â-**rō**'bĭd (or **air**-row-bid)
03	**Albuterol** (+ A. sulfate or salbutamol)	ăl'-**bu**'ter-ōl (or al-**BYOO**-ter-ole) săl-byū'tə-môl'
04	Alupent	**al**-u-pent
43	Alvesco	**al**-ves-co
40	Asmanex (twisthaler)	**as**-m*uh*-neks **twist**-hey-ler
05	**Atrovent**	At-ro-vent
06	**Azmacort**	**az**-ma-cort
07	Beclomethasone dipropionate	bek"lo-**meth**'ah-son dī' **pro'**pe-o-nāt (or be-kloe-**meth**-a-sone)
08	Beclovent	be' klo-vent" (or **be**-klo-vent)
09	Bitolterol	bi-tōl'ter-ōl (or bye-**tole**-ter-ole)
~~10~~	~~Brethaire~~	~~**breth**-air~~
11	Budesonide	byoo-**des**-oh-nide
12	**Combivent**	**com**-bi-vent
13	Cromolyn	**kro**'mŏ-lin (or **KROE**-moe-lin)
44	Dulera	**do**-lair-a
14	**Flovent**	**flow**-vent
15	Flovent Rotadisk	**flow**-vent **row**-ta-disk
16	Flunisolide	floo-**nis**'o-līd (or floo-**NISS**-oh-lide)
17	Fluticasone	flue-**TICK**-uh-zone
34	Foradil	*FOUR-a-dil*

35	Formoterol	for moh' te rol
~~18~~	~~Intal~~	~~**in-tel**~~
19	Ipratropium Bromide	ĭp-rah-**tro**'pe-um bro'mīd (or ip-ra-**TROE**-pee-um)
37	Levalbuterol tartrate	**lev-al-BYOU-ter-ohl**
20	Maxair	**măk**-sâr
21	Metaproteronol	met"ah-pro-**ter'**ĕ-nōl (or met-a-proe-**TER**-e-nole)
39	Mometasone furoate	**moe-MET-a-sone**
22	Nedocromil	ne-DOK-roe-mil
23	Pirbuterol	pēr-**bu**'ter-ōl (or peer-**BYOO**-ter-ole)
41	Pro-Air HFA	**proh-air HFA**
24	**Proventil**	pro"**ven**-til' (or pro-**vent**-il)
25	**Pulmicort Flexhaler**	**pul**-ma-cort **flex**-hail-er
36	**QVAR**	**q** -vâr (or q-vair)
03	Salbutamol (or Albuterol)	săl-byū'tə-môl'
26	Salmeterol	sal-ME-te-role
27	**Serevent**	**Sair**-a-vent
42	Symbicort	**sim**-b*uh*-kohrt
28	Terbutaline (+ T. sulfate)	ter-**bu'**tah-lēn (or ter-**BYOO**-ta-leen)
~~29~~	~~Tilade~~	~~**tie-laid**~~
30	Tornalate	**tor**-na-late
31	Triamcinolone acetonide	tri"am-**sin**'o-lōn as"ĕ-tō-nīd' (or trye-am-**SIN**-oh-lone)
32	Vanceril	**van**-sir-il
33	Ventolin	**vent**-o-lin
38	Xopenex HFA	*ZOH-pen-ecks*

PILLS_MED

	Medication	Pronunciation
01	**Accolate**	**ac**-o-late
02	Aerolate	**air**-o-late
03	**Albuterol**	ăl'-**bu**'ter-ōl (or al-**BYOO**-ter-all)
04	Alupent	**al**-u-pent
49	Brethine	**breth-een**
05	Choledyl (oxtriphylline)	**ko**-led-il
07	Deltasone	**del**-ta-sone
08	Elixophyllin	e-licks-**o**-fil-in
11	Medrol	**Med**-rol
12	Metaprel	**Met**-a-prell
13	Metaproteronol	met"ah-pro-**ter**'ĕ-nōl (or met-a-proe-**TER**-e-nole)
14	Methylpredinisolone	meth-ill-pred-**niss**-oh-lone (or meth-il-pred-**NIS**-oh-lone)
15	**Montelukast**	mont-e-**lu**-cast
17	Pediapred	Pee-**dee**-a-pred
18	**Prednisolone**	pred-NISS-oh-lone
19	**Prednisone**	PRED-ni-sone
21	Proventil	pro-**ven**-til
23	Respid	**res**-pid
24	**Singulair**	**sing**-u-lair
25	Slo-phyllin	**slow**- fil-in
26	Slo-bid	**slow**-bid
48	Terbutaline (+ T. sulfate)	ter byoo' ta leen
28	Theo-24	**thee**-o-24
30	Theochron	**thee** -o-kron
31	Theoclear	**thee**-o-clear
32	**Theodur**	**thee**-o-dur
33	**Theo-Dur**	**thee**-o-dur
35	**Theophylline**	thee-**OFF**-i-lin
37	Theospan	**thee**-o-span
40	T-Phyl	**t**-fil
42	**Uniphyl**	**u**-ni-fil
43	Ventolin	**vent**-o-lin
44	Volmax	**vole**-max
45	Zafirlukast	za-**FIR**-loo-kast
46	Zileuton	zye-**loo**-ton
47	Zyflo Filmtab	**zye**-flow **film** tab

SYRUP_ID

	Medication	Pronunciation
01	Aerolate	**air**-o-late
02	Albuterol	ăl'-**bu**'ter-ōl (or al-BYOO-ter-ole)
03	Alupent	**al**-u-pent
04	Metaproteronol	met"ah-pro-**ter**'ĕ-nōl (or met-a-proe-TER-e-nole)
05	Prednisolone	pred-NISS-oh-lone
06	Prelone	**pre**-loan
07	Proventil	Pro-**ven**-til
08	Slo-Phyllin	**slow**-fil-in
09	Theophyllin	thee-OFF-i-lin
10	Ventolin	**vent**-o-lin

NEB_ID

	Medication	Pronunciation
01	Albuterol	ăl'-**bu'**ter-ōl (or al-BYOO-ter-ole)
02	Alupent	**al**-u-pent
03	Atrovent	At-ro-vent
04	Bitolterol	bi-tōl'ter-ōl (or bye-**tole**-ter-ole)
05	Budesonide	byoo-**des**-oh-nide
06	Cromolyn	**kro'**mŏ-lin (or KROE-moe-lin)
07	DuoNeb	DUE-ow-neb
08	Intal	**in**-tel
09	Ipratroprium bromide	ĭp-rah-**tro**'pe-um bro'mīd (or ip-ra-**TROE**-pee-um)
10	Levalbuterol	lev al byoo' ter ol
11	Metaproteronol	met"ah-pro-**ter'**ĕ-nōl (or met-a-proe-TER-e-nole)
12	Proventil	Pro-**ven**-til
13	Pulmicort	**pul**-ma-cort
14	Tornalate	**tor**-na-late
15	Ventolin	**vent**-o-lin
16	Xopenex	*ZOH-pen-ecks*

Attachment 5

NOTE: The only changes made were in the for 2013 medication lists

BRFSS/ASTHMA SURVEY
CHILD QUESTIONNAIRE - 2015
CATI SPECIFICATIONS

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

MISDIAGNOSIS NOTE: If, during the survey, the interviewer discovers that the respondent never really had asthma because it was a misdiagnosis, then assign disposition code "**4471** Respondent was misdiagnosed; never had asthma" as a final code and terminate the interview.

{Read the statement below ONLY if you're conducting the survey via a cellphone}
Is this a safe time to talk with you now or are you driving? **(STATES HAVE THE OPTION OF INCLUDING THIS TEXT HERE OR AT THE END OF THE SURVEY INTRO BELOW.)**

Section 1. Introduction

For states identifying the Most Knowledgeable Person/Parent (MKP) at the BRFSS interview use language in Appendix A.

For states identifying the Most Knowledgeable Person/Parent (MKP) at the Asthma Call-Back use language in Appendix B.

Section 2. Informed Consent

For states identifying the Most Knowledgeable Person/Parent (MKP) at the BRFSS interview use language in Appendix A.

For states identifying the Most Knowledgeable Person/Parent (MKP) at the Asthma Call-Back use language in Appendix B.

Section 3. Recent History

AGEDX (3.1) **How old was {child's name} when a doctor or other health professional first said {he/she} had asthma**

[INTERVIEWER: ENTER 888 IF LESS THAN ONE YEARS OLD]

__ __ __(ENTER AGE IN YEARS)
[RANGE CHECK: IS 001-018, 777, 888, 999]

(777) DON'T KNOW
(888) Under 1 year old
(999) REFUSED

[CATI CHECK: IF RESPONSE = 77, 99, 88 VERIFY THAT 777, 888, 999 WERE NOT THE INTENT]

INCIDNT (3.2) **How long ago was that? Was it...**

READ CATEGORIES
(1) Within the past 12 months
(2) 1-5 years ago
(3) 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 {child's name} asthma? This could have been in a doctor's office, the hospital, an emergency room or urgent care center.**

[INTERVIEWER: READ RESPONSE OPTIONS IF NECESSARY]

(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 {he/she} 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 {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

Section 4. History of Asthma (Symptoms & Episodes in past year)

IF LAST SYMPTOMS (LASTSYMP 3.5) WERE WITHIN THE PAST 3 MONTHS (1, 2 OR 3) CONTINUE. IF LAST SYMPTOMS (LASTSYMP 3.5) WERE 3 MONTHS TO 1 YEAR AGO (4), SKIP TO EPISODE INTRODUCTION (EPIS_INT - BETWEEN 4.4 AND 4.5); IF LAST SYMPTOMS (LASTSYMP 3.5) WERE 1-5+ YEARS AGO (05, 06 OR 07), SKIP TO SECTION 5; IF NEVER HAD SYMPTOMS (88), SKIP TO SECTION 5, IF DK/REF (77, 99) 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) **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 PLUS DK AND REFUSED (LASTSYMP (3.5) = 1, 2, 3, 77, 99) CONTINUE HERE AS WELL**

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 **[SKIP TO INS1 in Section 5]**

(7) DON'T KNOW **[SKIP TO INS1 in Section 5]**
(9) REFUSED **[SKIP TO INS1 in Section 5]**

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

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

The best known value for whether or not the child "still has asthma" is used in the skip below. It can be the previously answered BRFSS module value or the answer to CUR_ASTH (2.2) if this question is asked in this call back survey If the respondent confirms in the "Informed Consent" question that the previously answered BRFSS module value is correct then the value from the BRFSS module question (BRFSS M2.2) is used. If the respondent does not agree with the previous BRFSS module value in "Informed Consent" then the question REPEAT (2.0) was asked (REPEAT = 1) then the value for CUR_ASTH (2.2) "Do you still have asthma?" is used.

IF respondent agrees (1. Yes) with "Informed Consent":

IF BRFSS module value for M2.2, "Does the child still have asthma?" = 2 (No), 7 (DK), or 9 (Refused) AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) AND
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) AND
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO Section 6; otherwise continue with Section 5.

The above "if" statement can also be restated in different words as:

IF BRFSS module value for M2.2, "Does the child still have asthma?" = ***2 (No), 7 (DK), or 9 (Refused) AND***
((LAST_MD = 4) OR
(LAST_MED = 1, 2, 3 or 4) OR
(LASTSYMP = 1, 2, 3 or 4)
THEN Continue with Section 5 otherwise skip to Section 6)

IF BRFSS module value for M2.2, "Does the child still have asthma?" = 1 (Yes), continue to Section 5.

IF respondent DOES NOT agree 2 (No) with "Informed Consent" REPEAT = 1:

IF CUR_ASTH (2.2) = 2 (No), 7 (DK), or 9 (Refused) AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) AND
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) AND

(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO Section 6; otherwise continue with Section 5.

The above "if" statement can also be restated in different words as:

IF* CUR_ASTH (2.2) = *2 (No), 7 (DK), or 9 (Refused) AND
((LAST_MD = 4) OR
(LAST_MED = 1, 2, 3 or 4) OR
(LASTSYMP = 1, 2, 3 or 4)
THEN Continue with Section 5; otherwise skip to Section 6)

IF* CUR_ASTH (2.2) = *1 (Yes) continue with section 5.

ACT_DAYS30 (5.6) **During just the past 30 days, 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

NER_TIME (5.7) **[IF LAST_MD= 88, 05, 06, 07; SKIP TO Section 6 {renamed from NR_Times} (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]

(888) ZERO (skip back to 5.8)
(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"]

[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) **[IF LASTSYMP ≥ 5 AND ≤ 7, SKIP TO Section 6**
IF LASTSYMP=88 (NEVER), SKIP TO Section 6]

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]

[CATI CHECK: IF RESPONSE TO 5.11 IS "YES" AND RESPONDENT SAYS NONE OR ZERO TO 5.12 ALLOW LOOPING BACK TO CORRECT 5.11 TO "NO"]

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. This should not be coded yes if the respondent only received a pamphlet or instructions to view a website or video since the question clearly states "talk with you".]

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?

[HELP SCREEN: Health professional includes doctors, nurses, physician assistants, nurse practitioners, and health educators]

(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?

[HELP SCREEN: Health professional includes doctors, nurses, physician assistants, nurse practitioners, and health educators]

(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?

[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_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.**

Is an air cleaner or purifier regularly used inside {child's name} home?

(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED

DEHUMID (7.2) **A dehumidifier is a small, portable appliance which removes moisture from the air.**

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 <u>indoors</u>?**

(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 (cannabis, 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 = 4, 5, 6, 7, 77, or 99, SKIP TO SECTION 9]**

Now I am going to ask questions about specific prescription medications {child's name} may have taken for asthma <u>in the past 3 months</u>. 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.

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_MED3 (8.7) **[when Respondent returns to phone:] Do you have all the medications?**

[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

[IF INHALERE (8.2) = 2 (NO) SKIP TO PILLS]

INH_SCR (8.8) **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)

For the following inhalers the respondent can choose up to eight medications; however, each medication can only be used once (in the past, errors such as 030303 were submitted in the data file). When 66 (Other) is selected as a response, the series of questions ILP03 (8.13) to ILP10 (8.19) is not asked for that response.

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.]

Note: The top ten items (in bold below) should be highlighted in the CATI system if possible so they can be found more easily.

	Medication	Pronunciation
01	**Advair** (+ A. Diskus)	**ăd**-vâr (or **add**-vair)
02	Aerobid	â-**rō**'bĭd (or **air**-row-bid)
03	**Albuterol** (+ A. sulfate or salbutamol)	ăl'-**bu**'ter-ōl (or al-**BYOO**-ter-ole) săl-byū'tə-môl'
04	Alupent	**al**-u-pent
43	Alvesco (+ Ciclesonide)	**al**-ves-co
40	Asmanex (twisthaler)	**as**-m*uh*-neks **twist**-hey-ler
05	**Atrovent**	At-ro-vent
06	**Azmacort**	**az**-ma-cort
07	Beclomethasone dipropionate	bek"lo-**meth**'ah-son dī' **pro'**pe-o-nāt (or be-kloe-**meth**-a-sone)
08	Beclovent	be' klo-vent" (or **be**-klo-vent)
09	Bitolterol	bi-tōl'ter-ōl (or bye-**tole**-ter-ole)
~~10~~	~~Brethaire~~ Discontinued - Delete	~~**breth air**~~
11	Budesonide	byoo-**des**-oh-nide
12	**Combivent**	**com**-bi-vent
13	Cromolyn	**kro**'mŏ-lin (or **KROE**-moe-lin)
44	Dulera	**do**-lair-a
14	**Flovent**	**flow**-vent
15	Flovent Rotadisk	**flow**-vent **row**-ta-disk
16	Flunisolide	floo-**nis**'o-līd (or floo-**NISS**-oh-lide)
17	Fluticasone	flue-**TICK**-uh-zone
34	Foradil	*FOUR-a-dil*
35	Formoterol	for moh' te rol
~~18~~	~~Intal~~ Discontinued - Delete	~~**in-tel**~~
19	Ipratropium Bromide	ĭp-rah-**tro**'pe-um bro'mīd (or ip-ra-**TROE**-pee-um)
37	Levalbuterol tartrate	**lev-al-BYOU-ter-ohl**
20	Maxair	**măk**-sâr
21	Metaproteronol	met"ah-pro-**ter'**ĕ-nōl (or met-a-proe-**TER**-e-nole)
39	Mometasone furoate	**moe-MET-a-sone**
22	Nedocromil	ne-DOK-roe-mil
23	Pirbuterol	pēr-**bu**'ter-ōl (or peer-**BYOO**-ter-ole)
41	Pro-Air HFA	**proh-air HFA**
24	**Proventil**	pro"**ven**-til' (or pro-**vent**-il)
25	**Pulmicort Flexhaler**	**pul**-ma-cort **flex**-hail-er
36	**QVAR**	**q** -vâr (or q-vair)

03	Salbutamol (or Albuterol)	săl-byū'tə-môl'
26	Salmeterol	sal-ME-te-role
27	**Serevent**	**Sair**-a-vent
42	Symbicort	**sim**-b*uh*-kohrt
28	Terbutaline (+ T. sulfate)	ter-**bu'**tah-lēn (or ter-**BYOO**-ta-leen)
~~29~~	~~Tilade~~ Discontinued - delete	~~tie-laid~~
30	Tornalate	**tor**-na-late
31	Triamcinolone acetonide	tri"am-**sin**'o-lōn as"ĕ-tō-nīd' (or trye-am-**SIN**-oh-lone)
32	Vanceril	**van**-sir-il
33	Ventolin	**vent**-o-lin
38	Xopenex HFA	*ZOH-pen-ecks*
66	Other, Please Specify	**[SKIP TO OTH_I1]**

[IF RESPONDENT SELECTS ANY ANSWER <66, SKIP TO ILP03]

(88) NO PRESCRIPTION INHALERS **[SKIP TO PILLS]**

(77) DON'T KNOW **[SKIP TO PILLS]**
(99) REFUSED **[SKIP TO PILLS]**

[100 ALPHANUMERIC CHARACTER LIMIT FOR 66]

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.

CATI programmers note that the text for 66 (other) should be checked to make sure one of the medication names above was not entered. If the medication entered is on the list above, then an error message should be shown.

[LOOP BACK TO ILP03 AS NECESSARY TO ADMINSTER QUESTIONS ILP03 THRU ILP10 FOR EACH MEDICINE 01-44 REPORTED IN INH_MEDS, BUT NOT FOR 66 (OTHER).]

[FOR FILL [MEDICINE FROM INH_MEDS SERIES] FOR QUESTIONS ILP03 THROUGH ILP10]

SKIP before ILP03
IF [MEDICINE FROM INH_MEDS SERIES] IS ADVAIR (01) OR FLOVENT ROTADISK (15) OR MOMETASONE FUROATE (39) OR ASMANEX (40) OR FORADIL (34) OR MAXAIR (20) OR PULMICORT (25) OR SEREVENT (27) OR SYMBICORT (42) 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 dry powder inhaler or disk inhaler, not a canister inhaler
(4) Medication has a built-in spacer/does not need a spacer

(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 or dry powder) and 4 (built in spacer) are primarily intended for medications Beclomethosone (7) Beclovent (08), Budesonide (11) and QVAR (36), which are known to come in disk or breathe activated inhalers (which do not use a spacer). However, new medications may come on the market that will need either category, so 3 or 4 can be used for other medications as well.]

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

ILP08 (8.18) **How many times per day or per week did {he/she} use [MEDICINE FROM INH_MEDS SERIES]**?

3 _ _	Times per DAY	**[RANGE CHECK: (>10)]**
4 _ _	Times per WEEK	**[RANGE CHECK: (>75)]**
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

[RANGE CHECK: 301-399, 401-499, 555, 666, 777, 999]

[ASK ILP10 ONLY IF INH_MEDS = 3, 4, 9, 10, 20, 21, 23, 24, 28, 30, 33, 37, 38, 41 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) **For the following pills the respondent can chose up to five medications; however, each medication can only be used once (in the past, errors such as 232723 were submitted in the data file).**

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.]

Note: The top ten items (in bold below) should be highlighted in the CATI system if possible so they can be found more easily.

	Medication	Pronunciation
01	**Accolate**	**ac**-o-late
02	Aerolate	**air**-o-late
03	**Albuterol**	ăl'-**bu**'ter-ōl (or al-**BYOO**-ter-all)
04	Alupent	**al**-u-pent
49	Brethine	**breth-een**
05	Choledyl (oxtriphylline)	**ko**-led-il
07	Deltasone	**del**-ta-sone
08	Elixophyllin	e-licks-**o**-fil-in
11	Medrol	**Med**-rol
12	Metaprel	**Met**-a-prell
13	Metaproteronol	met"ah-pro-**ter**'ĕ-nōl (or met-a-proe-**TER**-e-nole)
14	Methylprednisolone	meth-ill-pred-**niss**-oh-lone (or meth-il-pred-**NIS**-oh-lone)
15	**Montelukast**	mont-e-**lu**-cast
17	Pediapred	Pee-**dee**-a-pred
18	**Prednisolone**	pred-NISS-oh-lone
19	**Prednisone**	PRED-ni-sone
21	Proventil	pro-**ven**-til
23	Respid	**res**-pid
24	**Singulair**	**sing**-u-lair
25	Slo-phyllin	**slow**- fil-in
26	Slo-bid	**slow**-bid
48	Terbutaline (+ T. sulfate)	ter byoo' ta leen
28	Theo-24	**thee**-o-24
30	Theochron	**thee** -o-kron
31	Theoclear	**thee**-o-clear
32	**Theodur**	**thee**-o-dur
33	**Theo-Dur**	**thee**-o-dur
35	**Theophylline**	thee-**OFF**-i-lin
37	Theospan	**thee**-o-span
40	T-Phyl	**t**-fil
42	**Uniphyl**	**u**-ni-fil
43	Ventolin	**vent**-o-lin
44	Volmax	**vole**-max
45	Zafirlukast	za-**FIR**-loo-kast
46	Zileuton	zye-**loo**-ton
47	Zyflo Filmtab	**zye**-flow **film** tab
66	Other, please specify	**[SKIP TO OTH_P1]**

[IF RESPONDENT SELECTS ANY ANSWER FROM 01-49, SKIP TO PILL01]

(88) NO PILLS **[SKIP TO SYRUP]**

(77) DON'T KNOW **[SKIP TO SYRUP]**

(99) REFUSED **[SKIP TO SYRUP]**

[100 ALPHANUMERIC CHARACTER LIMIT FOR 66]

OTH_P1

ENTER OTHER MEDICATION IN TEXT FIELD
IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.

CATI programmers note that the text for 66 (other) should be checked to make sure one of the medication names above was not entered. If the medication entered is on the list above, then an error message should be shown.

[REPEAT QUESTION PILL01 AS NECESSARY FOR EACH PILL 01-49 REPORTED IN PILLS_MD, BUT NOT FOR 66 (OTHER).]

FOR FILL [MEDICATION LISTED IN PILLS_MD] FOR QUESTION PILL01]

PILL01 (8.22) **In the past 3 months, did {child's name} take [MEDICATION LISTED IN PILLS_MD] on a regular schedule every day?**
(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED

SYRUP (8.23) **In the past 3 months, has {he/she} taken prescription medicine 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) **For the following syrups the respondent can choose up to four medications; however, each medication can only be used once (in the past, errors such as 020202 were submitted in the data file).**

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	Pronunciation
01	Aerolate	**air**-o-late
02	Albuterol	ăl'-**bu**'ter-ōl (or al-BYOO-ter-ole)
03	Alupent	**al**-u-pent

04	Metaproteronol	met"ah-pro-**ter**'ĕ-nōl (or met-a-proe-TER-e-nole)
05	Prednisolone	pred-NISS-oh-lone
06	Prelone	**pre**-loan
07	Proventil	Pro-**ven**-til
08	Slo-Phyllin	**slow**-fil-in
09	Theophyllin	thee-OFF-i-lin
10	Ventolin	**vent**-o-lin
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]**

[100 ALPHANUMERIC CHARACTER LIMIT FOR 66]

OTH_S1

ENTER OTHER MEDICATION.
IF MORE THAN ONE MEDICATION IS GIVEN, ENTER ALL MEDICATIONS ON ONE LINE.

CATI programmers note that the text for 66 (other) should be checked to make sure one of the medication names above was not entered. If the medication entered is on the list above, then an error message should be shown.

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) AT HOME
(1) YES (2) NO (7) DK (9) REF

(8.26b) AT A DOCTOR'S OFFICE
(1) YES (2) NO (7) DK (9) REF

(8.26c) IN AN EMERGENCY ROOM

(1) YES (2) NO (7) DK (9) REF

(8.26d) AT WORK OR AT SCHOOL
(1) YES (2) NO (7) DK (9) REF

(8.26e) AT ANY OTHER PLACE
(1) YES (2) NO (7) DK (9) REF

NEB_ID (8.27)

For the following nebulizers, the respondent can chose up to five medications; however, each medication can only be used once (in the past, errors such as 0101 were submitted in the data file).

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	Pronunciation
01	Albuterol	ăl'-**bu'**ter-ōl (or al-BYOO-ter-ole)
02	Alupent	**al**-u-pent
03	Atrovent	At-ro-vent
04	Bitolterol	bi-tōl'ter-ōl (or bye-**tole**-ter-ole)
05	Budesonide	byoo-**des**-oh-nide
17	Combivent Inhalation solution	**com**-bi-vent
06	Cromolyn	**kro**'mŏ-lin (or KROE-moe-lin)
07	DuoNeb	DUE-ow-neb
08	Intal	**in**-tel
09	Ipratroprium bromide	ĭp-rah-**tro**'pe-um bro'mīd (or ip-ra-**TROE**-pee-um)
10	Levalbuterol	lev al byoo' ter ol
11	Metaproteronol	met"ah-pro-**ter'**ĕ-nōl (or met-a-proe-TER-e-nole)
18	Perforomist (Formoterol)	per-**form**-ist
12	Proventil	Pro-**ven**-til
13	Pulmicort	**pul**-ma-cort
14	Tornalate	**tor**-na-late
15	Ventolin	**vent**-o-lin
16	Xopenex	*ZOH-pen-ecks*
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.

CATI programmers note that the text for 66 (other) should be checked to make sure one of the medication names above was not entered. If the medication entered is on the list above, then an error message should be shown.

[LOOP BACK TO NEB01 AS NECESSARY TO ADMINISTER QUESTIONS NEB01 THROUGH NEB03 FOR EACH MEDICINE 01 THROUGH 18 (NEB_01 to NEB_18) REPORTED IN NEB_ID, BUT NOT FOR 66 (OTHER).]

FOR FILL [MEDICATION LISTED IN NEB_ID] FOR QUESTION NEB01 to NEB03]

NEB01 (8.28) **In the past 3 months, did {child's name} take [MEDICINE FROM NEB_ID 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

NEB02 (8.29) **In the past 3 months, did he/she take [MEDICINE FROM NEB_ID SERIES] on a regular schedule every day?**

(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED

NEB03 (8.30) **How many times per day or per week does he/she use [MEDICINE FROM NEB_ID SERIES]**?

3__ __ DAYS
4__ __ WEEKS

(555) NEVER
(666) LESS OFTEN THAN ONCE A WEEK

(777) DON'T KNOW / NOT SURE
(999) REFUSED

Section 9. Cost of Care

The best known value for whether or not the child "still has asthma" is used in the skip below. It can be the previously answered BRFSS module value or the answer to CUR_ASTH (2.2) if this question is asked in this call back survey If the respondent confirms in the "Informed Consent" question that the previously answered BRFSS module value is correct then the value from the BRFSS module question (BRFSS M2.2) is used. If the respondent does not agree with the previous BRFSS module value in "Informed Consent" then the question REPEAT (2.0) was asked (REPEAT = 1) then the value for CUR_ASTH (2.2) "Do you still have asthma?" is used.

IF respondent agrees 1 (Yes) with "Informed Consent":

IF BRFSS module value for M2.2, "Does the child still have asthma?" = 2 (No), 7 (DK), or 9 (Refused)
IF BRFSS module value for M2.2, "Does the child still have asthma?" = 1 (Yes), then continue with Section 9.

IF respondent DOES NOT agree 2 (No) with "Informed Consent" REPEAT = 1:

IF CUR_ASTH (2.2) = 2 (No), 7 (DK), or 9 (Refused)
AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO Section 10; otherwise continue with Section 9

(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO Section 10; otherwise continue with Section 9.

IF CUR_ASTH (2.2) = 1 (Yes), then continue with Section 9.

ASMDCOST (9.1) **Was there a time in the past 12 months when {child's name} needed to see his/her primary care doctor <u>for asthma</u> 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 <u>for {his/her} asthma care</u> 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 <u>for his/her asthma</u> 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

The best known value for whether or not the child "still has asthma" is used in the skip below. It can be the previously answered BRFSS module value or the answer to CUR_ASTH (2.2) if this question is asked in this call back survey If the respondent confirms in the "Informed Consent" question that the previously answered BRFSS module value is correct then the value from the BRFSS module question (BRFSS M2.2) is used. If the respondent does not agree with the previous BRFSS module value in "Informed Consent" then the question REPEAT (2.0) was asked (REPEAT = 1) then the value for CUR_ASTH (2.2) "Do you still have asthma?" is used.

IF respondent agrees 1 (Yes) with "Informed Consent":

IF BRFSS module value for M2.2, "Does the child still have asthma?" = 2 (No), 7 (DK), or 9 (Refused), AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO 10.8; otherwise continue with 10.5

IF BRFSS module value for M2.2, "Does the child still have asthma?" = 1 (Yes) then continue with 10.5.

IF respondent DOES NOT agree 2 (No) with "Informed Consent" REPEAT = 1:

IF CUR_ASTH (2.2) = 2 (No), 7 (DK), or 9 (Refused) AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO 10.8; otherwise continue with 10.5

IF CUR_ASTH (2.2) = 1 (Yes), then continue with 10.5.

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 THS 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) **[IF NO_SCHL = 2 (HOME SCHOOLED) SKIP TO SECTION 11] added in 2011**
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 YEARS OR 131 MONTHS SKIP TO SECTION 11]**
Does {child's name} go to day care outside his/her home?

(1) YES **[SKIP TO MISS_DCAR]**

(2) NO

(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]**

The best known value for whether or not the child "still has asthma" is used in the skip below. It can be the previously answered BRFSS module value or the answer to CUR_ASTH (2.2) if this question is asked in this call back survey If the respondent confirms in the "Informed Consent" question that the previously answered BRFSS module value is correct then the value from the BRFSS module question (BRFSS M2.2) is used. If the respondent does not agree with the previous BRFSS module value in "Informed Consent" then the question REPEAT (2.0) was asked (REPEAT = 1) then the value for CUR_ASTH (2.2) "Do you still have asthma?" is used.

IF respondent agrees 1 (Yes) with "Informed Consent":

IF BRFSS module value for M2.2, "Does the child still have asthma?" = 2 (No), 7 (DK), or 9 (Refused), AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO 10.14; otherwise continue with 10.12

IF BRFSS module value for M2.2, "Does the child still have asthma?" = 1 (Yes), then continue with 10.12.

IF respondent DOES NOT agree 2 (No) with "Informed Consent" REPEAT = 1:

IF CUR_ASTH (2.2) = 2 (No), 7 (DK), or 9 (Refused) skip to Section 10.14 AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO 10.14; otherwise continue with 10.12

IF CUR_ASTH (2.2) = 1 (Yes), then continue with 10.12.

MISS_DCAR (10.12) **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 THS 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) **Are you aware of any mold problems in {his/her} daycare?**

(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

The best known value for whether or not the child "still has asthma" is used in the skip below. It can be the previously answered BRFSS module value or the answer to CUR_ASTH (2.2) if this question is asked in this call back survey If the respondent confirms in the "Informed Consent" question that the previously answered BRFSS module value is correct then the value from the BRFSS module question (BRFSS M2.2) is used. If the respondent does not agree with the previous BRFSS module value in "Informed Consent" then the question REPEAT (2.0) was asked (REPEAT = 1) then the value for CUR_ASTH (2.2) "Do you still have asthma?" is used.

IF respondent agrees 1 (Yes) with "Informed Consent":

IF BRFSS module value for M2.2, "Does the child still have asthma?" = 2 (No), 7 (DK), or 9 (Refused), AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO SECTION 12; otherwise continue with Section 11

IF BRFSS module value for M2.2, "Does the child still have asthma?" = 1 (Yes), then continue with section 11.

IF respondent DOES NOT agree 2 (No) with "Informed Consent" REPEAT = 1:

IF CUR_ASTH (2.2) = 2 (No), 7 (DK), or 9 (Refused) skip to Section 12 AND
(LAST_MD (3.3) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LAST_MED (3.4) = 88 (Never) or 05, 06, 07, 77 or 99) **AND**
(LASTSYMP (3.5) = 88 (Never) or 05, 06, 07, 77 or 99)
THEN SKIP TO SECTION 12; otherwise continue with Section 11

IF CUR_ASTH (2.2) = 1 (Yes), then continue with section 11.

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 <u>in the past 12 months</u>. 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 phasing 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]

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

CATI Note: In the first space for the height (highlighted in yellow), if the respondent answers in feet/inches enter "0." If respondent answers in metric, put "9" in the first space.

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

CATI Note: In the first space for the weight (highlighted in yellow), if the respondent answers in pounds, enter "0." If respondent answers in kilograms, put "9" in the first space.

[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)
7 7 7 7 7 7	Don't know / Not sure
9 9 9 9 9 9	Refused

CATI note: **If the respondent gives pounds and ounces: from left to right, positions one and two will hold "0 0"; positions three and four will hold the value of pounds from 0 to 30; and the last two positions will hold 00 to 15 ounces.**

If the respondent gives kilograms and grams: from left to right, position one will hold "9"; positions 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 13.6 KILOGRAMS 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 {STATE NAME} 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**.

Appendix A:
Language for Identifying Most Knowledgeable Person during the BRFSS interview

Consent scripts for use during BRFSS 2011 Child asthma module when the most knowledgeable adult is identified during the BRFSS interview.

Child asthma module:

If BRFSS respondent indicates that the randomly selected child has ever had asthma (CASTHDX2 = 1 "yes") and the BRFSS adult never had asthma then arrange for a call-back interview. If both the BRFSS adult and the randomly selected child both have asthma the child is randomly selected for the call-back 50% of the time.

Only respondents who are the parent/guardian of the selected child with asthma are eligible for the child asthma call-back interview. This is required because the parent/guardian must give permission to collect information about the child even if the information is being given by someone else. (RCSRELN1 = 1, 3)

READ: **We would like to call again within the next 2 weeks to talk in more detail about your child's experiences with asthma. The information** will be used to help develop and improve the asthma programs in **{*state name*}**.

ADULTPERM

Would it be all right if we call back at a later time to ask additional questions about your child's asthma?

(1) Yes	
(2) No	(GO TO BRFSS closing or next module)
(7) Don't know/Not Sure	(GO TO BRFSS closing or next module)
(9) Refused	(GO TO BRFSS closing or next module)

CHILDName

Can I please have your child's first name, initials or nickname so we can ask about the right child when we call back? This is the *{#}* year old child which is the {*FIRST CHILD, SECOND, etc.*} CHILD.

[CATI: If more than one child, show child age *{#}* and which child was selected (*FIRST, SECOND, etc*.) from child selection module]

Enter child's first name, initials or nickname: _____

ADULTName

Can I please have your first name, initials or nickname so we know who refer to when we call back?

Enter respondent's first name, initials or nickname: _____

MOSTKNOW

Are you the parent or guardian in the household who knows the most about {C*HILDName}'s* asthma?

(1) Yes **[CATI SET MKPName = ADULTName]**

(2) No (GO TO **ALTName**)

(7) Don't know/Not Sure (GO TO **ALTName**)
(9) Refused (GO TO **ALTName**)

CBTIME: What is a good time to call you back? For example, evenings, days, weekends?

Enter day/time: _____

READ: **The information you gave us today and will give us when we call back will be kept confidential. We will keep identifying information like your child's name and your name and phone number on file, separate from the answers collected today. Even though you agreed today, you may refuse to participate in the future**.

[If state requires active linking consent continue, if not, go to BRFSS closing or next module]

LINKING CONSENT

READ: Some of the information that you shared with us today could be useful when combined with the information we will ask for during your child's asthma interview. If the information from the two interviews is combined, identifying information such as your phone number, your name, and your child's name will not be included.

PERMISS: May we combine your answers from today with your answers from the interview about your child's asthma that will be done in the next two weeks?

(1) Yes (GO TO BRFSS closing or next module)
(2) No (GO TO BRFSS closing or next module)

(7) Don't Know (GO TO BRFSS closing or next module)
(9) Refused (GO TO BRFSS closing or next module)

ALTName Can I please have the first name, initials or nickname of the person who knows the most about {*CHILDName*}'s asthma so we will know who to ask for when we call back?

Alternate's Name:_____
[CATI SET MKPName = ALTName]

ALTCBTime:

When would be a good time to call back and speak with *{ALTName}*. For example, evenings, days, weekends?

Enter day/time: _____

READ: The information you gave us today and that *{ALTName}* will give us when we call back will be kept confidential. We will keep their name and phone number, and your child's name on file, separate from the answers collected today. Even though you agreed today, *{ALTName}* may refuse to participate in the future.

[If state requires linking consent, continue; if not, go to BRFSS closing or next module]

LINKING CONSENT

READ: Some of the information that you shared with us today could be useful when combined with the information we will ask for during your child's asthma interview. If the information from the two interviews is combined, identifying information such as your phone number, your name, and your child's name will not be included.

PERMISS: May we combine your answers from today with the answers ***{ALTName}*** gives us during the interview about your child's asthma?

(1) Yes (GO TO BRFSS closing or next module)
(2) No (GO TO BRFSS closing or next module)

(7) Don't Know (GO TO BRFSS closing or next module)
(9) Refused (GO TO BRFSS closing or next module)

Introduction and consent sections for use during the Child Asthma Call-Back when the most knowledgeable adult is identified during the BRFSS interview:

[CATI: CHILDName, ADULTName, ALTName, MKPName, CASTHDX2, and CASTHNO2, RCSGENDR, calculated child's age, are from the BRFSS child asthma module and must be carried to the asthma call-back]

[CATI: BRFSS Respondent's SEX also should be carried to the Asthma call-back]

[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 {*STATE NAME*} health department and the Centers for Disease Control and Prevention about an asthma study we are doing in your state.

ALTERNATE (no reference to asthma):

Hello, my name is _____. I'm calling on behalf of the {*STATE NAME}* health department and the Centers for Disease Control and Prevention about a health study we are doing in your state.

1.1 Are you {*MKPName*}?

1. Yes (GO TO 1.5)
2. No

1.2 May I speak with {*MKPName* }?

1. Yes (GO TO 1.4 when person comes to phone)
2. Person not available

1.3 When would be a good time to call back and speak with *{MKPName}*. For example, evenings, days, weekends?

Enter day/time: _____

READ: Thank you we will call again later to speak with *{MKPName}*.
[CATI: Start over at introduction at next call.]

1.4 Hello, my name is _____. I'm calling on behalf of the {*STATE NAME*} 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*" if MKPName=ADULTName OR "*ADULTName*" if MKPName=ALTName} gave us permission to call again to ask some questions about

{*CHILDName*}'s asthma and said that you knew the most about that child's asthma.

ALTERNATE (no reference to asthma):

Hello, my name is _____. I'm calling on behalf of the {*STATE NAME*} 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*" if MKPName=ADULTName OR "*ADULTName"* if MKPName=ALTName} gave us permission to call again to ask some questions about {*CHILDName*}'s health and said that you knew the most about that child's health.

GO TO SECTION 2

1.5 During a recent phone interview {"*you*" if MKPName=ADULTName OR "*ADULTName*" if MKPName=ALTName} gave us permission to call again to ask some questions about {*CHILDName*}'s asthma and said that you knew the most about that child's asthma.

ALTERNATE (no reference to asthma):

During a recent phone interview {*"you"* if MKPName=ADULTName OR "*ADULTName*" if MKPName=ALTName} gave us permission to call again to ask some questions about {*CHILDName*}'s **health and said that you knew the most about that child's health.**

GO TO SECTION 2

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 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.

{*CHILDName*} was selected to participate in this study about asthma because of responses to questions about his or her asthma in a prior survey.

[If responses for sample child were "yes" (1) to CASTHDX2 and "no" (2) to CASTHNO2 in core BRFSS interview:]

READ: The answers to asthma questions during the earlier survey indicated that a doctor or other health professional said that {*CHILDName}* 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 {*CHILDName}* no longer has asthma, your interview will be very brief (about 5 minutes). [Go to section 3]

[If responses for sample child were "yes" (1) to CASTHDX2 and "yes" (1) to CASTHNO2 in core BRFSS survey:]

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

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

Since {*CHILDName*} has asthma now, your interview will last about 15 minutes. [Go to section 3]

REPEAT (2.0)

READ: I would like to repeat the questions from the previous survey now to make sure {*CHILDName}* qualifies for this study.

EVER_ASTH (2.1) **Have you ever been told by a doctor or other health professional that {*CHILDName}* 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?**

(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED

RELATION (2.3) What is your relationship to {*CHILDName*}?

(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 {*CHILDName*}**

(1) YES
(2) NO
(7) DON'T KNOW
(9) REFUSED

READ: {*CHILDName*} does qualify for this study, I'd like to continue unless you have any questions.

[If YES to 2.2 read:]

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

[If NO to 2.2 read:]

Since *{CHILDName}* 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 *{CHILDName}* has asthma now, your interview will probably last about 10 minutes. [Go to section 3]

TERMINATE:
Upon survey termination, READ:

I'm sorry {*CHILDName*} does not qualify for this study. I'd like to thank you on behalf of the {*STATE*} 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 {*1–800-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.

Appendix B:
Language for Identifying Most Knowledgeable Person at the Call-back

Consent scripts for use during BRFSS 2011 Child asthma module when the most knowledgeable adult is identified at the call-back interview.

Child asthma module:

If BRFSS respondent indicates that the randomly selected child has ever had asthma then arrange for a call-back interview.

Only respondents who are the parent/guardian of the selected child with asthma are eligible for the child asthma call-back interview. This is required because the parent/guardian must give permission to collect information about the child even if the information is being given by someone else.

CATI: (RCSRELN1 = 1 or 3 and CASTHDX2 = 1 "yes")

READ: **We would like to call again within the next 2 weeks to talk in more detail about your child's experiences with asthma. The information will be used to help develop and improve the asthma programs in {*state name*}.**

ADULTPERM

Would it be all right if we call back at a later time to ask additional questions about your child's asthma?

(1) Yes
(2) No (GO TO BRFSS closing or next module)

(7) Don't know/Not Sure (GO TO BRFSS closing or next module)
(9) Refused (GO TO BRFSS closing or next module)

CHILDName

Can I please have your child's first name, initials or nickname so we can ask about the right child when we call back? This is the *{#}* year old child which is the {*FIRST CHILD, SECOND, ETC.*} CHILD.

[CATI: If more than one child, show child age *{#}*and which child was selected (*FIRST, SECOND, ETC.*) from child selection module]

Enter child's first name, initials or nickname: _______

ADULTName

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

Enter respondent's first name, initials or nickname: _____

CBTIME: **What is a good time to call you back? For example, evenings, days, weekends**?

Enter day/time: _____

READ: The information you gave us today and will give us when we call back will be kept confidential. We will keep identifying information like your child's name and your name and phone number on file, separate from the answers collected today. Even though you agreed today, you may refuse to participate in the future.

[CATI: If state requires active linking consent continue, if not, go to BRFSS closing or next module]

LINKING CONSENT

READ: Some of the information that you shared with us today could be useful when combined with the information we will ask for during your child's asthma interview. If the information from the two interviews is combined, identifying information such as your phone number, your name, and your child's name will not be included.

PERMISS: May we combine your answers from today with your answers from the interview about your child's asthma that will be done in the next two weeks?

(1) Yes (GO TO BRFSS closing or next module)
(2) No (GO TO BRFSS closing or next module)

(7) Don't Know (GO TO BRFSS closing or next module)
(9) Refused (GO TO BRFSS closing or next module)

Introduction and consent sections for use during the Child Asthma Call-Back when the most knowledgeable adult is identified at call-back interview:

[CATI: CHILDName, ADULTName, ALTName, MKPName, CASTHDX2, and CASTHNO2, RCSGENDR, calculated child's age, are from the BRFSS child asthma module and must be carried to the asthma call-back]

[CATI: BRFSS Respondent's SEX also should be carried to the Asthma call-back]

[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 {*STATE NAME*} health department and the Centers for Disease Control and Prevention about an asthma study we are doing in your state.

ALTERNATE (no reference to asthma):

Hello, my name is _____. I'm calling on behalf of the *{STATE NAME}* health department and the Centers for Disease Control and Prevention about a health study we are doing in your state.

1.1 Are you {*ADULTName*}?

(1) Yes (go to 1.5 READ)
(2) No

1.2 May I speak with {*ADULTName*}?

(1) Yes (go to 1.4 READ when person comes to phone)
(2) Person not available

1.3 When would be a good time to call back and speak with *{ADULTName}*. For example, evenings, days, weekends?

Enter day/time: _____

READ: Thank you we will call again later to speak with *{ADULTName}*.
[CATI: Start over at introduction at next call.]

ADULTName comes to the phone:

1.4 READ: Hello, my name is _____. I'm calling on behalf of the {*STATE*} state health department and the Centers for Disease Control and Prevention about an asthma study we are doing in your state. (GO TO 1.5)

ALTERNATE (no reference to asthma):

Hello, my name is _____. I'm calling on behalf of the {*STATE*} state health department and the Centers for Disease Control and Prevention about a health study we are doing in your state.

1.5 READ: During a recent phone interview you gave us permission to call again to ask some questions about {*CHILDName*}'s asthma.

ALTERNATE (no reference to asthma):

During a recent phone interview you gave us permission to call again to ask some questions about {*CHILDName*}'s health.

KNOWMOST: **Are you the parent or guardian in the household who knows the most about {*CHILDName*}'s asthma?**

(1) YES (GO TO SECTION 2: Informed consent)
(2) NO

(7) DON'T KNOW/NOT SURE
(9) REFUSED

ALTPRESENT: **If the parent or guardian who knows the most about {*CHILDName*}'s asthma is present, may I speak with that person now?**

(1) YES [respondent transfers phone to alternate] GO TO READ ALTERNATE ADULT:
(2) Person is not available

(7) DON'T KNOW/NOT SURE [GO TO TERMINATE]
(9) REFUSED [GO TO TERMINATE]

ALTName **Can I please have the first name, initials or nickname of the person so we can call back and ask for them by name?**

Alternate's Name:_____

ALTCBTime**:**

When would be a good time to call back and speak with *{ALTName}*. For example, evenings, days, weekends?

Enter day/time: _____ **[CATI: AT NEXT CALL START AT 1.6]**

READ ALTERNATE ADULT:

Hello, my name is _____. I'm calling on behalf of the *{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 *{ADULTName}* indicated {he/she} would be willing to participate in

this study about *{CHILDName}'s* asthma. *{ADULTName}* has now indicated that you are more knowledgeable about *{CHILDName}'s* asthma. It would be better if you would complete this interview. {Should we allow the alternate to hand it back to the original person or even someone else? We could find ourselves in an infinite loop.}

I will not ask for your name, address, or other personal information that can identify you or *{CHILDName}*. Any information you give me will be confidential. If you have any questions, I can provide a telephone number for you to call to get more information.

[GO TO SECTION 2]

1.6 Hello, my name is _____. I'm calling on behalf of the {*STATE NAME*} state health department and the Centers for Disease Control and Prevention about an asthma study we are doing in your state.

ALTERNATE (no reference to asthma):

Hello, my name is _____. I'm calling on behalf of the {*STATE NAME*} state health department and the Centers for Disease Control and Prevention about a health study we are doing in your state.

1.7 Are you {*ALTName*}?

(1) Yes (go to 1.10 READ ALT 1)
(2) No

1.8 May I speak with {*ALTName*}?

(1) Yes (go to 1.11 READ ALT 2 when person comes to phone)
(2) Person not available

1.9 When would be a good time to call back and speak with *{ALTName}*. For example, evenings, days, weekends?

Enter day/time: _____

READ: **Thank you we will call again later to speak with *{ALTName}*.**
[CATI: Start over at 1.6 at next call.]

1.10 READ ALT 1

During a recent phone interview *{ADULTName}* indicated *{CHILDName}* had asthma and that you were more knowledgeable about *{his/her}* asthma. It would be better if you would complete this interview about *{CHILDName}*.

I will not ask for your name, address, or other personal information that can identify you or *{CHILDName}*. 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.

[GO TO SECTION 2]

1.11 READ ALT 2:

Hello, my name is _____. I'm calling on behalf of the *{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 *{ADULTName}* indicated *{CHILDName}* had asthma and that you were more knowledgeable about *{his/her}* asthma. It would be better if you would complete this interview about *{CHILDName}*.

I will not ask for your name, address, or other personal information that can identify you or *{CHILDName}*. 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.

[GO TO SECTION 2]

Section 2. Informed Consent

INFORMED CONSENT

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

{*CHILDName*} was selected to participate in this study about asthma because of responses to questions about his or her asthma in a prior survey.

[If responses for sample child were "yes" (1) to CASTHDX2 and "no" (2) to CASTHNO2 in core BRFSS interview:]

READ: **The answers to asthma questions during the earlier survey indicated that a doctor or other health professional said that {*CHILDName}* 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 {*CHILDName}* no longer has asthma, your interview will be very brief (about 5 minutes). [Go to section 3]

[If responses for sample child were "yes" (1) CASTHDX2 to and "yes" (1) to CASTHNO2 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 {*CHILDName}* had asthma sometime in his or her life, and that {*CHILDName}* 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. [Go to section 3]

REPEAT (2.0)

I would like to repeat the questions from the previous survey now to make sure {*CHILDName}* qualifies for this study.

EVER_ASTH (2.1) **Have you ever been told by a doctor or other health professional that {*CHILDName}* 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?**

(1) YES
(2) NO

(7) DON'T KNOW
(9) REFUSED

RELATION (2.3) **What is your relationship to** {***CHILDName}***?

(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 {*CHILDName*}**

(1) YES
(2) NO
(7) DON'T KNOW
(9) REFUSED

READ: **{*CHILDName*} does qualify for this study.**

[If YES to 2.2 read:]
Since *{CHILDName}* does have asthma now, your interview will last about 15 minutes. [Go to section 3]

[If NO to 2.2 read:]
Since *{CHILDName}* 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 *{CHILDName}* has asthma now, your interview will probably last about 10 minutes. [Go to section 3]

TERMINATE:
Upon survey termination, READ:

> **I'm sorry {*CHILDName*} does not qualify for this study. I'd like to thank you on behalf of the {*STATE*} 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 {*1–800-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.**

Appendix C:
Coding Notes and Pronunciation Guide

Coding Notes:

1) MISDIAGNOSIS NOTE: If, during the survey, the interviewer discovers that the respondent never really had asthma because it was a misdiagnosis, then assign disposition code "**4471** Resp. was misdiagnosed; never had asthma" as a final code and terminate the interview.

2) BACKCODE SYMPFREE (4.4) TO 14 IF LASTSYMP (3.5) = 88 (never) or = 04, 05, 06, or 07 OR IF SYMP_30D = 88. THIS WILL BE DONE BY BSB.

3) CATI Programmer's note: For the Other in the medications (in INH_MEDS, PILLS_MD, SYRUP_ID or NEB_ID. If "Other" has one of the following misspellings then a menu choice should have been made. Code for this and correct:

Medication	Common misspelling in "Other"
Zyrtec	Zertec, Zertek or Zerteck
Allegra	Alegra, Allegra or Allegra D
Claritin	Cleraton, Cleritin or Claritin D
Singulair	Singular, Cingulair or Cingular
Xopenex	Zopanox or Zopenex
Advair Diskus	Advair or Diskus
Albuterol	Aluterol Sulfate
Maxair	Maxair Autohaler

Pronunciation Guide:

The following is a pronunciation guide. The top ten medications are shown bolded. Audio files are available from the BRFSS coordinator' upload/download site.

INH_MEDS

	Medication	Pronunciation
01	**Advair**	**ăd**-vâr (or **add**-vair)
02	Aerobid	â-**rō**'bĭd (or **air**-row-bid)
03	**Albuterol** (+ A. sulfate or salbutamol)	ăl'-**bu**'ter-ōl (or al-**BYOO**-ter-ole) săl-byū'tə-môl'
04	Alupent	**al**-u-pent
40	Asmanex (twisthaler)	**as**-m*uh*-neks **twist**-hey-ler
05	**Atrovent**	At-ro-vent
06	**Azmacort**	**az**-ma-cort
07	Beclomethasone dipropionate	bek"lo-**meth**'ah-son dī' **pro'**pe-o-nāt (or be-kloe-**meth**-a-sone)
08	Beclovent	be' klo-vent" (or **be**-klo-vent)
09	Bitolterol	bi-tōl'ter-ōl (or bye-**tole**-ter-ole)
10	Brethaire	**breth**-air
11	Budesonide	byoo-**des**-oh-nide

12	**Combivent**	**com**-bi-vent
13	Cromolyn	**kro'**mŏ-lin (or **KROE**-moe-lin)
14	**Flovent**	**flow**-vent
15	Flovent Rotadisk	**flow**-vent **row**-ta-disk
16	Flunisolide	floo-**nis**'o-līd (or floo-**NISS**-oh-lide)
17	Fluticasone	flue-**TICK**-uh-zone
34	Foradil	*FOUR-a-dil*
35	Formoterol	for moh' te rol
18	Intal	**in**-tel
19	Ipratropium Bromide	ĭp-rah-**tro**'pe-um bro'mīd (or ip-ra-**TROE**-pee-um)
37	Levalbuterol tartrate	**lev-al-BYOU-ter-ohl**
20	Maxair	**măk**-sâr
21	Metaproteronol	met"ah-pro-**ter'**ĕ-nōl (or met-a-proe-**TER**-e-nole)
39	Mometasone furoate	**moe-MET-a-sone**
22	Nedocromil	ne-DOK-roe-mil
23	Pirbuterol	pēr-**bu**'ter-ōl (or peer-**BYOO**-ter-ole)
41	Pro-Air HFA	**proh-air HFA**
24	**Proventil**	pro"**ven**-til' (or pro-**vent**-il)
25	**Pulmicort Flexhaler**	**pul**-ma-cort **flex**-hail-er
36	**QVAR**	**q** -vâr (or q-vair)
03	Salbutamol (or Albuterol)	săl-byū'tə-môl'
26	Salmeterol	sal-ME-te-role
27	**Serevent**	**Sair**-a-vent
42	Symbicort	**sim**-b*uh*-kohrt
28	Terbutaline (+ T. sulfate)	ter-**bu'**tah-lēn (or ter-**BYOO**-ta-leen)
29	Tilade	**tie**-laid
30	Tornalate	**tor**-na-late
31	Triamcinolone acetonide	tri"am-**sin**'o-lōn as"ĕ-tō-nīd' (or trye-am-**SIN**-oh-lone)
32	Vanceril	**van**-sir-il
33	Ventolin	**vent**-o-lin
38	Xopenex HFA	*ZOH-pen-ecks*

PILLS_MED

	Medication	Pronunciation
01	**Accolate**	**ac**-o-late
02	Aerolate	**air**-o-late
03	**Albuterol**	ăl'-**bu**'ter-ōl (or al-**BYOO**-ter-all)
04	Alupent	**al**-u-pent
49	Brethine	**breth-een**
05	Choledyl (oxtriphylline)	**ko**-led-il
07	Deltasone	**del**-ta-sone
08	Elixophyllin	e-licks-**o**-fil-in
11	Medrol	**Med**-rol
12	Metaprel	**Met**-a-prell
13	Metaproteronol	met"ah-pro-**ter**'ĕ-nōl (or met-a-proe-**TER**-e-nole)
14	Methylpredinisolone	meth-ill-pred-**niss**-oh-lone (or meth-il-pred-**NIS**-oh-lone)
15	**Montelukast**	mont-e-**lu**-cast
17	Pediapred	Pee-**dee**-a-pred
18	**Prednisolone**	pred-NISS-oh-lone
19	**Prednisone**	PRED-ni-sone
21	Proventil	pro-**ven**-til
23	Respid	**res**-pid
24	**Singulair**	**sing**-u-lair
25	Slo-phyllin	**slow**- fil-in
26	Slo-bid	**slow**-bid
48	Terbutaline (+ T. sulfate)	ter byoo' ta leen
28	Theo-24	**thee**-o-24
30	Theochron	**thee** -o-kron
31	Theoclear	**thee**-o-clear
32	**Theodur**	**thee**-o-dur
33	**Theo-Dur**	**thee**-o-dur
35	**Theophylline**	thee-**OFF**-i-lin
37	Theospan	**thee**-o-span
40	T-Phyl	**t**-fil
42	**Uniphyl**	**u**-ni-fil
43	Ventolin	**vent**-o-lin
44	Volmax	**vole**-max
45	Zafirlukast	za-**FIR**-loo-kast
46	Zileuton	zye-**loo**-ton
47	Zyflo Filmtab	**zye**-flow **film** tab

SYRUP_ID

	Medication	Pronunciation
01	Aerolate	**air**-o-late
02	Albuterol	ăl'-**bu**'ter-ōl (or al-BYOO-ter-ole)
03	Alupent	**al**-u-pent
04	Metaproteronol	met"ah-pro-**ter**'ĕ-nōl (or met-a-proe-TER-e-nole)
05	Prednisolone	pred-NISS-oh-lone
06	Prelone	**pre**-loan
07	Proventil	Pro-**ven**-til
08	Slo-Phyllin	**slow**-fil-in
09	Theophyllin	thee-OFF-i-lin
10	Ventolin	**vent**-o-lin

NEB_ID

	Medication	Pronunciation
01	Albuterol	ăl'-**bu'**ter-ōl (or al-BYOO-ter-ole)
02	Alupent	**al**-u-pent
03	Atrovent	At-ro-vent
04	Bitolterol	bi-tōl'ter-ōl (or bye-**tole**-ter-ole)
05	Budesonide	byoo-**des**-oh-nide
06	Cromolyn	**kro**'mŏ-lin (or KROE-moe-lin)
07	DuoNeb	DUE-ow-neb
08	Intal	**in**-tel
09	Ipratroprium bromide	ĭp-rah-**tro**'pe-um bro'mīd (or ip-ra-**TROE**-pee-um)
10	Levalbuterol	lev al byoo' ter ol
11	Metaproteronol	met"ah-pro-**ter'**ĕ-nōl (or met-a-proe-TER-e-nole)
12	Proventil	Pro-**ven**-til
13	Pulmicort	**pul**-ma-cort
14	Tornalate	**tor**-na-late
15	Ventolin	**vent**-o-lin
16	Xopenex	*ZOH-pen-ecks*

Attachment 6
Transmittal Letter

[TO BE COMPLETED ON BIDDER'S LETTERHEAD]

Date:	Bidder Phone No.:
Bidder Name:	Bidder Fax No.:
Bidder Address:	Bidder Contact E-mail Address:
Federal Employee Identification Number:	NYS SFS Vendor ID #:

Vendor RFP Designated Contact Person: *<bidder representative for RFP response>*
Vendor RFP Designated Contact Details: *<address [if different from above], telephone(s), fax, email>*

[Insert Bidder's complete name and address, including the name, mailing address, email address, fax number and telephone number for both the authorized signatory and the person to be contacted regarding the proposal] submits this firm and binding offer to the Department in response to the above- referenced RFP and agrees as follows:

1. Bidder provides the following statement which describes the legal structure of the entity submitting the proposal: **[Insert Bidder's Response];**

2. Bidder accepts the contract terms and conditions contained in this RFP, including any exhibits and attachments;

3. Bidder acknowledges receipt of all Department amendments to this RFP, as may be amended;

4. Bidder (i) does not qualify its proposal, or include any exceptions from the RFP and (ii) acknowledges that should any alternative proposals or extraneous terms be submitted with the proposal, such alternate proposals or extraneous terms will not be evaluated by the Department;

5. Bidder agrees that the proposal and all provisions of the proposal will remain valid for minimum of 365 calendar days from the closing date for submission of proposals;

6. Bidder certifies:

    a. That there are business relationships and/or ownership interests for the above named organization that may represent a conflict of interest for the organization as bidder, as described in the RFP. Attached to this letter is a description of how the potential conflict of interest and/or disclosure of confidential information relating to this contract will be avoided; **OR**

    b. That no conflict of interest relationship exists for the above named organization as bidder

7. Bidder is/is not [indicate one] proposing to utilize the services of any subcontractor(s). If a proposal is submitted which proposes to utilize the services of a subcontractor(s), the bidder provides, in an Appendix to this Transmittal Letter, a subcontractor summary for each listed subcontractor and certifies that the information provided is complete and accurate.

The summary document for each listed subcontractor should contain the following information:

   a. Complete name of the subcontractor;

   b. Complete address of the subcontractor;

   c. A general description of the scope of work to be performed by the subcontractor;

   d. Percentage of work the subcontractor will be providing;

   e. A statement confirming that the subcontractor is prepared, if requested by the Department, to present evidence of legal authority to do business in New York State, subject to the sole satisfaction of the Department; and

   f. The subcontractor's assertion that it does not discriminate in its employment practices with regards to race, color, religion, age (except as provided by law) sex, marital status, political affiliation, national origin, or handicap.

8. Bidder attests that they have the ability to and will have under the contract, if awarded, the call center located and operated within the continental United States.

The undersigned individual affirms and represents that he/she has the legal authority and capacity to sign and submit this bid on behalf of **[Insert Bidder's Name]** as well as to execute a contract with the Department.

Signature of Authorized Official:

_____

Printed Name of Authorized Official:

Date:

Attachment 7

Bid Price Cost Proposal
Part A - NYS BRFSS /Asthma Call Back Survey

Instructions: Please provide bids for the cost per completed interview for landline interviews and cost per completed interview for cell phone interviews for the annual NYS BRFSS and cost per completed interview for landline and cell phone interviews for the asthma call back survey. All costs associated with advance preparation for conducting the interviews and other ongoing expenses should be factored into these costs per completed interview. Costs for subsequent years over the amount quoted will be increased or decreased per the price adjustment clause, Section F. 5 Payment.

Annual payment will be reduced by the percentage of completed landline and/or cell phone interviews below landline/cell phone goal established prior to the survey start date, see Section F. 5 Payment.

Note: DOH does not guarantee current or future utilization. Actual numbers may be higher or lower.

NYSDOH - Behavioral Risk Factor Surveillance System, RFP # 16526

Bidder Name:_____

Year One Anticipated (January – December 2017)	Annual NYS BRFSS	Price Per Completed Interview
Landline	Per completed interview price for up to 5,500 completed landline interviews	$_____
	Per completed interview price for 5,501 or above completed landline interviews	$_____
Cell Phone	Per completed interview price for up to 4,500 completed cell phone interviews	$_____
	Per completed interview price for 4,501 or above completed cell phone interviews	$_____
	Asthma Call Back Survey	
Landline	Per completed interview price for up to of 400 completed landline interviews	$_____
	Per completed interview price for 401 or above completed landline interviews	$_____
Cell Phone	Per completed interview price for up to 350 completed cell phone interviews	$_____
	Per completed interview price for 351 or above completed cell phone interviews	$_____

Part B - NYS Expanded County Level BRFSS
Option 1 and Option 2

Instructions: Please provide bids for the cost per completed interview (Option 1 and Option 2) for landline interviews and cost per completed interview for cell phone interviews for a survey conducted at the county level, and treating New York City boroughs as county equivalents. The costs associated with advance preparation for conducting the interviews and other ongoing expenses should be factored into these costs per completed interview. All payments made to contractors will be solely based on price per completed interviews with payment beginning following the first voucher submitted for first month of data collection.

Bidders must provide bids for both Option 1 and Option 2. Option (s) may be exercised by the Department dependent on funding availability and DOH needs. The Department does not commit to exercising option 1 and/or option 2 during the life of the contract; decision will be dependent on funding availability and the department's needs.

For each Option, the annual payment will be reduced by the percentage of completed landline and/or cellphone interviews below the county level landline/cellphone goal established prior to the survey start date, see Section F. 5 Payment.

The goal number of interviews to be completed per county will be established in advance of the survey start date, to be determined.

Note: THE NYSDOH does not guarantee current or future utilization. Actual numbers may be higher or lower.

The NYSDOH does not guarantee they will exercise Option 1 and/or Option 2 during the contract term.

Bidder Name:_____

Option 1: Expanded BRFSS: The Expanded (county-level) BRFSS is expected to be conducted in 2018 or 2019 and will require additional survey activities (sampling plan development, sample order and purchase, statistical weighting, development of documentation and technical reports). Option may be exercised dependent on funding availability and DOH needs. The Department does not commit to exercising the option during the life of the contract and will be dependent on funding availability and the department's needs. Bidders are asked to complete the Bid Price Cost Proposal Form Part B, Option 1 to submit prices for the Expanded BRFSS activities:

OPTION 1 Anticipated January 1 – December 31, 2018	**NYS Expanded (County-Level) BRFSS**	**Price Per completed interview**
Landline	Per completed interview price for up to 11,000 completed landline interviews	$_____
	Per completed interview price for 11,001 or above completed landline interviews	$_____
Cell Phone	Per completed interview price for a total of 9,000 completed cell phone interviews	$_____
	Per completed interview price for 9,001 or above completed cell phone interviews	$_____

NYSDOH - Behavioral Risk Factor Surveillance System, RFP # 16526

Bidder Name:_____

Option 2: Expanded BRFSS: The Expanded (county-level) BRFSS is expected to be conducted in 2020 or 2021 and will require additional survey activities (sampling plan development, sample order and purchase, statistical weighting, development of documentation and technical reports). Option may be exercised dependent on funding availability and DOH needs. The Department does not commit to exercising the option during the life of the contract and will be dependent on funding availability and the department's needs. Bidders are asked to complete the Bid Price Cost Proposal Form Part B, Option 2 to submit prices for the Expanded BRFSS activities:

OPTION 2 Anticipated January 1 – December 31, 2018	NYS Expanded (County-Level) BRFSS	Price Per completed interview
Landline	Per completed interview price for up to 11,000 completed landline interviews	$_____
	Per completed interview price for 11,001or above completed landline interviews	$_____
Cell Phone	Per completed interview price for a total of 9,000 completed cell phone interviews	$_____
	Per completed interview price for 9,001 or above completed cell phone interviews	$_____

Attachment 8
Lobbying Form

PROCUREMENT TITLE: _____RFP # _____

Bidder Name:
Bidder Address:

Bidder Vendor ID No:
Bidder Fed ID No:

A. 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)

B. 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.

_____ _____
(Officer Signature) (Date)

_____
(Officer Title) (Telephone)

_____
(e-mail Address)

Attachment 9

NO-BID FORM

PROCUREMENT TITLE: _____RFP #_____

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 10
Vendor Responsibility Attestation

To comply with the Vendor Responsibility Requirements outlined in Section F, Administrative, 9. Vendor Responsibility Questionnaire, I hereby certify:

Choose one:

☐ An on-line Vender Responsibility Questionnaire has been updated or created at OSC's website: https://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
Encouraging Use of New York Businesses in Contract Performance

I. Background

New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the state and the nation. In recognition of their economic activity and leadership in doing business in New York State, bidders/proposers for this contract for commodities, services or technology are strongly encouraged and expected to consider New York State businesses in the fulfillment of the requirements of the contract. Such partnering may be as subcontractors, suppliers, protégés or other supporting roles.

Bidders/proposers need to be aware that all authorized users of this contract will be strongly encouraged, to the maximum extent practical and consistent with legal requirements, to use responsible and responsive New York State businesses in purchasing commodities that are of equal quality and functionality and in utilizing service and technology. Furthermore, bidders/proposers are reminded that they must continue to utilize small, minority and women-owned businesses, consistent with current State law.

Utilizing New York State businesses in State contracts will help create more private sector jobs, rebuild New York's infrastructure, and maximize economic activity to the mutual benefit of the contractor and its New York State business partners. New York State businesses will promote the contractor's optimal performance under the contract, thereby fully benefiting the public sector programs that are supported by associated procurements.

Public procurements can drive and improve the State's economic engine through promotion of the use of New York businesses by its contractors. The State therefore expects bidders/proposers to provide maximum assistance to New York businesses in their use of the contract. The potential participation by all kinds of New York businesses will deliver great value to the State and its taxpayers.

II. Required Identifying Information

Bidders/proposers can demonstrate their commitment to the use of New York State businesses by responding to the question below:

Will New York State Businesses be used in the performance of this contract?

____ ____
YES NO

If yes, identify New York State businesses that will be used and attach identifying information. Information should include at a minimum: verifiable business name, New York address and business contact information.

Business Name	**Business Address**	**Contact Name**	**Contact Phone**	**Contact Email Address**

Attachment 12
M/WBE Procurement Forms

NEW YORK STATE DOH M/WBE RFP REQUIRED FORMS

All DOH procurements have a section entitled **"MINORITY AND WOMEN OWNED BUSINESS ENTERPRISE REQUIREMENTS."** This section of procurement sets forth the established DOH goal for that particular procurement and also describes the forms that must be completed with their bid. Below is a summary of the forms used in the DOH MWBE Participation Program by a bidder.

Form #1: Bidder MWBE Utilization Plan - This document should be completed by all bidders responding to RFPs with an MWBE goal greater than zero. The bidder must demonstrate how it plans to meet the stated MWBE goal. In completing this form, the bidder should describe the steps taken to establish communication with MWBE firms and identify current or future relationships with certified MWBE firms. The second page of the form should list the MWBE certified firms that the vendor plans to engage with on the project and the amount that each certified firm is projected to be paid. Plans to work with uncertified firms or women and minority staffed firms do not meet the criteria for participation. The firm must be owned and operated by a Woman and/or Minority and must be certified by NYS Empire State Development to be eligible for participation. If the plan is not submitted or is deemed deficient**,** the bidder may be sent a notice of deficiency. It is mandatory that all awards with goals have a utilization plan on file.

Form #2: MWBE Utilization Waiver Request - This document should be filled out by the bidder if the utilization plan (Form #1) indicates less than the stated participation goal for the procurement. In this instance, Form #2 must accompany Form #1 with the bid. If Form #2 is provided and goal was initially set higher, revised goal approval will be necessary from DOB. When completing Form #2, it is important that the bidder thoroughly document the steps that were taken to meet the goal and provide evidence in the form of attachments to the document. The required attachments are listed on Form #2 and will document the good-faith efforts taken to meet the desired goal. A bidder can also attach additional evidence outside of those referenced attachments. Without evidence of good-faith efforts, in the form of attachments or other documentation, the Department of Health may not approve the waiver and the bidder may be deemed non-responsive.

New MWBE firms are being certified daily and new MWBE firms may now be available to provide products or services that were historically unavailable. If Form #2 is found by DOH to be deficient, the bidder may be sent a deficiency letter which will require a revised form to be returned within 7 business days of receipt to avoid a finding of non-compliance. DOH may work directly with firm to resolve minor deficiencies via e-mail.

Form #3: Replaced by Online Compliance System - https://ny.newnycontracts.com Contractors will need to login and submit payments to MWBE Firms in this online system once payments to these vendors commence.

Form#4 – MWBE Staffing Plan

This form should be completed based on the composition of staff working on the project. Enter the numbers or counts in the corresponding boxes and add up the totals in each column. This form is for diversity research purposes only and has no bearing on MWBE goal achievement.

Form#5 – EEO and MWBE Policy Statement

This is a standard EEO policy that needs to be signed and dated and submitted. If Bidder has their own EEO policy it may be submitted instead of endorsing this document.

- M/WBE Form #1 -

New York State Department of Health

M/WBE UTILIZATION PLAN

Bidder/Contractor Name:	
Vendor ID:	**Telephone No.** **Email:**
RFP/Contract Title:	**RFP/Contract No.**

Description of Plan to Meet M/WBE Goals

PROJECTED M/WBE USAGE

	%	**Amount**
1. Total Dollar Value of Proposal Bid	**100**	**$**
2. MBE Goal Applied to the Contract		**$**
3. WBE Goal Applied to the Contract		**$**
4. M/WBE Combined Totals		**$**

"Making false representation or including information evidencing a lack of good faith as part of, or in conjunction with, the submission of a Utilization Plan is prohibited by law and may result in penalties including, but not limited to, termination of a contract for cause, loss of eligibility to submit future bids, and/or withholding of payments. Firms that do not perform commercially useful functions may not be counted toward MWBE utilization."

New York State Department of Health
M/WBE UTILIZATION PLAN

MINORITY OWNED BUSINESS ENTERPRISE (MBE) INFORMATION

In order to achieve the MBE Goals, bidder expects to subcontract with New York State certified MINORITY-OWNED entities as follows:

MBE Firm (Exactly as Registered)	Description of Work (Products/Services) [MBE]	Projected MBE Dollar Amount
Name Address City, State, ZIP Employer I.D. Telephone Number ( ) -		$
Name Address City, State, ZIP Employer I.D. Telephone Number ( ) -		$
Name Address City, State, ZIP Employer I.D. Telephone Number ( ) -		$

New York State Department of Health
M/WBE UTILIZATION PLAN

WOMEN OWNED BUSINESS ENTERPRISE (WBE) INFORMATION

In order to achieve the WBE Goals, bidder expects to subcontract with New York State certified WOMEN-OWNED entities as follows:

WBE Firm (Exactly as Registered)	Description of Work (Products/Services) [WBE]	Projected WBE Dollar Amount
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$** _____
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$** _____
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$** _____

- M/WBE Form #2 -

New York State Department of Health

Waiver Request

Offeror/Contractor Name: Click here to enter text.	**Federal Identification No.:** Click here to enter number.
Address: Click here to enter text.	**Solicitation/Contract No.:** Click here to enter number.
City, State, Zip Code: Click here to enter text.	**M/WBE Goal: MBE** %%**% WBE** %%**%** (From Lines 2 and 3 from Form #1)

By submitting this form and the required information, the officer or/contractor certifies that every Good Faith Effort has been taken to promote M/WBE participation pursuant to the M/WBE requirements set forth under the contract.

Contractor is requesting a:

☐MBE Waiver – A waiver of the MBE Goal for this procurement is requested. Total Partial

☐WBE Waiver – A waiver of the WBE Goal for this procurement is requested. Total Partial

☐ **Waiver Pending ESD Certification** – (Check here if subcontractors or suppliers of Contractor are not certified M/WBE, but an application for certification has been filed with Empire State Development.)

Date of such filing with Empire State Development: Click here to enter a date.

_____ _____

PREPARED BY (Signature) **Date:**

SUBMISSION OF THIS FORM CONSTITUTES THE OFFEROR/CONTRACTOR'S ACKNOWLEDGEMENT AND AGREEMENT TO COMPLY WITH THE M/WBE REQUIREMENTS SET FORTH UNDER NYS EXECUTIVE LAW, ARTICLE 15-A AND 5 NYCRR PART 143. FAILURE TO SUBMIT COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A FINDING OF NONCOMPLIANCE AND/OR TERMINATION OF THE CONTRACT.

Name and Title of Preparer (Printed or Typed):	**Telephone Number:**	**Email Address:**

Submit with the bid or proposal or if submitting after award submit to:
doh.sm.mwbe@health.ny.gov

********** FOR DMWBD USE ONLY **********

REVIEWED BY:	**DATE:**

Waiver Granted: ☐YES ☐NO

MBE: ☐ WBE: ☐

☐Total Waiver **☐Partial Waiver**

☐ESD Certification Waiver

☐*Conditional

☐Notice of Deficiency Issued

_____

***Comments:**

- M/WBE Form #4 -

New York State Department of Health
M/WBE STAFFING PLAN

For project staff, consultants and/or subcontractors working on this grant complete the following plan. This has no impact on MWBE utilization goals, or the submitted Utilization Plan - Form#1. This is for diversity research purposes.

Contractor Name_____

Address_____

_____

STAFF	Total	Male	Female	Black	Hispanic	Asian/ Pacific Islander	Other
Executive/Senior level Officials							
Managers/Supervisors							
Professionals							
Technicians							
Administrative Support							
Craft/Maintenance Workers							
Laborers and Helpers							
Service Workers							
Totals							

_____
(Name and Title)

_____
(Signature)

_____
Date

- M/WBE Form #5 –

MINORITY AND WOMEN-OWNED BUSINESS ENTERPRISES – EQUAL EMPLOYMENT OPPORTUNITY POLICY STATEMENT

M/WBE AND EEO POLICY STATEMENT

I, _____, the (awardee/contractor)_____ agree to adopt the following policies with respect to the project being developed or services rendered at

_____

M/WBE

This organization will and will cause its contractors and subcontractors to take good faith actions to achieve the M/WBE contract participations goals set by the State for that area in which the State-funded project is located, by taking the following steps:

Actively and affirmatively solicit bids for contracts and subcontracts from qualified State certified MBEs or WBEs, including solicitations to M/WBE contractor associations.
Request a list of State-certified M/WBEs from AGENCY and solicit bids from them directly.
Ensure that plans, specifications, request for proposals and other documents used to secure bids will be made available in sufficient time for review by prospective M/WBEs.
Where feasible, divide the work into smaller portions to enhanced participations by M/WBEs and encourage the formation of joint venture and other partnerships among M/WBE contractors to enhance their participation.
Document and maintain records of bid solicitation, including those to M/WBEs and the results thereof. Contractor will also maintain records of actions that its subcontractors have taken toward meeting M/WBE contract participation goals.
Ensure that progress payments to M/WBEs are made on a timely basis so that undue financial hardship is avoided, and that bonding and other credit requirements are waived or appropriate alternatives developed to encourage M/WBE participation.

_____
Name & Title

_____
Signature & Date

EEO

(a) This organization will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing programs of affirmative action to ensure that minority group members are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on state contracts.

(b)This organization shall state in all solicitation 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 disability or marital status.

(c) At the request of the contracting agency, this organization shall request each employment agency, labor union, or authorized 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 this organization's obligations herein.

(d) Contractor shall comply with the provisions of the Human Rights Law, all other State and Federal statutory and constitutional non-discrimination provisions. Contractor and subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

(e) This organization will include the provisions of sections (a) through (d) of this agreement in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each subcontractor as to work in connection with the State contract.

DETAILED MWBE FORMS INSTRUCTIONS
Miscellaneous Specific

Form#1 – MWBE Utilization Plan

Page#1 of Form#1:

Description of Plan - Describe any steps/details that support Bidder/Contractor plan to meet the MWBE goals stated in the procurement/contract.

Line#1 - **Total Dollar Value of Proposal Bid –** This line should represent the total dollar amount of bid. The total value is eligible for MWBE goal setting.

Line#2 - MBE Goal Applied to the Contract– Bidder/Contractor lists the amount to be paid/subcontracted to Certified Minority-owned Business Enterprise(s) and the percentage this amount represents of the Total Dollar Value of Proposal Bid listed on Line #1.

Example: If paying two MBE firms $100,000 & $50,000 each and Total Dollar Value of Proposal Bid listed on line#1 is $1,000,000 list 15% and $150,000 on Line#2.

Line#3 - WBE Goal Applied to the Contract– Bidder/Contractor lists the amount to be paid to a Certified Woman-owned Business Enterprise and states the percentage this amount is of the Total Value listed on Line #1.

Example: If Bidder/Contractor is paying two WBE firms $50,000 & $100,000 each and the Total Dollar Value of Proposal Bid listed on line#1 is $1,000,000 Bidder/Contractor would list 15% and $150,000 on Line#2 of the Utilization Plan.

Line#4 - **MWBE Combined totals -** Bidder/Contractor totals Line #2 and Line #3 for both Percentage and Amount to state the Combined M&W percentages and Combined M&W amount.

Example: Using the above Line #2 and Line #3 examples for payment data, Bidder/Contractor achieves a combined MWBE % of 30% and a combined MWBE amount of $300,000. (15%M and 15%W; $150,000M + $150,000W). MWBE combined Total/Total Dollar Value Eligible = the MWBE % (300,000/1,000,000 = 30%).

Page#2 of Form#1:

The first column (left column): Bidder/Contractor lists any Minority-owned Business Enterprises (MBE) that Bidder/Contractor is subcontracting with or purchasing from and the MBE contact/company information.

The second column (center column): Bidder/Contractor describes what type of work certified MBE will be providing or what product certified MBE will be supplying to Bidder/Contractor.

The third column (right column): Bidder/Contractor states the amount to be paid to the certified MBE during the term of the contract. The amount totaled from Page #2 should equal the amount listed on Line#2 of Page#1.

Page#3 of Form#1:

The first column (left column)**:** Bidder/Contractor lists any Woman-owned Business Enterprises (WBE) that Bidder/Contractor will be subcontracting with or purchasing from and WBE contact/company information.

The second column (center column): Bidder/Contractor describes what type of work certified WBE will be providing or what product certified WBE will be supplying to Bidder/Contractor.

Third column (right column): Bidder/Contractor states the amount to be paid to the certified WBE during the term of the contract. The amount totaled from Page#3 should equal the amount listed on Line#3 of Page#1.

Form#2 – MWBE Utilization Waiver Request

"Form#1 MWBE Utilization Plans" that commit to a goal % less than the stated MWBE goal percentage in procurement must be accompanied by a "Form#2 MWBE Utilization Waiver Request". A Bidder/Contractor may qualify for a partial or total waiver of the MWBE goal requirements established on a State contract only upon the submission of a waiver form by a Bidder/Contractor, documenting good-faith efforts by the Contractor to meet the goal requirements of the state contract and a consideration of applicable factors. The ability to subcontract with M/WBEs and separately the ability to purchase from M/WBEs must be addressed in attachments on all waiver requests.

Fill out the header with the name of the Bidder/Contractor requesting the waiver under Offeror/Contractor Name, include your Federal Identification ID, Address, Solicitation/Contract Number, and M/WBE Goals. Check off the appropriate box for the type of waiver that is being requested and whether it is a total or partial waiver. If the Waiver is Pending ESD Certification, meaning the subcontractor has applied for certification with Empire State Development, check off that box and state the date that they applied for certification. Directly below the Pending ESD Certification area, sign and date the waiver. Provide the name of the preparer as well as a telephone number and email address (Bidder/Contractor direct contact number of person authorized to discuss submission).

The following attachments should be provided:

1. A statement setting forth your basis for requesting a partial or total waiver. The statement should at a minimum include the services being subcontracted out and why a portion of those services cannot be subcontracted to certified MWBE(s). In addition, statement must also include what purchases of equipment and supplies are being made and why those purchases cannot be provided by certified MWBE(s).

2. The names of general circulation, trade association, and M/WBE-oriented publications in which you solicited certified M/WBEs for the purposes of complying with your participation goals related to this contract.

3. A list identifying the date(s) that all solicitations for certified M/WBE participation were published in any of the above publications.

4. A list of all certified M/WBEs appearing in the NYS Directory of Certified Firms that were solicited for purposes of complying with your certified M/WBE participation levels.

5. Copies of notices, dates of contact, letters, and other correspondence as proof that solicitations were made in writing and copies of such solicitations, or a sample copy of the solicitation if an identical solicitation was made to all certified M/WBEs.

6. Provide copies of responses to your solicitations received by you from certified M/WBEs.

7. Provide a description of any contract documents, plans, or specifications made available to certified M/WBEs for purposes of soliciting their bids and the date and manner in which these documents were made available.

8. Provide documentation of any negotiations between you, the Bidder/Contractor, and the M/WBEs undertaken for purposes of complying with the certified M/WBE participation goals.

9. Provide any other information you deem relevant which may help us in evaluating your request for a waiver.

*** All attachments are created by the entity requesting the waiver. These are self-generated attachments and are not provided by the agency.**

Attachment 13

Sample Contract Language and Appendices

MISCELLANEOUS / CONSULTANT SERVICES

STATE AGENCY (Name and Address):
Department of Health
Corning Tower
Albany, NY 12237

NYS COMPTROLLER'S NUMBER: C#

ORIGINATING AGENCY GLBU: DOH01
DEPARTMENT ID: 345XXXX (Use unit ID)

CONTRACTOR (Name and Address):

TYPE OF PROGRAM(S):

CHARITIES REGISTRATION NUMBER:

CONTRACT TERM
FROM:
TO:

CONTRACTOR HAS ( ) HAS NOT ( ) TIMELY FILED WITH THE ATTORNEY GENERAL'S CHARITIES BUREAU ALL REQUIRED PERIODIC OR ANNUAL WRITTEN REPORTS

FUNDING AMOUNT FOR CONTRACT TERM:

FEDERAL TAX IDENTIFICATION NUMBER:

STATUS:
CONTRACTOR IS ( ) IS NOT ( ) A SECTARIAN ENTITY

NYS VENDOR IDENTIFICATION NUMBER:

MUNICIPALITY NO. (if applicable)

CONTRACTOR IS ( ) IS NOT ( ) A NOT-FOR-PROFIT ORGANIZATION
CONTRACTOR IS ( ) IS NOT ( ) A N Y STATE BUSINESS ENTERPRISE

( ) IF MARKED HERE, THIS CONTRACT IS RENEWABLE FOR ___ ADDITIONAL ONE-YEAR PERIOD(S) AT THE SOLE OPTION OF THE STATE AND SUBJECT TO APPROVAL OF THE OFFICE OF THE STATE COMPTROLLER.

BID OPENING DATE:

APPENDICES ATTACHED AND PART OF THIS AGREEMENT
Precedence shall be given to these documents in the order listed below.

X APPENDIX A Standard Clauses as required by the Attorney General for all State Contracts.
X APPENDIX X Modification Agreement Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods)
X STATE OF NEW YORK AGREEMENT
X APPENDIX D General Specifications
X APPENDIX B Request For Proposal (RFP)
X APPENDIX C Proposal
X APPENDIX E-1 Proof of Workers' Compensation Coverage
X APPENDIX E-2 Proof of Disability Insurance Coverage
__ APPENDIX H Federal Health Insurance Portability and Accountability Act Business Associate Agreement
X APPENDIX G Notices
X APPENDIX M Participation by Minority Group Members and Women with respect to State Contracts: Requirements and Procedures

Contract No.: C#

IN WITNESS THEREOF, the parties hereto have executed or approved this AGREEMENT on the dates below their signatures.

CONTRACTOR	STATE AGENCY
By:_____	By:_____
Printed Name	Printed Name
Title:_____	Title: _____
Date:_____	Date:_____
	State Agency Certification: "In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract."

STATE OF NEW YORK)
)SS.:
County of _____)

On the ___ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
(Signature and office of the individual taking acknowledgement)

ATTORNEY GENERAL'S SIGNATURE	STATE COMPTROLLER'S SIGNATURE
Title:_____	Title:_____
Date:_____	Date:_____

GLBU: DOH01APPENDIX X

Contract Number:_____ Contractor:_____

Amendment Number X-_____ BSC Unit ID: _3450000_____

This is an AGREEMENT between THE STATE OF NEW YORK, acting by and through NYS Department of Health, having its principal office at Albany, New York, (hereinafter referred to as the STATE), and _____ (hereinafter referred to as the CONTRACTOR), for amendment of this contract.

This amendment makes the following changes to the contract (check all that apply):

_____ Modifies the contract period at no additional cost

_____ Modifies the contract period at additional cost

_____ Modifies the budget or payment terms

_____ Modifies the work plan or deliverables

_____ Replaces appendix(es) _____ with the attached appendix(es)_____

_____ Adds the attached appendix(es) _____

_____ Other: (describe) _____

This amendment *is*__ *is not*__ a contract renewal as allowed for in the existing contract.

All other provisions of said AGREEMENT shall remain in full force and effect.

Additionally, Contractor certifies that it is not included on the prohibited entities list published at http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf as a result of the Iran Divestment Act of 2012 (Act), Chapter 1 of the 2012 Laws of New York. Under the Act, the Commissioner of the Office of General Services (OGS) has developed a list (prohibited entities list) of "persons" who are engaged in "investment activities in Iran" (both are defined terms in the law). Contractor (or any assignee) also certifies that it will not utilize on such Contract any subcontractor that is identified on the prohibited entities list.

Prior to this amendment, the contract value and period were:

$_____ From ___/___/___ to ___/___/___.
(Value before amendment) (Initial start date)

This amendment provides the following modification (complete only items being modified):

$_____ From ___/___/___ to ___/___/___.

This will result in new contract terms of:

$ _____ From ___/___/___ to ___/___/___.
(All years thus far combined) (Initial start date) (Amendment end date)

Revised 6/3/2013

Signature Page for:

Contract Number:__________ Contractor:_________________________

Amendment Number: X-_____ BSC Unit ID: _3450000_______

_ _

IN WITNESS WHEREOF, the parties hereto have executed this AGREEMENT as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE:

By:________________________________ Date: _________________________

(signature)

Printed Name:______________________________________

Title:____

STATE OF NEW YORK)
) SS:
County of ____________)

On the ___ day of ___________ in the year ______ before me, the undersigned, personally appeared ___________________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

____

(Signature and office of the individual taking acknowledgement)

_ _

STATE AGENCY SIGNATURE

"In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract."

By:________________________________ Date:______________________________

(signature)

Printed Name:______________________________________

Title:____

_ _

ATTORNEY GENERAL'S SIGNATURE

By:________________________________ Date:______________________________

STATE COMPTROLLER'S SIGNATURE

By:_______________________________ Date:______________________________

Revised 6/3/2013

APPENDIX A: STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS
REVISED Appendix A dated January 2014

APPENDIX A

STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

PLEASE RETAIN THIS DOCUMENT
FOR FUTURE REFERENCE.

January 2014

TABLE OF CONTENTS

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 State's previous written consent, and attempts to do so are null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract let pursuant to Article XI of the State Finance Law may be waived at the discretion of the contracting agency and with the concurrence of the State Comptroller where the original contract was subject to the State Comptroller's approval, where the assignment is due to a reorganization, merger or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that any Contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments 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). However, such pre-approval shall not be required for any contract established as a centralized contract through the Office of General Services or for a purchase order or other transaction issued under such centralized contract.

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 (including gender identity or expression), national origin, sexual orientation, military status, age, disability, predisposing genetic characteristics, marital status or domestic violence victim 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. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-

a of Section 220 of the Labor Law shall be a condition precedent to payment by the any State approved sums due and owing for work done upon the project.

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) Identification Number(s). Every invoice or New York State Claim for Payment submitted to a New York State agency by a payee, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property must include the payee's identification number. The number is any or all of the following: (i) the payee's Federal employer identification number, (ii) the payee's Federal social security number, and/or (iii) the payee's Vendor Identification Number assigned by the Statewide Financial System. Failure to include such number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or Claim for Payment, 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 the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, 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 and 5 NYCRR 143, 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 the following shall apply and by signing this agreement the Contractor certifies and affirms that it is Contractor's equal employment opportunity policy that:

(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, shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts 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. 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 Department of Economic Development's Division 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 Section 165 of the State Finance Law, (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
Albany, New York 12245
Telephone: 518-292-5100
Fax: 518-292-5884
email: opa@esd.ny.gov

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
633 Third Avenue
New York, NY 10017
212-803-2414
email: mwbecertification@esd.ny.gov
https://ny.newnycontracts.com/FrontEnd/VendorSearchPublic.asp

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. COMPLIANCE WITH NEW YORK STATE INFORMATION SECURITY BREACH AND NOTIFICATION ACT. 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).

23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW. If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal or similar services, then, in accordance with Section 163 (4-g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded the contract, the Department of Civil Service and the State Comptroller.

24. PROCUREMENT LOBBYING. To the extent this agreement is a "procurement contract" as defined by State Finance Law Sections 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law Sections 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

25. CERTIFICATION OF REGISTRATION TO COLLECT SALES AND COMPENSATING USE TAX BY CERTAIN STATE CONTRACTORS, AFFILIATES AND SUBCONTRACTORS.
To the extent this agreement is a contract as defined by Tax Law Section 5-a, if the contractor fails to make the certification required by Tax Law Section 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

26. **IRAN DIVESTMENT ACT**. By entering into this Agreement, Contractor certifies in accordance with State Finance Law §165-a that it is not on the "Entities Determined to be Non-Responsive Bidders/Offerers pursuant to the New York State Iran Divestment Act of 2012" ("Prohibited Entities List") posted at: http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf
Contractor further certifies that it will not utilize on this Contract any subcontractor that is identified on the Prohibited Entities List. Contractor agrees that should it seek to renew or extend this Contract, it must provide the same certification at the time the Contract is renewed or extended. Contractor also agrees that any proposed Assignee of this Contract will be required to certify that it is not on the Prohibited Entities List before the contract assignment will be approved by the State.

During the term of the Contract, should the state agency receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, the state agency will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then the state agency shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not
limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the Contractor in default. The state agency reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

STATE OF NEW YORK
AGREEMENT

This AGREEMENT is hereby made by and between the State of New York Department of Health (STATE) and the public or private agency (CONTRACTOR) identified on the face page hereof.

WITNESSETH:

WHEREAS, the STATE has formally requested contractors to submit bid proposals for the project described in Appendix B for which bids were opened on the date noted on the face pages of this AGREEMENT; and

WHEREAS, the STATE has determined that the CONTRACTOR is the successful bidder, and the CONTRACTOR covenants that it is willing and able to undertake the services and provide the necessary materials, labor and equipment in connection therewith;

NOW THEREFORE, in consideration of the terms hereinafter mentioned and also the covenants and obligations moving to each party hereto from the other, the parties hereto do hereby agree as follows:

I. Conditions of Agreement

A. This AGREEMENT incorporates the face pages attached and all of the marked appendices identified on the face page hereof.

B. The maximum compensation for the contract term of this AGREEMENT shall not exceed the amount specified on the face page hereof.

C. This AGREEMENT may be renewed for additional periods (PERIOD), as specified on the face page hereof.

D. To exercise any renewal option of this AGREEMENT, the parties shall prepare new appendices, to the extent that any require modification, and a Modification Agreement (the attached Appendix X is the blank form to be used). Any terms of this AGREEMENT not modified shall remain in effect for each PERIOD of the AGREEMENT. The modification agreement is subject to the approval of the Office of the State Comptroller.

E. Appendix A (Standard Clauses as required by the Attorney General for all State contracts) takes precedence over all other parts of the AGREEMENT.

F. For the purposes of this AGREEMENT, the terms "Request For Proposal" and "RFP" include all Appendix B documents as marked on the face page hereof.

G. For the purposes of this AGREEMENT, the term "Proposal" includes all Appendix C documents as marked on the face page hereof.

II. Payment and Reporting

A. The CONTRACTOR shall submit complete and accurate invoices and/or vouchers, together with supporting documentation required by the contract, the State Agency and the State Comptroller, to the STATE's designated payment office in order to receive payment to one of the following addresses:

i. Preferred Method: Email a .pdf copy of your signed voucher to the BSC at: accountspayable@ogs.ny.gov with a subject field as follows:
Subject: **Unit ID: 3450263 Contract #TBD**

(Note: **do not** send a paper copy in addition to your emailed voucher.)

ii. Alternate Method: Mail vouchers to BSC at the following U.S. postal address:

NYS Department of Health
Unit ID 3450263
PO Box 2117
Albany, NY 12220-0117

B. Payment of such invoices and/or vouchers by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law.

Payment for invoices and/or vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at helpdesk@sfs.ny.gov or by telephone at 1-855-233-8363. CONTRACTOR acknowledges that it will not receive payment on any invoices and/or vouchers submitted under this Contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9, must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at http://www.osc.state.ny.us/vendors/vendorguide/guide.htm.

III. Term of Contract

A. Upon approval of the Office of the State Comptroller, this AGREEMENT shall be effective for the term as specified on the cover page.

B. This Agreement may be terminated by mutual written agreement of the contracting parties.

C. This Agreement may be terminated by the Department for cause upon the failure of the Contractor to comply with the terms and conditions of this Agreement, including the attachments hereto, provided that the Department shall give the contractor written notice via registered or certified mail, return receipt requested, or shall deliver same by hand-receiving Contractor’s receipt therefor, such written notice to specify the Contractor’s failure and the termination of this Agreement. Termination shall be effective ten (10) business days from receipt of such notice, established by the receipt returned to the Department. The Contractor agrees to incur no new obligations nor to claim for any expenses made after receipt of the notification of termination.

D. This Agreement may be deemed terminated immediately at the option of the Department upon the filing of a petition in bankruptcy or insolvency, by or against the Contractor. Such termination shall be immediate and complete, without termination costs or further obligations by the Department to the Contractor.

E. 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.

IV. Proof of Coverage

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:

A. Workers' Compensation, for which one of the following is incorporated into this contract as Appendix E-1:

1. CE-200, 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

2. 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

3. SI-12 – Certificate of Workers' Compensation Self-Insurance, OR GSI-105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance.

B. Disability Benefits coverage, for which one of the following is incorporated into this contract as Appendix E-2:

1. CE-200, 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

2. DB-120.1 – Certificate of Disability Benefits Insurance OR

3. DB-155 – Certificate of Disability Benefits Self-Insurance

V. Indemnification

A. The CONTRACTOR shall be solely responsible and answerable in damages for any and all accidents and/or injuries to persons (including death) or property arising out of or related to the services to be rendered by the CONTRACTOR or its subcontractors pursuant to this AGREEMENT. The CONTRACTOR shall indemnify and hold harmless the STATE and its officers and employees from claims, suits, actions, damages and costs of every nature arising out of the provision of services pursuant to this AGREEMENT.

B. The CONTRACTOR is an independent contractor and may neither hold itself out nor claim to be an officer, employee or subdivision of the STATE nor make any claims, demand or application to or for any right based upon any different status.

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 specifications, 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, e-mail, 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 shall 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 allowance 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 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. 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 for use 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 Information Technology Services.

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.

N. Date/Time Warranty

1. Definitions: For the purposes of this warranty, the following definitions apply:

   "Product" shall include, without limitation: when solicited from a vendor in a State government entity's contracts, RFPs, IFBs, or mini-bids, 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.

   "Third Party Product" shall include product manufactured or developed by a corporate entity independent from the vendor and provided by the 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) 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. Date/Time Warranty Statement

   Contractor warrants that Product(s) furnished pursuant to this Contract 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) transitions, including leap year calculations. Where a Contractor proposes or an acquisition requires that specific Products must perform as a package or system, this warranty shall apply to the Products as a system.

   Where Contractor is providing ongoing services, including but not limited to: i) consulting, integration, code or data conversion, ii) maintenance or support services, iii) data entry or processing, or iv) contract administration services (e.g., billing, invoicing, claim processing), Contractor warrants that services shall be provided in an accurate and timely manner without interruption, failure or error due to the inaccuracy of Contractor’s business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) various date/time transitions, including leap year calculations. Contractor shall be responsible for damages resulting from any delays, errors or untimely performance resulting therefrom, including but not limited to the failure or untimely performance of such services.

This Date/Time Warranty shall survive beyond termination or expiration of this contract through: a) ninety (90) days or b) the Contractor's or Product manufacturer/developer's stated date/time warranty term, whichever is longer. Nothing in this warranty statement shall be construed to limit any rights or remedies otherwise available under this Contract for breach of warranty.

O. No Subcontracting Subcontracting by the contractor shall not be permitted except by prior written approval of the Department of Health. All subcontracts shall contain provisions specifying that the work performed by the subcontractor must be in accordance with the terms of this AGREEMENT, and that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the AGREEMENT between the STATE and the CONTRACTOR.

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 judgment 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 judgment 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. 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. 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 or 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.

X. 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 whom 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.

Y. <u>Confidentiality Clauses</u>

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.

Z. 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 following address New York State Department of Health, Bureau of Contracts Room -2756, Corning Tower, Albany, NY 12237; 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, Albany NY 12239, ATTN: Consultant Reporting.

AA. Provisions Related to New York State Procurement Lobbying Law 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.

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

CC. Lead Guidelines All products supplied pursuant to this agreement shall meet local, state and federal regulations, guidelines and action levels for lead as they exist at the time of the State's acceptance of this contract.

DD. On-Going Responsibility

1. General Responsibility Language: The CONTRACTOR shall at all times during the Contract term remain responsible. The Contractor agrees, if requested by the Commissioner of Health or his or her designee, to present evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity.
2. Suspension of Work (for Non-Responsibility) :The Commissioner of Health or his or her designee, in his or her sole discretion, reserves the right to suspend any or all activities under this Contract, at any time, when he or she discovers information that calls into question the responsibility of the Contractor. In the event of such suspension, the Contractor will be given written notice outlining the particulars of such suspension. Upon issuance of such notice, the Contractor must comply with the terms of the suspension order. Contract activity may resume at such time as the Commissioner of Health or his or her designee issues a written notice authorizing a resumption of performance under the Contract.

3. Termination (for Non-Responsibility) : Upon written notice to the Contractor, and a reasonable opportunity to be heard with appropriate Department of Health officials or staff, the Contract may be terminated by Commissioner of Health or his or her designee at the Contractor's expense where the Contractor is determined by the Commissioner of Health or his or her designee to be non-responsible. In such event, the Commissioner of Health or his or her designee may complete the contractual requirements in any manner he or she may deem advisable and pursue available legal or equitable remedies for breach.

EE. Provisions Related to Iran Divestment Act As a result of the Iran Divestment Act of 2012 (Act), Chapter 1 of the 2012 Laws of New York, a provision has been added to the State Finance Law (SFL), § 165-a, effective April 12, 2012. Under the Act, the Commissioner of the Office of General Services (OGS) has developed a list (prohibited entities list) of "persons" who are engaged in "investment activities in Iran" (both are defined terms in the law). Pursuant to SFL § 165-a(3)(b), the initial list has been posted on the OGS website at http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf.

By entering into this Contract, CONTRACTOR (or any assignee) certifies that it will not utilize on such Contract any subcontractor that is identified on the prohibited entities list. Additionally,

CONTRACTOR agrees that should it seek to renew or extend the Contract, it will be required to certify at the time the Contract is renewed or extended that it is not included on the prohibited entities list. CONTRACTOR also agrees that any proposed Assignee of the Contract will be required to certify that it is not on the prohibited entities list before the New York State Department of Health may approve a request for Assignment of Contract.
During the term of the Contract, should New York State Department of Health receive information that a person is in violation of the above referenced certification, New York State Department of Health will offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment which is in violation of the Act within 90 days after the determination of such violation, then New York State Department of Health shall take such action as may be appropriate including, but not limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the CONTRACTOR in default.

New York State Department of Health reserves the right to reject any request for assignment for an entity that appears on the prohibited entities list prior to the award of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the prohibited entities list after contract award.

Appendix G
NOTICES

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

(a) via certified or registered United States mail, return receipt requested;

(b) by facsimile transmission;

(c) by personal delivery;

(d) by expedited delivery service; or

(e) by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time to time designate:

State of New York Department of Health
Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

[*Insert Contractor Name*]
Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this AGREEMENT by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representative for the purposes of receiving notices under this AGREEMENT. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems, and/or for dispute resolution.

Appendix M

PARTICIPATION BY MINORITY GROUP MEMBERS AND WOMEN WITH RESPECT TO STATE CONTRACTS: REQUIREMENTS AND PROCEDURES

I. General Provisions

A. The New York State Department of Health is required to implement the provisions of New York State Executive Law Article 15-A and 5 NYCRR Parts 142-144 ("MWBE Regulations") for all State contracts as defined therein, with a value (1) in excess of $25,000 for labor, services, equipment, materials, or any combination of the foregoing or (2) in excess of $100,000 for real property renovations and construction.

B. The Contractor to the subject contract (the "Contractor" and the "Contract," respectively) agrees, in addition to any other nondiscrimination provision of the Contract and at no additional cost to the New York State New York State Department of Health (the "New York State Department of Health"), to fully comply and cooperate with the New York State Department of Health in the implementation of New York State Executive Law Article 15-A. These requirements include equal employment opportunities for minority group members and women ("EEO") and contracting opportunities for certified minority and women-owned business enterprises ("MWBEs"). Contractor's demonstration of "good faith efforts" pursuant to 5 NYCRR §142.8 shall be a part of these requirements. These provisions shall be deemed supplementary to, and not in lieu of, the nondiscrimination provisions required by New York State Executive Law Article 15 (the "Human Rights Law") or other applicable federal, state or local laws.

C. Failure to comply with all of the requirements herein may result in a finding of non-responsiveness, non-responsibility and/or a breach of contract, leading to the withholding of funds or such other actions, liquidated damages pursuant to Section VII of this Appendix or enforcement proceedings as allowed by the Contract.

II. Contract Goals

A. For purposes of this contract, the New York State Department of Health hereby establishes an overall goal of 30% for Minority and Women-Owned Business Enterprises ("MWBE") participation, 15% for Minority-Owned Business Enterprises ("MBE") participation and 15% for Women-Owned Business Enterprises ("WBE") participation (based on the current availability of qualified MBEs and WBEs).

B. For purposes of providing meaningful participation by MWBEs on the Contract and achieving the Contract Goals established in Section II-A hereof, Contractor should reference the directory of New York State Certified MBWEs found at the following internet address: https://ny.newnycontracts.com/

Additionally, Contractor is encouraged to contact the Division of Minority and Woman Business Development ((518) 292-5250; (212) 803-2414; or (716) 846-8200) to discuss additional methods of maximizing participation by MWBEs on the Contract.

C. Where MWBE goals have been established herein, pursuant to 5 NYCRR §142.8, Contractor must document "good faith efforts" to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract. In accordance with Section 316-a of Article 15-A and 5 NYCRR §142.13, the Contractor acknowledges that if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation

goals set forth in the Contract, such a finding constitutes a breach of contract and the Contractor shall be liable to the New York State Department of Health for liquidated or other appropriate damages, as set forth herein.

III. Equal Employment Opportunity (EEO)

A. Contractor agrees to be bound by the provisions of Article 15-A and the MWBE Regulations promulgated by the Division of Minority and Women's Business Development of the Department of Economic Development (the "Division"). If any of these terms or provisions conflict with applicable law or regulations, such laws and regulations shall supersede these requirements.

B. Contractor shall comply with the following provisions of Article 15-A:

1. Contractor and Subcontractors shall undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, EEO shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.
2. The Contractor shall submit an EEO policy statement to the New York State Department of Health within seventy two (72) hours after the date of the notice by New York State Department of Health to award the Contract to the Contractor.
3. If Contractor or Subcontractor does not have an existing EEO policy statement, the New York State Department of Health may provide the Contractor or Subcontractor a model statement (see Form #5 - Minority and Women-Owned Business Enterprises Equal Employment Opportunity Policy Statement).
4. The Contractor's EEO policy statement shall include the following language:

    a. The Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force.
    b. The Contractor shall state in all solicitations or advertisements for employees that, in the performance of the 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.
    c. 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.
    d. The Contractor will include the provisions of Subdivisions (a) through (c) of this Subsection 4 and Paragraph "D" of this Section III, which provides for relevant provisions of the Human Rights Law, in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each subcontractor as to work in connection with the Contract.

C. Form #4 - Staffing Plan

To ensure compliance with this Section, the Contractor shall submit a staffing plan to document the composition of the proposed workforce to be utilized in the performance of the Contract by the specified categories listed, including ethnic background, gender, and Federal occupational categories. Contractors shall complete the Staffing plan form and submit it as part of their bid or proposal or within a reasonable time, but no later than the time of award of the contract.

D. Contractor shall comply with the provisions of the Human Rights Law, all other State and Federal statutory and constitutional non-discrimination provisions. Contractor and subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

IV. MWBE Utilization Plan

A. The Contractor represents and warrants that Contractor has submitted an MWBE Utilization Plan (Form #1) either prior to, or at the time of, the execution of the contract.

B. Contractor agrees to use such MWBE Utilization Plan for the performance of MWBEs on the Contract pursuant to the prescribed MWBE goals set forth in Section III-A of this Appendix.

C. Contractor further agrees that a failure to submit and/or use such MWBE Utilization Plan shall constitute a material breach of the terms of the Contract. Upon the occurrence of such a material breach, New York State Department of Health shall be entitled to any remedy provided herein, including but not limited to, a finding of Contractor non-responsiveness.

V. Waivers

A. For Waiver Requests Contractor should use Form #2 – Waiver Request.

B. If the Contractor, after making good faith efforts, is unable to comply with MWBE goals, the Contractor may submit a Request for Waiver form documenting good faith efforts by the Contractor to meet such goals. If the documentation included with the waiver request is complete, the New York State Department of Health shall evaluate the request and issue a written notice of acceptance or denial within twenty (20) days of receipt.

C. If the New York State Department of Health, upon review of the MWBE Utilization Plan and updated Quarterly MWBE Contractor Compliance Reports determines that Contractor is failing or refusing to comply with the Contract goals and no waiver has been issued in regards to such non-compliance, the New York State Department of Health may issue a notice of deficiency to the Contractor. The Contractor must respond to the notice of deficiency within seven (7) business days of receipt. Such response may include a request for partial or total waiver of MWBE Contract Goals.

VI. Quarterly MWBE Contractor Compliance Report

A. Contractor is required to submit a Quarterly MWBE Contractor Compliance Report to the New York State Department of Health by the 10th day following each end of quarter over the

term of the Contract documenting the progress made towards achievement of the MWBE goals of the Contract. Data should be submitted via the online compliance system at https://ny.newnycontracts.com.

VII. Liquidated Damages - MWBE Participation

A. Where New York State Department of Health determines that Contractor is not in compliance with the requirements of the Contract and Contractor refuses to comply with such requirements, or if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals, Contractor shall be obligated to pay to the New York State Department of Health liquidated damages.

B. Such liquidated damages shall be calculated as an amount equaling the difference between:
   1. All sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and
   2. All sums actually paid to MWBEs for work performed or materials supplied under the Contract.

C. In the event a determination has been made which requires the payment of liquidated damages and such identified sums have not been withheld by the New York State Department of Health, Contractor shall pay such liquidated damages to the New York State Department of Health within sixty (60) days after they are assessed by the New York State Department of Health unless prior to the expiration of such sixtieth day, the Contractor has filed a complaint with the Director of the Division of Minority and Woman Business Development pursuant to Subdivision 8 of Section 313 of the Executive Law in which event the liquidated damages shall be payable if Director renders a decision in favor of the New York State Department of Health.

Attachment 14
HRI Consultant Agreement

Attachment 14
CONSULTANT AGREEMENT

THIS AGREEMENT, made as of «Start_Date» (the “Effective Date”), 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 Riverview Center, 150 Broadway, Ste. 560, Menands, NY 12204, hereinafter referred to as **HRI**, and **«CONSULTANT_NAME»**, located at «Address_One», «Address_Two»«City», «STATE», «Zip», herein after referred to as the **CONSULTANT**.

WITNESSETH

WHEREAS, HRI has been awarded a grant from «Sponsor_Name» for the conduct of a project entitled "«Project_Title»"; and,

WHEREAS, funding for the project, in whole or in part, is provided under a federal government grant or contract; 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 services for HRI.

NOW THEREFORE, in consideration of the promises, 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 employee or 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_Name».

2. The Agreement shall be effective and allowable costs may be incurred by the Consultant from the Effective Date and shall continue until «End_Date» (the “Term”) unless terminated sooner as hereinafter provided or extended by written agreement of the parties.

3. In full and complete consideration of Consultant's performance hereunder, HRI agrees to compensate Consultant 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. Any reimbursement payable hereunder by HRI to the Consultant shall be subject to retroactive reductions and/or repayment for amounts included therein which are identified by HRI, on the basis of any review or audit, to not constitute an allowable cost or charge hereunder.

4. The Scope of Work and Budget in Exhibit "A" may be modified as conditions warrant by mutual agreement between HRI and Consultant, and confirmed in writing. In no event shall the total consideration under this Agreement exceed Total Contract Amount Typed Out Dollars ($«Total_Contract_Amt_In_Numbers»).

5. Consultant acknowledges and agrees that all work products, deliverables, designs, writings, inventions, discoveries, and related materials, (collectively “Works”) made, produced or delivered by Consultant in the performance of its obligations hereunder will be owned exclusively by HRI. All copyrightable Works are "works made for hire". Consultant will assign, and hereby assigns and transfers, to HRI all intellectual property rights in and to Works, including without limitation, copyrights, patent rights, trademark rights, and trade secret rights. 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 all Works shall be original except for such portion from copyrighted works as may be included with Consultant’s advance 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. 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.

6. 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 State of New York and the NYS Department of Health.

7. 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, without the advance written consent of HRI.

8. 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 or agent of HRI. This Agreement shall not be construed to contain any authority, either expressed or implied, enabling the Consultant to incur any expense or perform any act on behalf of HRI.

9. Consultant is solely responsible for complying with all applicable laws and obtaining, at Consultant's sole expense, any and all licenses, permits, or authorizations necessary to perform services hereunder. Without limiting the generality of the foregoing, Consultant acknowledges and agrees, to the extent required by Article 15 of the New York State Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, that Consultant 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, Consultant agrees that neither it nor its authorized subcontractors, if any, 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. Consultant 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. Consultant further agrees to the related terms and conditions set forth in Appendix "A".

10. This Agreement shall be void and no force and effect unless Consultant shall provide and maintain coverage during the life of this Agreement for the benefit of such employees as are required to be covered by the provisions of Workers' Compensation Law.

11. Unless otherwise agreed by HRI, Consultant shall maintain, or cause to be maintained, during the Term of this Agreement, insurance or self-insurance equivalents of the following types and amounts: a) Commercial General Liability (CGL) with limits of insurance of not less than $1,000,000 each occurrence and $2,000,000 annual aggregate: b) HRI and the People of the State of New York shall be included as Additional Insureds on the Consultant's CGL, using ISO Additional Insured Endorsement CG 20 10 11 85 or an endorsement providing equivalent coverage to the Additional Insureds. The CGL insurance for the Additional Insureds shall be as broad as the coverage provided for the Named Insured Consultant. It shall apply as primary and non-contributing insurance before any insurance maintained by the Additional Insureds; c) other such insurance as may be specified by HRI, depending on the project and services provided by Consultant.

12. Consultant shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance of the services under this Agreement (collectively, "Records"). The Records must be kept for the balance of the calendar year in which they are created and for six years thereafter. HRI shall have reasonable access to such Records as necessary for the purposes of inspection, audit, and copying. Records shall be maintained as Confidential Information and protected from public disclosure.

13. This Agreement, including all applicable attachments and appendices thereto, 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 in writing, duly executed by both parties hereto.

14. 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, or as directed by the project sponsor. Such termination shall not affect any commitments which, in the judgment of HRI, have become legally binding prior to the effective date of termination. Upon termination of the Agreement by either party for any reason, Consultant shall immediately turn over to HRI any works in progress, materials, and deliverables (whether completed or not) related to the services performed up to the 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.

15. Consultant acknowledges and agrees that, during the course of performing services for HRI, it may receive information of a confidential nature, whether marked or unmarked ("Confidential Information"). Consultant agrees to protect such Confidential Information with the same degree of care it uses to protect its own confidential information of similar nature and importance, but with no less than reasonable care. Consultant will not use Confidential Information

for any purpose other than to facilitate the provision of services under this Agreement, and Consultant will not disclose Confidential Information to any third party without HRI's advance written consent.

16. Consultant represents and warrants that: a) it has the full right and authority to enter into and perform under this Agreement; b) it will perform the services set forth in Exhibit "A" in a workmanlike manner consistent with applicable industry practices; c) the services, work products, and deliverables provided by Consultant will conform to the specifications in Exhibit "A"; d) there is no pending or threatened claim or litigation that would have a material adverse impact on its ability to perform as required by this Agreement.

17. Consultant shall have no interest, financial or otherwise, direct or indirect, or engage in any business, transaction, or professional activity, that may create a conflict with the proper discharge of Consultant's duties under this Agreement. In the event any actual or potential conflict arises, Consultant agrees to notify HRI in writing within ten (10) days to allow HRI to evaluate any potential impact on Consultant's performance under this Agreement.

18. Consultant agrees to defend, indemnify and hold HRI, its agents and employees, the New York State Department of Health, and the People of the State of New York, harmless from any losses, claims, damages, expenses, and liabilities (including reasonable attorneys' fees arising out of: (i) any act or omission by Consultant in connection with the performance of services constituting negligence, willful misconduct, or fraud; (ii) the breach of the confidentiality obligations set forth herein; (iii) any claim for compensation or payment asserted by any employee or agent of Consultant; (iv) Consultant's failure to carry out Consultant's responsibilities under this Agreement; (v) any intellectual property infringement or misappropriation by Consultant in connection with the services provided under this Agreement.

19. Should any provision of this Agreement be proven to be invalid or legally ineffective, the overall validity of this Agreement shall not be affected. Unless the parties agree on an amended provision, the invalid provision shall be deemed to be replaced by a valid provision accomplishing as far as possible the purpose and intent of the parties at the date of the Agreement.

20. The failure of HRI to assert a right hereunder or to insist on compliance with any term or condition of this Agreement shall not constitute a waiver of that right of HRI, or other rights of HRI under the Agreement, or excuse a subsequent failure to perform any such term or condition by Consultant.

21. This Agreement shall be governed and construed in accordance with the laws of the State of New York. The jurisdictional venue for any legal proceedings involving this Agreement shall be in the State of New York. Disputes involving this Agreement may not be submitted to binding arbitration.

22. In addition to the methods of process allowed by the State Civil Practice Law & Rules (CPLR), in any litigation arising under or with respect to this Agreement, Consultant hereby consents to the service of process upon it by registered or certified mail, return receipt requested, and will promptly notify HRI in writing in the event there is any change of address to which service of process can be made.

23. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Delivery of an executed signature page to the Agreement by facsimile transmission or PDF shall be as effective as delivery of a manually signed counterpart.

24. Consultant agrees to abide by the terms and conditions of Appendix "A" attached hereto and made a part hereof, including the provisions required for federally funded projects, if applicable.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the Effective Date.

HEALTH RESEARCH, INC.	**«CONSULTANT_NAME»**
_____	_____
Cheryl A. Mattox	Name
Executive Director	Title

Attachment 15
Appendix A to Health Research Inc. Consultant Agreement

HEALTH RESEARCH, INC.
APPENDIX A to CONSULTANT AGREEMENT

The parties to the attached Agreement further agree to be bound by the following terms, which are hereby made a part of said Agreement:

1. During the performance of the Agreement, the Consultant agrees as follows:

   (a) The Consultant 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 Consultant will send to each labor union or representative of workers within which the Consultant 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 Consultant's agreement under clauses (a) through (g) (hereinafter called "non-discrimination clauses"). If the Consultant was directed to do so by the contracting agency as part of the bid or negotiation of this Agreement, the Consultant 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 Agreement 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 Consultant 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 Consultant 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 Consultant will state, in all solicitations or advertisement for employees placed by or on behalf of the Consultant, 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 Consultant 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 Consultant'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 Agreement 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 Consultant has not complied with these non-discrimination clauses, and the Consultant may be declared ineligible for future agreements made by or on behalf of HRI, the State or a public authority or agency of the State, until the Consultant satisfies the State Commissioner of Human Rights that the Consultant 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 Consultant, and an opportunity has been afforded to the Consultant 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 Consultant 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 Consultant 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 Consultant 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 Consultant shall promptly notify HRI.

2. Assurances Required by DHHS--PHS (Where Applicable)

(a) Human Subjects, Derived Materials or Data

The Consultant 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 Consultant 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 Consultant. The Consultant and HRI agree to complete a HHS 596 form on an annual basis.

(b) Laboratory Animals

The Consultant agrees to abide by PHS policy requiring that laboratory animals not suffer unnecessary discomfort, pain or injury. The Consultant 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 Consultant 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 Consultant 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 Consultant 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 Consultant.

(d) Promoting Objectivity in Research

Consultant agrees to comply with the DHHS/PHS regulatory requirements on Responsibility of Applicants for Promoting Objectivity in Research and financial conflicts of interest set forth in 42 C.F.R Parts 50 and 94.

(e) Other DHHS-PHS Regulations

The Consultant agrees to comply with applicable DHHS regulations concerning Civil Rights and Equal Opportunity, Student Unrest Provisions, Handicapped Individuals and Sex Discrimination.

(f) Additional Assurances

Under this grant, should any additional DHHS-PHS regulations be promulgated, the Consultant and HRI will review and agree, if feasible, to include them as part of this Agreement

The following provisions 3-9 are applicable to federally funded projects:

3. Anti-Kickback Act Compliance

If the subject Agreement or any subcontract hereunder is in excess of $2,000 and is for construction or repair, Consultant 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, "Consultants 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 Consultant 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 Consultant shall report all suspected or reported violations to the Federal-awarding agency.

4. Davis-Bacon Act Compliance
If required by Federal programs legislation, and if this subject Agreement or any subcontract hereunder is a construction contract in excess of $2,000, Consultant 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, Consultants 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, Consultants 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 Consultant shall report all suspected or reported violations to the Federal-awarding agency.

5. Contract Work Hours and Safety Standards Act Compliance
Consultant agrees that, if this subject Agreement 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, Consultant 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 Consultant 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. Consultant agrees that this clause shall be included in all lower tier contracts hereunder as appropriate.

6. Clean Air Act Compliance
If this subject Agreement is in excess of $100,000, Consultant 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).

7. Notice as Required Under Public Law 103-333
The Consultant 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.

8. 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 Consultant shall not discriminate against an individual with a disability, as defined in the ADA, in providing services, programs or activities pursuant to this Agreement.

9. Required Federal Certifications
Acceptance of this Agreement by Consultant constitutes certification that the Consultant 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 Consultant is not delinquent on any Federal debt.

Acceptance of this Agreement constitutes certification by the Consultant that:

No Federal appropriated funds have been paid or will be paid, by or on behalf of the Consultant, 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 Consultant 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 Consultant 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 Consultant 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 Consultant agrees to notify HRI immediately if there is a change in its status relating to any of the above certifications.

Appendix C – Additions to Consultant Agreement

1. System for Award Management (SAM) – for all agreements

   Consultant is required to register with SAM.gov and maintain active status as stated in 2 CFR Subtitle A, Chapter 1, and Part 25 of Code of Federal Regulations. Consultant must maintain the accuracy/currency of the information in SAM at all times during which your entity has an active agreement with HRI. Additionally, your entity is required to review and update the information at least annually after the initial registration, and more frequently if required by changes in your information.

2. Equal Employment Opportunity – for all agreements

   This contractor and subcontractor shall abide by the requirements of 41 CFR 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability, and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities.

   This contractor and subcontractor shall abide by the requirements of 41 CFR 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans, and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans.

3. Whistleblower Policy – for all federally funded agreements

   Congress has enacted whistleblower protection statue 41 U.S.C. 4712, which applies to all employees working for contractors, grantees, subcontractors, and subgrantees on federal grants and contracts. This program requires all grantees, subgrantees and subcontractors to: inform their employees working on any federally funded award they are subject to the whistleblower rights and remedies of the program; inform their employee in writing of employee whistleblower protections under 41 U.S.C. 4712 in the predominant native language of the workforce; and Contractors and grantees will include such requirements in any agreement made with a subcontractor or subgrantee.

   The statue (41 U.S.C. 4712) states that an “employee of a contractor, subcontractor, grantee [or subgrantee] may not be discharged, demoted, or otherwise discriminated against as a reprisal for “whistleblowing”. In addition, whistleblower protections cannot be waived by any agreement, policy, form, or condition of employment.

   Whistleblowing is defined as making a disclosure “that the employee reasonably believes is evidence of any of the following: gross mismanagement of a federal contract or grant; a gross waste of federal funds; an abuse of authority relating to a federal contract or grant; a substantial and specific danger to public health or safety; or a violation of law, rule, or regulation related to a federal contract or grant (including the competition for, or negotiation of, a contract or grant). To qualify under the statute, the employee’s disclosure must be made to: a Member of Congress or a representative of a Congressional committee; or an Inspector General; or the Government Accountability Office; or a Federal employee responsible for contract or grant oversight or management at the relevant agency; or an authorized official of the Department of Justice or other law enforcement agency; or a court or grand jury; a management official or other employee of the contractor, subcontractor, grantee or subgrantee who has the responsibility to investigate, discover or address misconduct.

Attachment 16

Cover Page

Behavioral Risk Factor Surveillance System (BRFSS) RFP No. 16526

Title of Proposal: _____

Bidder Firm Name: _____

Address: _____

Phone No.: _____ **Fax No.:** _____

E-Mail Address: _____

New York Statewide Financial System Vendor ID No. (If applicable): _____

Location of Call Center: _____

Individual Authorized to Sign Contract: _____

Address: _____

Phone No.: _____ **Fax No.:** _____

E-Mail Address: _____

Signature: _____

Project Manager Name: _____

Address: _____

Phone No.: _____ **Fax No.:** _____

E-Mail Address: _____

Contact Person Name: _____

Address: _____

Phone No.: _____ **Fax No.:** _____

E-Mail Address: _____

Attachment 17
Reference Submission Form

Bidder's Organization Name _____

Please provide a minimum of two (2) reference organizations and complete the fields below. Please also provide a project-identifying title, a brief description of the scope of the services provided, dates of service, deadlines, reports produced, and other relevant information.

1) Organization Name_____
   Contact Name and Professional Title_____
   Address & Telephone Number_____

   _____
   _____
   _____

2) Organization Name_____
   Contact Name and Professional Title_____
   Address & Telephone Number_____

   _____
   _____
   _____

3) Organization Name_____
   Contact Name and Professional Title_____
   Address & Telephone Number_____

   _____
   _____
   _____

4) Organization Name_____
   Contact Name and Professional Title_____
   Address & Telephone Number_____

   _____
   _____
   _____

Attachment 18
State/HRI Contract Period and Activities Chart

Attachment 18
State HRI Contract Period and Activities

October 1, 2016 - March 31, 2022

		January	February	March	April	May	June	July	August	September	October	November	December
2016											Prep for 2017 Survey		
2017		Survey Data Collection											
											Prep for 2018 Survey		
2018		Data cleaning, preparation and Submission of 2017 final data											
		Survey Data Collection											
											Prep for 2019 Survey		
2019		Data cleaning, preparation and Submission of 2018 final data											
		Survey Data Collection											
											Prep for 2020 Survey		
2020		Data cleaning, preparation and Submission of 2019 final data											
		Survey Data Collection											
											Prep for 2021 Survey		
2021		Data cleaning, preparation and Submission of 2020 final data											
		Survey Data Collection											

ATTACHMENT 19
DIVERSITY PRACTICES QUESTIONNAIRE

I, _____, as _____ (title) of _____firm or company (hereafter referred to as the company), swear and/or affirm under penalty of perjury that the answers submitted to the following questions are complete and accurate to the best of my knowledge:

1. Does your company have a Chief Diversity Officer or other individual who is tasked with supplier diversity initiatives? Yes or No

If Yes, provide the name, title, description of duties, and evidence of initiatives performed by this individual or individuals.

2. What percentage of your company's gross revenues (from your prior fiscal year) was paid to New York State certified minority and/or women-owned business enterprises as subcontractors, suppliers, joint-venturers, partners or other similar arrangement for the provision of goods or services to your company's clients or customers?

3. What percentage of your company's overhead (i.e. those expenditures that are not directly related to the provision of goods or services to your company's clients or customers from your prior fiscal year) was paid to New York State certified minority- and women-owned business enterprises as suppliers/contractors?[1]

4. Does your company provide technical training[2] to minority- and women-owned business enterprises? Yes or No

If Yes, provide a description of such training which should include, but not be limited to, the date the program was initiated, the names and the number of minority- and women-owned business enterprises participating in such training, the number of years such training has been offered and the number of hours per year for which such training occurs.

5. Is your company participating in a government approved minority- and women-owned business enterprise mentor-protégé program? Yes or No

If Yes, identify the governmental mentoring program in which your company participates and provide evidence demonstrating the extent of your company's commitment to the governmental mentoring program.

6. Does your company include specific quantitative goals for the utilization of minority- and women-owned business enterprises in its non-government procurements? Yes or No

[1] Do not include onsite project overhead.
[2] Technical training is the process of teaching employees how to more accurately and thoroughly perform the technical components of their jobs. Training can include technology applications, products, sales and service tactics, and more. Technical skills are job-specific as opposed to soft skills, which are transferable.

If Yes, provide a description of such non-government procurements (including time period, goal, scope and dollar amount) and indicate the percentage of the goals that were attained.

7. Does your company have a formal minority- and women-owned business enterprise supplier diversity program? Yes or No

If Yes, provide documentation of program activities and a copy of policy or program materials.

8. Does your company plan to enter into partnering or subcontracting agreements with New York State certified minority- and women-owned business enterprises if selected as the successful respondent? Yes or No

Signature of Owner/Official _____

Printed Name of Signatory _____

Title _____

Name of Business _____

Address _____

City, State, Zip _____

STATE OF _____
COUNTY OF) ss:

On the _____ day of _____, 201_, before me, the undersigned, a Notary Public in and for the State of _____, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this certification and said person executed this instrument.

_____
Notary Public