

WOMEN'S INTERAGENCY HIV STUDY  
 FOLLOW-UP VISIT  
**HEALTH CARE UTILIZATION**  
**FORM 25**

**SECTION A: GENERAL INFORMATION**

A1. PARTICIPANT ID: ENTER NUMBER HERE ONLY IF ID LABEL IS NOT AVAILABLE

|\_|-|\_|-|\_|\_|\_|-|\_|

A2. WIHS STUDY VISIT #:

\_\_ \_\_

A3. FORM VERSION:

1 0 / 0 1 / 9 8  
 M D Y

A4. DATE OF INTERVIEW:

\_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_  
 M D Y

A5. INTERVIEWER'S INITIALS:

\_\_ \_\_ \_\_

A6. DATE OF LAST STUDY VISIT  
 (FROM VISIT CONTROL SHEET)

\_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_  
 M D Y

A7. TIME MODULE BEGAN:

|\_|\_| : |\_|\_| AM.....1  
 PM.....2

**INTRODUCTION TO PARTICIPANT:**

At this time, I am going to ask you some questions about your use of health care.

WIHS ID #

**SECTION B: UTILIZATION OF SERVICES**

For these questions, I am going to use the words “health care provider” to mean any doctor, nurse practitioner, or physician assistant you may go to for medical care.

B1. Since your study visit on \_\_\_ / \_\_\_ / \_\_\_, have you seen a health care provider?  
M D Y

YES .....1  
NO .....2 (B5)

a. How many times did you see a health care provider, not including WIHS visits, since your (MONTH) visit?

\_\_\_\_\_  
#TIMES

B2. Since your (MONTH) study visit, when you went for medical care, did you usually (more than half of the time) see the same health care provider or group of providers for your medical appointments?

YES .....1  
NO .....2 (B3)

a. (Since your (MONTH) study visit,) how many times have you been seen by this health provider or group of providers?

\_\_\_\_\_  
#TIMES

**B3. HAND PARTICIPANT RESPONSE CARD 11.**

Since your (MONTH) study visit, where have you usually gone (more than half the time) to receive medical care?

- Doctor’s office or clinic .....1
- Emergency room in a hospital.....2
- Drug treatment clinic.....3
- Prison clinic.....4
- Nursing home .....5
- Mobil unit/clinic.....6
- Other place .....7

\_\_\_\_\_  
**(SPECIFY)**

WIHS ID #

B4. Now I'm going to ask you about all of the places you may have received care (since your (MONTH) study visit). Since (MONTH) where have you gone to receive medical care? Did you go to ...

- |   | <u>YES</u> | <u>NO</u>      |
|---|------------|----------------|
| a. The doctor's office or clinic.....   | 1          | 2              |
| b. The emergency room in a hospital .....   | 1          | 2 (c)          |
| i.) How many times have you received care at the emergency room since your (MONTH) visit? |            |                |
|   |            | _ _ <br>#TIMES |
| c. A drug treatment clinic.....   | 1          | 2              |
| d. A prison clinic .....  | 1          | 2              |
| e. Nursing home .....   | 1          | 2              |
| f. Mobil unit/clinic.....   | 1          | 2              |
| g. Another place .....  | 1          | 2 (B5)         |
| i.) _____<br>(SPECIFY)  |            |                |

**IF B4bi > 3, ASSESS NEED FOR REFERRAL**

B5. Now I'm going to ask you some questions about care or social services that you may have received at any time since your (MONTH) study visit. (Since your (MONTH) study visit,) has an agency assisted you with food, such as food stamps or WIC, meals on wheels, food pantries, or arranged to have groceries delivered to your home?

- YES .....1  
NO.....2

B6. Since your (MONTH) study visit, has a social service agency helped you find a place to live?

- YES .....1  
NO.....2

B7. (Since your (MONTH) study visit,) have you received care from a dentist or dental hygienist other than through this study?

- YES .....1  
NO.....2

B8. (Since your (MONTH) study visit,) have you been seen by a social worker or a case manager to help you obtain services?

- YES .....1  
NO.....2

WIHS ID #

B9. (Since your (MONTH) study visit,) have you received care or services from visiting nurses?

YES .....1  
NO .....2

B10. (Since your (MONTH) study visit,) have you received care or services from paid home health aides or homemakers? This includes people in your family who are paid.

YES .....1  
NO .....2

B11. (Since your (MONTH) study visit,) have you received care or services from a counselor or mental health professional?

YES .....1  
NO .....2

WIHS ID #

**SECTION C: HEALTH INSURANCE**

C2. Do you currently have any health insurance at all?

YES .....1  
NO .....2 (C13)

**INSTRUCTIONS: ASK QUESTIONS C3 - C11. IF THE RESPONSE IS YES (CODE 1) ASK QUESTION "a" UNLESS THE BOX IS SHADED.**

[READ C3; C5-C11]  *CALIFORNIA ONLY: [READ C4-C11]  Do you currently have...	YES	NO	a. Do you or your family members pay for any of the insurance premium?	
			YES	NO
C3. ALL STATES EXCEPT CALIFORNIA: Medicaid?	1(C5)	2 (C5)		
C4. *CALIFORNIA ONLY: Medi-CAL?	1	2		
C5. Medicare?	1	2		
C6. AIDS Drug Assistance Program, ADAP?	1	2		
C7. CHAMPUS or other veteran's health insurance?	1	2 (C8)	1	2
C8. Student Health Coverage?	1	2 (C9)	1	2
C9. Private insurance (not including Medicaid or Medicare)?	1	2 (C10)	1	2
C10. Dental Insurance?	1	2		
C11. Other types of health insurance? _____ _____ (SPECIFY)	1	2 (C12)		

C12. Do any of these plans assist with prescriptions/medications?

YES .....1  
NO .....2

