

Non-Energy Impacts of the Home Uplift Program Survey for Residents



Consent Form

Please complete the information below, if you are willing to participate in this study.

CONSENT FOR SURVEY

I have read and understand all information in the Project Description. I have received a copy of this form. I agree to participate in this survey.

Main respondent's name (Please print) _____

Signature _____ **Date** _____

CONSENT (ALL OTHER HOUSEHOLD MEMBERS, IF APPLICABLE)

Yes, I am providing third-party consent for all my household members (including children and other dependents) to provide information about them on the survey.

No, I am not providing third-party consent for all my household members (including children and other dependents) to provide information about them on the survey.

Signature _____ **Date** _____

* * *

PLEASE RETURN THIS COMPLETED CONSENT FORM TO US WITH YOUR COMPLETED SURVEY!

Survey for Residents

All of your responses will be protected and will remain confidential and will not be traced back to you or your household. Your answers will not be shared with anyone connected to the property where you live. In this survey, we ask questions about living in your home and about your household.

This survey should be answered by an **adult who has lived in the home for at least 12 months**. If no adult has lived in the home for at least 12 months, please do not complete the survey.

THANK YOU!

SECTION A. INTRODUCTION

PLEASE RECORD YOUR NAME and ADDRESS. (If you have a separate mailing address, please record it at the end of this survey. Use your physical location below.)

Your Name (*Print clearly*): _____

Street Address Line 1: _____

Street Address Line 2 (*optional*): _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

A1. How long have you lived in your current home?

Years: _____ Months: _____

A2. Do you own or rent your home?

Own Rent Other situation: _____

A3. Including yourself, how many people normally live in this household? Do not include anyone who is just visiting, those away in the military, or children who are away at college.

Number of people in household: _____



A4. Can you please provide the names of all household members and their gender, age, and if they are employed or attend school?

Person 1 First Name (Yourself) _____	Person 2 First Name _____
Gender: _____ Age: _____	Gender: _____ Age: _____
Employed for wages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employed for wages? <input type="checkbox"/> Yes <input type="checkbox"/> No
In school? <input type="checkbox"/> Yes <input type="checkbox"/> No	In school? <input type="checkbox"/> Yes <input type="checkbox"/> No
Lives in the home most days during the month? <input type="checkbox"/> Yes <input type="checkbox"/> No	Lives in the home most days during the month? <input type="checkbox"/> Yes <input type="checkbox"/> No
Person 3 First Name _____	Person 4 First Name _____
Gender: _____ Age: _____	Gender: _____ Age: _____
Employed for wages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employed for wages? <input type="checkbox"/> Yes <input type="checkbox"/> No
In school? <input type="checkbox"/> Yes <input type="checkbox"/> No	In school? <input type="checkbox"/> Yes <input type="checkbox"/> No
Lives in the home most days during the month? <input type="checkbox"/> Yes <input type="checkbox"/> No	Lives in the home most days during the month? <input type="checkbox"/> Yes <input type="checkbox"/> No

Person 5 First Name _____	Person 6 First Name _____
Gender: _____ Age: _____	Gender: _____ Age: _____
Employed for wages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employed for wages? <input type="checkbox"/> Yes <input type="checkbox"/> No
In school? <input type="checkbox"/> Yes <input type="checkbox"/> No	In school? <input type="checkbox"/> Yes <input type="checkbox"/> No
Lives in the home most days during the month <input type="checkbox"/> Yes <input type="checkbox"/> No	Lives in the home most days during the month <input type="checkbox"/> Yes <input type="checkbox"/> No
Person 7 First Name _____	Person 8 First Name _____
Gender: _____ Age: _____	Gender: _____ Age: _____
Employed for wages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employed for wages? <input type="checkbox"/> Yes <input type="checkbox"/> No
In school? <input type="checkbox"/> Yes <input type="checkbox"/> No	In school? <input type="checkbox"/> Yes <input type="checkbox"/> No
Lives in the home most days during the month? <input type="checkbox"/> Yes <input type="checkbox"/> No	Lives in the home most days during the month? <input type="checkbox"/> Yes <input type="checkbox"/> No

B

SECTION B. INDOOR AIR TEMPERATURE

The following questions are about your home's temperature in winter and in summer.

B1. Does your home have a thermostat that controls the heating and/or cooling in your home?

- Yes
 No → SKIP to B2
 Don't know → SKIP to B2

B1a. What equipment does your thermostat control?

- Central heating only
- Central cooling only
- Central heating and cooling
- Don't know
- Refused

B2. During the winter, what is the temperature when someone is inside your home during the day? *Please give us your best estimate.*

Enter degrees Fahrenheit: _____

B3. During the summer, what is the temperature when someone is inside your home during the day? *Please give us your best estimate.*

Enter degrees Fahrenheit: _____

Thinking about the past 12 months... <i>Please check one box</i>	Very cold	Cold	Comfortable	Hot	Very hot
B4. Which of the following statements best describes the indoor temperature of your home during the <i>WINTER</i>?					
B5. Which of the following statements best describes the indoor temperature of your home during the <i>SUMMER</i>?					

B6. During the past 12 months, how often was your home at a temperature that you felt was unsafe or unhealthy? Check one

- Almost every month
- Some months
- 1 or 2 months
- Never

For the next set of questions, please think about whether or not you were exposed to near freezing temperatures inside your home that made you feel so badly that you had to seek medical attention for your symptoms. These symptoms are different from having a cold or a flu, BUT are more serious and could include not being able to think clearly, not being able to easily speak, breathe or move, not being able to feel your hands or feet, or fainting.

B7. During the past 12 months, has anyone in the household had to stay overnight in the HOSPITAL because your home was too COLD?

- Yes
- No → SKIP to B8
- Don't know → SKIP to B8

B7a. If Yes, who in the household had to stay overnight in the HOSPITAL and how many times? Please list all individuals, including yourself.	How many times stayed overnight in the HOSPITAL?
First name: _____	
First name: _____	
First name: _____	

B8. Not counting hospitalizations, during the past 12 months, did anyone in the household go to the EMERGENCY ROOM at a hospital because your home was too COLD?

- Yes
- No → SKIP to B9
- Don't know → SKIP to B9

B8a. If Yes, who in the household went to the EMERGENCY ROOM and how many times? Please list all individuals, including yourself.	How many times went to the EMERGENCY ROOM?
First name: _____	
First name: _____	
First name: _____	

B

B9. During the past 12 months, did anyone in the household have to visit a DOCTOR'S OFFICE because your home was too COLD?

- Yes No → SKIP to B10 Don't know → SKIP to B10

B9a. If Yes, how many times did those household members have to go to the DOCTOR'S OFFICE in the past 12 months because your home was too cold? Please list all individuals, including yourself.	How many times went to the DOCTOR'S OFFICE?
First name: _____	
First name: _____	
First name: _____	
First name: _____	

B10. Did any of the medical emergencies from your home being too COLD happen during a natural disaster or power outage?

- Yes
 No
 There were no medical emergencies
 Don't know

Next you will see the same set of questions, but this time they are about times when your home was **too HOT**. Please think about whether or not you were exposed to extremely hot temperatures inside your home that made you feel so badly that you had to seek medical attention for your symptoms. These symptoms are different from having a fever, **BUT** are more serious and could include a severe rash, cramps, swelling in the legs or hands, fainting, panting or fast breathing, or heatstroke.

B11. During the past 12 months, has anyone in the household had to stay overnight in the HOSPITAL because your home was too HOT?

Yes No → SKIP to B12 Don't know → SKIP to B12

B11a. If Yes, who in the household had to stay overnight in the HOSPITAL and how many times? Please list all individuals, including yourself.	How many times stayed overnight in the HOSPITAL?
First name: _____	
First name: _____	
First name: _____	

B12. Not counting hospitalizations, during the past 12 months, did anyone in the household go to the EMERGENCY ROOM at a hospital because your home was too HOT?

Yes No → SKIP to B13 Don't know → SKIP to B13

B12a. If Yes, who in the household went to the EMERGENCY ROOM and how many times? Please list all individuals, including yourself.	How many times went to the EMERGENCY ROOM?
First name: _____	
First name: _____	
First name: _____	

B

B13. During the past 12 months, did anyone in the household have to visit a DOCTOR'S OFFICE because your home was too HOT?

- Yes No → SKIP to B14 Don't know → SKIP to B14

B13a. If Yes, how many times did those household members have to go to the DOCTOR'S OFFICE in the past 12 months because your home was too hot? Please list all individuals, including yourself.	How many times went to the DOCTOR'S OFFICE?
First name: _____	
First name: _____	
First name: _____	

B14. Did any of the medical emergencies from your home being too HOT happen during a natural disaster or power outage?

- Yes
 No
 There were no medical emergencies
 Don't know

SECTION C. GENERAL HEALTH QUESTIONS



<i>During the past 30 days...</i>	Number of DAYS
C1. During the past 30 days, for about how many days do you feel you did not get enough rest or sleep?	
C2. 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?	
C3. 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?	
C4. 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?	

C5. In the past 3 months, have you had headaches that are either new or more frequent or severe than ones you have had before?

- Yes
- No
- Does not suffer from headaches → SKIP to C6
- Don't know

C5a. Thinking about the past 3 months, how would you rate the severity of your headaches?

- Mild; You are able to function normally
- Moderate; Your ability to function is slightly decreased
- Severe; Your ability to function is severely decreased
- Extremely painful or incapacitating; You are totally bedridden

C5b. During the past 3 months, did you take any prescription medications for migraines?

- Yes
- No
- Don't know



C5c. During the past 3 months, did you take any medications, including over the counter medications like Tylenol, for other types of headaches?

Yes No Don't know

C5d. During the past 12 months, did you see a doctor, nurse, or other health professional for urgent treatment of worsening migraines?

Yes No → SKIP to C6 Don't know → SKIP to C6

C5e. How many different times did you have to be admitted to a hospital, visit an emergency room, or an urgent care center in the past 12 months because of migraines?

Number times you went to the HOSPITAL: _____

Number times you visited an EMERGENCY DEPARTMENT: _____

Number times you visited an URGENT CARE CENTER: _____

C6. Has anyone in the household ever experienced lead poisoning?

Yes No Don't know

Please list all individuals, including yourself who had lead poisoning.

First name: _____

First name: _____

First name: _____

First name: _____



C7. Can you please tell me the names of any females currently living in the home that *are or have been* pregnant in the last 12 months?

If none → SKIP to SECTION D.

Person 1 First Name: _____	Person 2 First Name: _____
<p>C8. During the past 12 months, did Person 1 give birth?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No →SKIP to SECTION D</p> <p>C8a. Was/were the infant(s) born... <i>Check one</i></p> <p><input type="checkbox"/> Before due date <input type="checkbox"/> On due date <input type="checkbox"/> After due date <input type="checkbox"/> Don't know</p> <p>C8b. Was/were the infant(s) born at or above average birth weight? <i>Check one</i></p> <p><input type="checkbox"/> All were average to above average birth weight <input type="checkbox"/> At least one low birth weight <input type="checkbox"/> Don't Know</p> <p>C8c. Did a physician continue to monitor the weight of (any of) the infant(s) because they were concerned?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>	<p>C8. During the past 12 months, did Person 2 give birth?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No →SKIP to SECTION D</p> <p>C8a. Was/were the infant(s) born... <i>Check one</i></p> <p><input type="checkbox"/> Before due date <input type="checkbox"/> On due date <input type="checkbox"/> After due date <input type="checkbox"/> Don't know</p> <p>C8b. Was/were the infant(s) born at or above average birth weight? <i>Check one</i></p> <p><input type="checkbox"/> All were average to above average birth weight <input type="checkbox"/> At least one low birth weight <input type="checkbox"/> Don't Know</p> <p>C8c. Did a physician continue to monitor the weight of (any of) the infant(s) because they were concerned?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>

D

SECTION D. ASTHMA & COPD

D1. Have you ever been told by a doctor or other health professional that you have asthma?

Yes No →SKIP to D7 Don't know →SKIP to D7

D1a. Do you still have asthma?

Yes No

Symptoms of asthma include coughing, wheezing, shortness of breath, chest tightness or phlegm production when you have a cold or respiratory infection.

D2. How long has it been since you last had any symptoms of asthma? Check one

- Less than one day ago
- 1-6 days ago
- 1 week to less than 3 months ago
- 3 months to less than 1 year ago
- 1 year to less than 3 years ago →SKIP to D7
- More than 3 years ago →SKIP to D7
- Never →SKIP to D7
- Don't Know →SKIP to D7

Asthma attacks, also called "flare-ups", refer to periods of worsening asthma symptoms that make you limit your activity more than you usually do or make you seek medical care.

D3. During the past 3 months how many asthma flare-ups did you have?

Number of flare-ups: _____

An urgent care center treats people with illnesses or injuries that must be addressed immediately and cannot wait for a regular medical appointment.

D4. During the past 12 months, have you had to visit an URGENT CARE CENTER because of asthma?

Number of times went to URGENT CARE for asthma: _____

D5. During the past 12 months, have you had to stay overnight in a HOSPITAL because of asthma? Do not include a visit to the emergency room.

Number of times in HOSPITAL for asthma: _____

D6. Not counting hospitalizations and urgent care visits, during the past 12 months, did you go to an EMERGENCY ROOM because of asthma?

Number of times went to EMERGENCY ROOM for asthma: _____

D7. Has *anyone else* in the home, including children, ever been told by a doctor or other health professional that they have asthma?

Yes No →SKIP to D13 Don't know →SKIP to D13

Person 1 with Asthma First Name: _____	Person 2 with Asthma First Name: _____
D7a. Does this person still have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No	D7a. Does this person still have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No
D8. How long has it been since this person last had any symptoms of asthma? <input type="checkbox"/> Less than one day ago <input type="checkbox"/> 1-6 days ago <input type="checkbox"/> 1 week to less than 3 months ago <input type="checkbox"/> 3 months to less than 1 year ago <input type="checkbox"/> 1 year to less than 3 years ago <input type="checkbox"/> More than 3 years ago <input type="checkbox"/> Never	D8. How long has it been since this person last had any symptoms of asthma? <input type="checkbox"/> Less than one day ago <input type="checkbox"/> 1-6 days ago <input type="checkbox"/> 1 week to less than 3 months ago <input type="checkbox"/> 3 months to less than 1 year ago <input type="checkbox"/> 1 year to less than 3 years ago <input type="checkbox"/> More than 3 years ago <input type="checkbox"/> Never
D9. During the past 3 months how many asthma flare-ups has this person had? Number Flare-ups: _____	D9. During the past 3 months how many asthma flare-ups has this person had? Number Flare-ups: _____
D10. During the past 12 months, has this person had to visit an urgent care center because of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of times: _____	D10. During the past 12 months, has this person had to visit an urgent care center because of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of times: _____
D11. During the past 12 months, has this person had to stay overnight in a hospital because of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of times: _____	D11. During the past 12 months, has this person had to stay overnight in a hospital because of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of times: _____
D12. Not counting hospitalizations and urgent care visits, during the past 12 months, did this person go to an emergency room because of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of times: _____	D12. Not counting hospitalizations and urgent care visits, during the past 12 months, did this person go to an emergency room because of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of times: _____

D

Person 3 with Asthma First Name: _____	Person 4 with Asthma First Name: _____
D7a. Does this person still have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No	D7a. Does this person still have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No
D8. How long has it been since this person last had any symptoms of asthma? <input type="checkbox"/> Less than one day ago <input type="checkbox"/> 1-6 days ago <input type="checkbox"/> 1 week to less than 3 months ago <input type="checkbox"/> 3 months to less than 1 year ago <input type="checkbox"/> 1 year to less than 3 years ago <input type="checkbox"/> More than 3 years ago <input type="checkbox"/> Never	D8. How long has it been since this person last had any symptoms of asthma? <input type="checkbox"/> Less than one day ago <input type="checkbox"/> 1-6 days ago <input type="checkbox"/> 1 week to less than 3 months ago <input type="checkbox"/> 3 months to less than 1 year ago <input type="checkbox"/> 1 year to less than 3 years ago <input type="checkbox"/> More than 3 years ago <input type="checkbox"/> Never
D9. During the past 3 months how many asthma flare-ups has this person had? Number Flare-ups: _____	D9. During the past 3 months how many asthma flare-ups has this person had? Number Flare-ups: _____
D10. During the past 12 months, has this person had to visit an urgent care center because of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of times: _____	D10. During the past 12 months, has this person had to visit an urgent care center because of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of times: _____
D11. During the past 12 months, has this person had to stay overnight in a hospital because of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of times: _____	D11. During the past 12 months, has this person had to stay overnight in a hospital because of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of times: _____
D12. Not counting hospitalizations and urgent care visits, during the past 12 months, did this person go to an emergency room because of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of times: _____	D12. Not counting hospitalizations and urgent care visits, during the past 12 months, did this person go to an emergency room because of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of times: _____

Breathing problems may be caused by chronic obstructive pulmonary disease or "COPD". COPD is often referred to as a chronic bronchitis and/or emphysema and is a serious lung disease that slowly gets worse over time.

D13. Have you ever been told by a doctor or health professional that you have COPD, emphysema, or chronic bronchitis?

Yes No →SKIP to D18 Don't know →SKIP to D18

D14. Have you ever been given a breathing test to diagnose your COPD, chronic bronchitis, or emphysema?

Yes No Don't know

D15. Other than a routine visit, have you had to see a doctor in the past 12 months for symptoms related to shortness of breath, bronchitis, or other COPD or emphysema flare-ups?

Yes No Don't know

D16. Did you have to visit an urgent care center, emergency room or be admitted to a hospital in the past 12 months because of your COPD, chronic bronchitis, or emphysema?

Yes No →SKIP to D17 Don't know →SKIP to D17

D16a. If Yes, how many different times in the past 12 months?

Number times you visited an URGENT CARE CENTER: _____
Number times you visited an EMERGENCY DEPARTMENT: _____
Number times you went to the HOSPITAL: _____

D17. How many different medications do you currently take each day to help with your COPD, chronic bronchitis, or emphysema?

Number of medications: _____

Please answer questions D18 through D23 if there are children with asthma in the home.

D18. Does your home have pets such as dogs, cats, hamsters, birds or other feathered or furry pets that spend time indoors?

Yes No →SKIP to D19 Don't know →SKIP to D19

D

D18a. Are pets allowed in the bedroom(s) of the child/children with asthma?

Yes No Don't know

D19. Does the child or children with asthma use mattress covers made especially for controlling dust mites? *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.*

Yes No Don't know

D20. Does the child or children with asthma use pillow covers made especially for controlling dust mites? *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.*

Yes No Don't know

D21. Does the child or children with asthma have carpeting or rugs in their bedroom? *This does not include throw rugs small enough to be laundered.*

Yes No Don't know

D22. Have you seen mold in the room of the child or children with asthma in the past 30 days?

Yes No Don't know

D23. Are air fresheners or scented candles used anywhere inside the home?

Yes No Don't know

SECTION E. HOME CONDITIONS and HAZARDS



<i>During the past 12 months, how often have you or other members of your household found:</i>	All the time	Most of the time	Some of the time	Never	Don't know
E1. Your home too drafty (breezy, cold/damp air blowing in)					
E2. Your home too dusty					

<i>Please check one response for the following statements:</i>	Not infested at all	Hardly infested	Somewhat infested	Very infested	Extremely infested
E3. How infested is your home with cockroaches or other insects?					
E4. How infested is your home with rats, mice or other rodents?					

E5. Have you seen mold in your home in the past 12 months?

Yes No Don't know

E6. Have you seen standing water in your home in the past 12 months?

Yes No Don't know

E7. How much outdoor noise do you hear indoors when the windows are closed?

A great deal Some Hardly any
 None at all →SKIP to E8 Don't know →SKIP to E8

E7a. Thinking about the past 12 months, how much does this outdoor noise interfere with your sleep at night? Check one

None at all Slightly Moderately
 Very much Extremely Don't know

E8. How often do you smell odors from outside your home when the windows are closed?

A great deal Some Hardly any
 None at all Don't know

F

SECTION F. HEATING, COOKING and VENTILATION

F1. Do you use any of the following types of extra heating equipment in your home? Check all that apply

- Electric space heater
- Vented natural gas fireplace
- Unvented natural gas fireplace
- Wood fireplace
- Unvented propane or kerosene heater
- None of the above
- Don't know

F2. Is gas used for cooking in your home?

- Yes No Don't know

<i>Please check one response for the following statements:</i>	Never	Rarely	Sometimes	Frequently	All the time
F3. During the past winter, how often did you use your oven to heat your home?					
F4. How often are one or more windows open in your home in the SUMMER?					
F5. How often are one or more windows open in your home in the WINTER?					

An exhaust fan (usually above the stove) is often used to vent moisture, smoke and fumes.

F6. Is an exhaust fan that vents to the outside used regularly when cooking in your kitchen?

- Yes No Don't know

SECTION G. HEALTH AND SAFETY HAZARDS

G

This next section asks questions about other conditions inside your home related to health and safety.

G1. Do you now smoke cigarettes every day, some days, or not at all? Check one

- Every day Some days Not at all

G2. Which one of the following statements best describes the rules about smoking inside your home? Check one

- No one is allowed to smoke anywhere inside your home
 Smoking is allowed at some places or at some times
 Smoking is permitted anywhere and anytime

G3. How often does anyone smoke inside your home? Would you say...

- Daily
 Weekly
 Monthly
 Less than monthly
 Never
 Don't know

G4. Is a wood burning fireplace or wood burning stove used in your home?

- Yes No Don't know

G5. Are unvented gas logs, unvented gas fireplaces, or unvented gas stoves used in your home? "Unvented" means no chimney or the chimney flue is kept closed during operation.

- Yes No Don't know

G

G6. Does your main heating system have an air filter?

Yes No →SKIP to G7 Don't know →SKIP to G7

G6a. Is the air filter in your heating system a High Efficiency Particulate Arresting (HEPA) filter?

Yes No Don't know

G7. Do you have a CO (or carbon monoxide) monitor in your house?

Yes No →SKIP to G8 Don't know →SKIP to G8

G7a. Is your CO monitor currently working?

Yes No Don't know

G8. In the past 12 months, did anyone in the household see a medical professional because of carbon monoxide (CO) poisoning?

Yes No Don't know

G9. In the past 12 months did anyone in the household see a medical professional for food poisoning because your refrigerator was not at a temperature that was safe for food?

Yes No Don't know

G10. In the past 12 months how many times did you have to throw away food because your refrigerator was broken or lost power?

Number of times: ____

G11. In the past 12 months, did anyone in the household see a medical professional because of burns from scalding hot water coming out of a faucet or showerhead inside your home?

Yes No Don't know

G12. Do you have one or more smoke detectors in your house?

Yes No →SKIP to G13 Don't know →SKIP to G13

G12a. How many smoke detectors are there in your house?

Enter number of smoke detectors: _____

G12b. How many of these smoke detectors are currently working?

Enter number of working smoke detectors: _____

G13. In the past 12 months, how many times was the fire department called to put out a fire in your home?

Number of times fire department called: _____

G14. In the past 12 months did any fire start in your home as a result of using an alternate *heating* source, such as space heaters, electric blankets, your kitchen stove or oven, a heating stove, or a fireplace?

Yes No Don't know

G15. In the past 12 months did any fire start in your home as a result of the building's primary heating source, such as a furnace?

Yes No Don't know



G16. In the past 12 months, how many individuals needed medical attention because of fire-related injuries such as burns or smoke inhalation?

Number of individuals: _____ If zero →SKIP to G17

Person 1	Person 2
First Name: _____	First Name: _____
G16a. What types of medical attention did they seek? Check all that apply	G16a. What types of medical attention did they seek? Check all that apply
<input type="checkbox"/> Office visit	<input type="checkbox"/> Office visit
<input type="checkbox"/> Urgent care	<input type="checkbox"/> Urgent care
<input type="checkbox"/> Emergency room	<input type="checkbox"/> Emergency room
<input type="checkbox"/> Hospital	<input type="checkbox"/> Hospital
<input type="checkbox"/> Burn unit	<input type="checkbox"/> Burn unit
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Don't know	<input type="checkbox"/> Don't know

G17. In the past 12 months, did anyone in the household suffer a trip or fall *inside the home* that required them to see a medical professional?

Yes No →SKIP to SECTION H Don't know →SKIP to SECTION H

Person 1	Person 2
First Name: _____	First Name: _____
G17a. What types of medical attention did they seek? Check all that apply	G17a. What types of medical attention did they seek? Check all that apply
<input type="checkbox"/> Office visit	<input type="checkbox"/> Office visit
<input type="checkbox"/> Urgent care	<input type="checkbox"/> Urgent care
<input type="checkbox"/> Emergency room	<input type="checkbox"/> Emergency room
<input type="checkbox"/> Hospital	<input type="checkbox"/> Hospital
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Don't know	<input type="checkbox"/> Don't know
G17b. As a result of the trip or fall, what was the injury? Please describe below	G17b. As a result of the trip or fall, what was the injury? Please describe below
_____	_____
_____	_____

SECTION H. LIFE SATISFACTION



The following statements are about what it's like to live within your community.

Please tell me how satisfied you are with each of the following? <i>Please check one</i>	Not at all satisfied	Not very satisfied	Neither satisfied nor dissatisfied	Fairly satisfied	Very satisfied
H1. Your life in general					
H2. Your health					
H3. Your present standard of living					

SECTION I. HEALTH CARE COVERAGE AND AFFORDABILITY

11. In the past 12 months have you had any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?

- Yes → SKIP to I2 No Don't know

I1a. If No or Don't Know: Just to confirm, do you have health insurance or coverage through any of the following plans?

- Not covered by any plan → SKIP to I3
- Plan from a current or past employer/union/school
- Plan through a professional association
- Plan bought on own
- Plan bought by someone who does not live in this household
- Medicare
- Medicaid/State health insurance
- TRICARE
- Other military health insurance
- Indian health service
- Indigent care
- Other plan: _____
- Don't know → SKIP to I3

12. Does your health plan pay for at least some of the cost of prescription medicines?

- Yes No Don't know

13. During the past 12 months, have you or other adults in your household had any problems paying medical bills?

- Yes No Don't know

14. During the past 12 months, was there any time your household members needed prescription medicines but didn't get them because you couldn't afford it?

- Yes No Don't know

15. Over the past 12 months, how often did members of your household not fill a prescription or took less than the full dose of a prescribed medicine in order to pay the utility bill? Check one

- Every month
- Every other month
- Every 3 months
- Every 6 months
- Once in 12 months
- Never
- Not responsible for paying utility bills
- Don't know

16. Over the past 12 months, how frequently has your household not paid energy bills in order to purchase prescription medicines? Check one

- Every month
- Every other month
- Every 3 months
- Every 6 months
- Once in 12 months
- Never
- Not responsible for paying utility bills
- Don't know

J

SECTION J. ENERGY BILLS AND TRADE-OFFS

Some agencies offer assistance with paying for energy bills.

J1. Did your household receive energy assistance this year?

- Yes No ->SKIP to J2 Don't know ->SKIP to J2

J1a. When did you receive energy assistance? Check all that apply

- Winter Spring Summer Fall

J1b. Who did you receive energy assistance from? Check all that apply

- Local agency Church Utility company
Family or friends State agency Other
Don't know

J2. During the past 12 months, how often did people you know help pay your energy bills? Check one

- Almost every month Some months 1 or 2 months
Never Don't know

J3. How hard is it to pay for your energy bills? Check one

- Very hard Hard Neither hard nor easy
Easy Very easy Don't know

J4. Over the past 12 months, how often has your household not paid energy bills in order to pay other utility bills (water/sewage/telephone/secondary energy fuel type) Check one

- Every month
- Every other month
- Every 3 months
- Every 6 months
- Once in 12 months
- Never
- Not responsible for paying utility bills
- Don't know

J5. Over the past 12 months, how often has your household not paid other utilities in order to pay the primary energy bill? Check one

- Every month
- Every other month
- Every 3 months
- Every 6 months
- Once in 12 months
- Never →SKIP to J6
- Not responsible for paying utility bills →SKIP to J6
- Don't know →SKIP to J6

J5a. What utilities were not paid for in order to pay an energy bill? Check all that apply

- Water
- Sewage
- Telephone
- Secondary energy fuel type
- Other _____
- Don't know

J6. During the past summer did you worry that your home would not have electricity or cooling?

- Yes No Don't know

J7. During the past winter did you worry that your home would not have electricity or heat?

- Yes No Don't know



J8. In the past year, have you used any of the following to assist with paying your energy bill? Check all that apply

- Payday loan
- Tax refund anticipation loan
- Car title loan
- Other type of short-term, high interest loan
- Pawn shop
- None →SKIP to J9
- Don't know →SKIP to J9

J8a. If YES to any of the above, how often did you need to use these?

- Almost every month
- Some months
- 1 or 2 months
- Don't know

J9. When home energy bills are not paid on time, it is common for energy utilities and suppliers to send late notices. During the past 12 months, how often did you receive a disconnect, shut-off, or non-delivery notice? Check one

- Almost every month
- Some months
- 1 or 2 months
- Never
- Don't know

J10. In the past 12 months, was your electricity or natural gas ever disconnected because you were unable to pay your home energy bill?

- Yes No →SKIP to J11 Don't know →SKIP to J11

J10a. While your electricity or natural gas was disconnected, was there a time when you wanted to use your main source of heat but were unable to?

- Yes No Don't know

J10b. While your electricity was disconnected, was there a time when you wanted to use your air conditioner but were unable to?

- Yes No Don't know

J11. Over the past 12 months, how often has your household *not purchased food* in order to pay an energy bill? *Check one*

- Every month
- Every other month
- Every 3 months
- Every 6 months
- Once in 12 months
- Never
- Not responsible for paying utility bills
- Don't know

J12. Over the past 12 months, how often has your household *not paid energy bills* in order to purchase food? *Check one*

- Every month
- Every other month
- Every 3 months
- Every 6 months
- Once in 12 months
- Never
- Not responsible for paying utility bills
- Don't know

J13. In the past four weeks, did you or any household member go a whole day and night without eating anything because there was not enough food?

- Yes No Don't know

J14. In the past four weeks, did you worry that you or your household members would not have nutritious food?

- Yes No Don't know

J15. In the past 12 months did you or any members of your household receive food stamps or WIC assistance (Women, Infants, and Children nutrition program) to help pay for food?

- Yes No Don't know

J16. In the past 12 months, did you have to temporarily move out of your home because of any of the following reasons? *Check all that apply*

- Did not have power Flooding Fire
- Home was too hot Home was too cold Don't know

SECTION K. EMPLOYMENT AND EDUCATION

K1. Is the primary wage earner in the household currently...?

- Employed for wages
- Self-employed
- Out of work more than 1 year → SKIP to K4
- Out of work less than 1 year → SKIP to K4
- A homemaker → SKIP to K4
- A student and not employed → SKIP to K4
- Retired → SKIP to K4

K1a. Are you or the primary wage earner in the household employed full-time or part-time?

- Full-time
- Part-time
- Don't know
- N/A

<i>In the past 12 months, about how many days of work did the primary wage earner miss because of...</i>	Number of DAYS
K2. Illness or injury? (Do not include maternity leave.)	
K3. Illness or injury of <i>another</i> household member?	

<p>K4. Does your health keep you from working at a job?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>	<p>K6. In the past 12 months, did anyone in the household receive income from any of the following sources?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Social Security <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Welfare payments or case assistance <input type="checkbox"/> Veteran's payments (VA Benefits) <input type="checkbox"/> Unemployment Compensation <input type="checkbox"/> No, did not receive any of the above <input type="checkbox"/> Don't know
<p>K5. Does your health keep you from doing work around the house?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>	

<i>Thinking about children in the home that attend preschool or school...</i>	Number of DAYS
<p>K7. If you have any children in pre-school, which child missed the most days of school in the past 12 months? How many days was it?</p> <p>First name: _____</p>	
<p>K8. If you have any children in school (Grades K-12), which child or young person missed the most days of school in the past 12 months? How many days was it?</p> <p>First name: _____</p>	



SECTION L. DEMOGRAPHICS

L1. Are you currently...?

- Married or
A member of an unmarried couple
- Divorced
- Widowed
- Separated
- Never married
- Don't want to answer

L2. What is the highest degree or level of school you completed?

- No schooling completed
- Kindergarten to grade 12 (no diploma)
- High school diploma or GED
- Some college, no college degree
- Associate's degree
- Bachelor's degree
- Master's degree
- Professional degree
- Doctorate degree

L3. Do you consider yourself to be of Hispanic or Latino origin, such as Mexican, Puerto Rican, Cuban, or other Spanish background?

- Yes No Don't want to answer

L4. Which describes your race? *You can select more than one category.*

- White
- Black or African-American
- Asian
- Native Hawaiian or Other Pacific Islander
- Other: _____
- Don't want to answer

L5. If you selected more than one race, which one of these groups BEST represents your race? *Check one.*

- White
- Black or African-American
- Asian
- Native Hawaiian or Other Pacific Islander
- Other: _____
- Don't want to answer

That is the end of the survey!

We do have one additional opportunity for you. We are looking for households who would be willing to let us visit their home and be interviewed. This will help us better understand what it is like living in a home that needs home energy improvements. We will provide you with an additional incentive of \$50 total for assisting with that part of our research. We will contact you if chosen, as not everyone interested will need to be visited.

Are you interested in participating in this part of our research?

- Yes
 No

THANK YOU!

Thank you for your participation! You will receive your \$20 gift card in the mail to compensate you for your time. Please make sure your mailing address on the first page of this survey is correct.