Persons using assistive technology may not be able to fully access information in this file. For assistance, e-mail niddk-cr@imsweb.com. Include the Web site and filename in your message.

AFRICAN AMERICAN STUDY OF KIDNEY DISEASE AND HYPERTENSION
AASK COHORT STUDY
CLOSE OUT FORM # 198

This form is completed at the "Last Data Collection Visit" which will be held sometime between March and June, 2007.

1. Identification Number...	2. Name Code...	3. Visit Number...	4. Visit Date: mm/dd/yyyy... VISDT

5. Do you have health insurance? (0=no, 1=yes, 9=unknown for each type)
   a. Private, such as Blue Cross ..... Private
   b. HMO/Preferred Provider ..... Hmo
   c. Medicaid ..... Medicaid
   d. Medicare ..... medicare
   e. Other health insurance plan ..... oth_insure

6. a. Do you have a personal care provider? (0=no, 1=yes) ..... PCP
   b. Have you seen your personal care provider in the last year? (0=no, 1=yes) ..... Seen_PCP
   c. If no to either 6a or 6b, was participant referred or scheduled to see a personal care provider/community based medical service? (0=no, 1=yes) ..... Sched_PCP

7. a. Do you have a kidney specialist? (0=no, 1=yes) ..... Kd_Spec
   b. If no, was participant referred to a kidney specialist? (0=no, 1=yes) ..... Meds_paid

8. How will your medications be paid for after the Study ends? ..... Nref_Kd_Spec

   0=No coverage, out of pocket
   1=Covered by insurance
   2=Pharmaceutical co-assistance program
   3=Pharmacy assistance program
   4=Medicaid
   5=Medicare
   6=VA

200. Date this form completed (mm/dd/yyyy) ..... __/__/__ Compl_dt

201. Certification ID of person completing this form ..... _____ Compl_by

For Clinical Center Use Only:
Certification ID of person entering this form: _____
Date Entered: __/__/____