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Frequent Hemodialysis Network
BASELINE DEMOGRAPHICS, EMPLOYMENT, and INCOME - FORM #105

Instructions: This form is completed at baseline.

1. Participant ID #	2. Alpha Code	3a.Visit Type	3b. Visit Number	4. Date: dd/mon/yyyy

5. Marital status:.....__
   - 1=Never been married
   - 2=Married
   - 3=Common law marriage/partnered/ living together unmarried
   - 4=Separated
   - 5=Divorced
   - 6=Widowed

6. Household Size: (For Questions 6 a-d: 0=No, 1=Yes)
   a. Lives with family (e.g., spouse, children, parents):.....__
   b. Lives alone:.....__
   c. Lives with others (e.g., retirement community, rooming house):.....__
   d. Homeless:.....__

7. Highest level of formal education achieved?..... __ __
   - 1=Nursery school - 8th Grade
   - 2=9th-12th grade, no diploma
   - 3=High school graduate
   - 4=Vocational/technical/business
   - 5=Some college, no degree
   - 6=Associate degree
   - 7=Bachelor's degree
   - 8=Refused
   - 9=Unknown
   - 10=Master's/Doctorate

8. Has the patient ever been employed for pay? (0=No, 1=Yes).....__

9. What was the last year the patient was employed?.....__ __ __ __
   (Enter current year if currently employed)

10. Current work status:.....__ __
    - 01=Student, not employed
    - 02=Student, employed
    - 03=Homemaker
    - 04=Not working, not seeking work, disabled
    - 05=Not working, not seeking work, not disabled
    - 07=Not working, seeking work, not disabled
    - 08=Employed full-time
    - 09=Employed part-time
    - 10=Retired
    - 06=Not working, seeking work, disabled
    - 99=Unknown

11. Current household gross annual income (in your own country's currency)?.....__

1=<$10,000	6=$40,000-$49,000
2=$10,000-$14,999	7=$50,000-$99,000
3=$15,000-$19,999	8=>$100,000
4=$20,000-$29,999	9=Unknown or refused
5=$30,000-$39,000	

Patient Health Insurance: (For questions 12a-h: 0=No, 1=Yes, 8=Not Applicable)

12. **Column A:** What type of health insurance does the patient have?
Column B: Are any of the insurance plans the patient listed an HMO (Health Maintenance Organization)?

		A Have?	**B HMO?**
a.	Medicare:	__	__
b.	Medicaid or State Medical Assistance:	__	__
c.	State or county program other than Medicaid:	__	__
d.	Employer-sponsored or retiree health plan:	__	__
e.	Privately-purchased policy (e.g., Medigap or Medicare supplement):	__	__
f.	Veterans benefit, TriCare or military health plan:	__	__
g.	Canadian health care benefits:	__	__
h.	None:	__	

13. a. Is Medicare paying for this patient's hemodialysis? .....__
0=No, answer Question 13b
1=Yes, skip to Question 200.
(Note: This question may need to be completed by your Billing Department.)

b. If no to Question 13a, why not?.....__
1=Patient recently started hemodialysis
2=Patient is Canadian
3=U.S. Patient has alternative insurance

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

201. Username of person reviewing completeness of this form.....__ __ __ __ __ __ __

For Clinical Center Use Only:

202. Username of person entering this form: __ __ __ __ __ __ __

203. Date Entered: (dd/mon/yyyy) __ __/__ __ __ /__ __ __ __