Section 9: Determining Economic Burden related to COVID19, COVID19-like symptoms (COVID19 COST SURVEY)

Data Field
Have you had or sought care for symptoms concerning for COVID19 (cough, fever, body aches, loss of smell)? Yes No
Survey Date: MM-DD-YY
Nativity status (if not answered previously)
Part I. Costs associated with care-seeking for COVID19 related symptoms and COVID19 diagnosis. This survey is to be administered to patients with symptoms consistent with COVID19 including chronic cough, who are diagnosed with COVID19 and may be at different stages of their treatment. The questions and answers of this section should reflect ALL costs related to care-seeking for their COVID19 related symptoms, for diagnosis of COVID19, and any costs related to treatment to date. Of cough and the costs related to attending the current clinic visit.
1a.When did you first experience symptoms (cough, fever, body aches, loss of smell) that prompted COVID19 testing? MM-DD-YY ➔ Months: ____ → Days: _____ (REDCap automatically calculates weeks and days since symptom onset based on survey date and reported date of symptom onset)
1b. When did you test positive for Coronavirus/COVID-19? MM-DD-YY
2. Up until now, how many total visits have you ever made to other health centers, including urgent care, emergency department visits, hospitalizations, to seek care or advice for COVID-19 and/or COVID-19 related symptoms? Enter ##
3.Thinking about all the back-and-forth to health centers that you had to do, how much **TOTAL <u>TRAVEL</u> TIME** did you spend on seeking health care for COVID-19? Include going to and from health facilities, going to and from lab or testing facilities (hours), etc. __hours
4. How much out-of-pocket money did you spend on **TRANSPORTANTION** to get all health care for COVID-19? **$_____**
5. How much **TOTAL TIME** did you spend <u>getting health care</u> for COVID19? Include waiting time, waiting for lab/testing results, multiple clinic/urgent care/emergency care, days in hospital, (days)? **__days**

6. Did you spend any out-of-pocket money on medical expenses including clinical care and urgent care fees, co-payments, testing, xrays, medicines or other items like personal protective equipment (masks) for COVID19 care?
No, skip to question 9
Yes
Unsure/Don't Know

7. If yes or don't know, what did you spend out-of-pocket money on? (check all that apply)
Office visits/co-pays
Radiology Tests
Lab testing
Medicines
Personal protective equipment (this includes masks, gloves, etc)
Other, specify: _____ _____

8. How much total out-of-pocket money did you spend on all health care for COVID19 for OFFICE VISITS OR CO-PAYS? (complete for each checked answer for question 7):
$_____

8. How much total out-of-pocket money did you spend on all health care for COVID19 for RADIOLOGY TESTS? (complete for each checked answer for question 7):
$_____

8. How much total out-of-pocket money did you spend on all health care for COVID19 for LAB TESTING? (complete for each checked answer for question 7):
$_____

8. How much total out-of-pocket money did you spend on all health care for COVID19 for MEDICINES? (complete for each checked answer for question 7):
$_____

8. How much total out-of-pocket money did you spend on all health care for COVID19 for PERSONAL PROTECTIVE EQUIPMENT? (complete for each checked answer for question 7):
$_____

8. How much total out-of-pocket money did you spend on all health care for COVID19 for ANY OTHER MEDICAL PAYMENTS? (complete for each checked answer for question 7):
$_____

9. Did your health insurance offset all of your costs of seeking care for COVID-19 (or related symptoms)?
No
Yes → skip to question 11
Unsure/Don't know

10. If your insurance did not cover all of your health care costs, how much did you end up paying out of pocket?
$_____

11. Did you have to spend additional money on housing or accommodations when you had COVID-19?
No → skip to next section
IF yes, how much additional money did you spend on housing or accommodations? $_____

Part II. Income Changes. This section is intended to document changes in financial status (including but not limited to income) that the patient experienced because of COVID19 care seeking and COVID19 diagnosis.

Question
1. Has your primary or normal work/job changed since you have had COVID-19? No → skip to question 3 Yes
2. What is your current work/job now? (Enter short description)
3. Did your income or your household's income change BECAUSE you were diagnosed/treated for COVID19? No → skip to question 5 Yes Unsure
3. Approximately, what is your household's **monthly** income **now** having COVID-19 (include income sources such as disability/SSI, social security, other assistance services)? The reported monthly household income before the coronavirus pandemic was $[HH income reported in the SES survey]. $_____
4a. If prefer to not answer with exact amount: a. $500-1000 b. 1000-1499 c. 1500-1999 d. 2000-2999 e. 3000-3999 f. 4000-4999 g. 5000-6999 h. 7000-8999 i. 9000-11999 j. >12,000
4. Have you or anyone in your family needed to work additional jobs now as a result of your COVID-19 related costs or COVID-19 diagnosis? Yes No
6. Did you or your household receive any social welfare payment for your health or COVID-19 related issues? Yes

No

7. If yes, what type and amount since COVID-19 diagnosis? (check all that apply)

a. Paid sick leave?
    i. Amount of paid sick leave (after tax) since COVID-19 diagnosis?
b. Disability grant
    i. Amount of disability grant (after tax) since COVID-19 diagnosis?
c. Income support for low-income?
    i. Amount of income support for low income (after tax) since COVID-19 diagnosis?
d. Unemployment benefits
    i. Amount unemployment benefits (after tax) since COVID-19 diagnosis: _____
e. Other, specify type. List other types of payment one at a time: _____
    i. Amount received (after tax) for _____ since COVID-19 diagnosis (specify for each): _____
f. Other, specify type. List other types of payment one at a time: _____
    i. Amount received (after tax) for _____ since COVID-19 diagnosis (specify for each): _____
g. Other, specify type. List other types of payment one at a time: _____
    i. Amount received (after tax) for _____ since COVID-19 diagnosis (specify for each): _____

10. Did you receive any support from the health department or clinic to health you and your household financially, or to provide you with food, transportation, housing for your COVID-19? (check all that apply)
None
Food
Transportation
Housing
Other, specify: _____

11. What would you have had to spend out of pocket for those supports/items if the health department or clinic had not provided it for you? (check all that apply)
Food
Transportation
Housing
Other _____

12. Did you or your household use any savings (cash or bank deposits) to cover costs due your COVID-19 symptoms or diagnosis?
No
Yes
Unsure

13. Did you borrow any money to cover costs due to your COVID-19 symptoms or diagnosis?
No
Yes
Unsure

14. Have you sold any of your property, household items, or assets to finance the cost of your illness? No Yes Unsure
15. To what extent do you feel like COVID19 has affected your household financially? (FREE TEXT)

Thank you for your time.