

SAMPLE COPY OF THE PECUNIA Resource Use Measurement (PECUNIA RUM) Instrument

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**Programme in Costing, resource use measurement and outcome
valuation for Use in multi-sectoral National and International
health economic evaluAtions**

PECUNIA
Resource Use Measurement
(PECUNIA RUM)
Instrument



This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 779292.

INTRODUCTION

In this questionnaire we are trying to find out about the various impacts of your health. Please read the instructions provided for each question carefully. Questions that can be skipped are clearly indicated. If you have difficulty answering any of the questions or knowing details, please provide the best answer you can.

Your responses will be treated as confidential.

Thank you very much in advance for helping us by completing this questionnaire.

Structure of the questionnaire

This questionnaire consists of the following sections.

Section A. Place of living and overnight stays

Section B. Non-residential health and social care

Section C. Medication

Section D. Unpaid help (informal care)

Section E. Education

Section F. Employment and productivity

Section G. Safety and justice system

Section H. Out-of-pocket and other expenses

Section I. Final remarks



Further information about the PECUNIA RUM

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SECTION A: PLACE OF LIVING AND OVERNIGHT STAYS

In this section, we ask you about your **usual place of living** and any overnight stays you have had in the **past 3 months** (i.e. in the **past 90 nights**).

A1 Where have you lived or stayed overnight (e.g. in hospital) in the past 3 months?	
<i>Please tick all answers that apply and indicate the number of nights that you spent in each place. If you are unsure, please tick 'Other' and provide details.</i>	
1 Individual or shared flat or house	<input type="checkbox"/> _____ nights
2 Family or friend's flat or house	<input type="checkbox"/> _____ nights
3 Dormitory (e.g. boarding school, university residence)	<input type="checkbox"/> _____ nights
4 Paid temporary accommodation (e.g. hotel)	<input type="checkbox"/> _____ nights
5 Emergency shelter (e.g. temporary shelter for homeless)	<input type="checkbox"/> _____ nights
6 Sheltered housing (e.g. housing with assistance, supported housing)	<input type="checkbox"/> _____ nights
7 Nursing home (e.g. residential care home with nursing)	<input type="checkbox"/> _____ nights
8 Other long-term residential care home	<input type="checkbox"/> _____ nights
9 Therapeutic community home (e.g. temporary group residence for therapeutic purposes)	<input type="checkbox"/> _____ nights
10 Hospital	
Type of hospital department/service (e.g. oncology, surgery, psychiatry): _____	<input type="checkbox"/> _____ nights
Type of hospital department/service (e.g. oncology, surgery, psychiatry): _____	<input type="checkbox"/> _____ nights
Type of hospital department/service (e.g. oncology, surgery, psychiatry): _____	<input type="checkbox"/> _____ nights
11 Residential palliative care (e.g. hospice)	<input type="checkbox"/> _____ nights
12 Place of detention (e.g. prison)	<input type="checkbox"/> _____ nights
13 On the street	<input type="checkbox"/> _____ nights
14 Other, please specify: _____	<input type="checkbox"/> _____ nights



SECTION B: NON-RESIDENTIAL HEALTH AND SOCIAL CARE

In this section, we ask you about any **non-residential health and social care services** you have used in the **past 3 months** to help you with an illness or other life problems (e.g. being a victim of crime, care needs). These services include non-emergency contacts (e.g. primary care), day care (e.g. admission to a hospital as a day patient), contacts with support/self-help groups, emergency contacts (e.g. emergency ambulance rides), contacts with helplines, and vocational services (e.g. sheltered workshops).

B1 Non-emergency outpatient/social care services

B1.1 Have you used any non-emergency outpatient/social care services in the past 3 months?

Non-emergency outpatient/social care services could include routine check-up appointments, scheduled appointments to discuss any physical or mental health issues, and telephone or online contacts (e.g. phone consultation, online prescription ordering). Please only consider the services you used for yourself and not those you may have used on behalf of someone else.

Yes Please go to question B1.2

No Please go to question B2

I don't know/I would rather not say Please go to question B2

B1.2 How many times have you used any of the following non-emergency outpatient/social care services in the past 3 months?

Please tick all answers that apply and indicate the number of times you have used a given service. If you are unsure, please tick 'Other' and provide details.

		Number of times
1	General practitioner (GP)/family doctor	<input type="checkbox"/> _____ times
2	Dental care	<input type="checkbox"/> _____ times
3	Specialist medical care (e.g. orthopaedist, psychiatrist, gynaecologist) Please specify: _____	<input type="checkbox"/> _____ times
4	Diagnostic imaging services (e.g. MRI, CT scan) Please specify: _____	<input type="checkbox"/> _____ times
5	Diagnostic laboratory services (e.g. genetic testing, blood tests) Please specify: _____	<input type="checkbox"/> _____ times
6	Home health care (e.g. nursing care, palliative care) Please specify: _____	<input type="checkbox"/> _____ times
7	Other health care (e.g. psychologist, physiotherapist, dietician) Please specify: _____	<input type="checkbox"/> _____ times
8	Social care (e.g. social worker) Please specify: _____	<input type="checkbox"/> _____ times
9	Holistic health care (e.g. acupuncturist, homeopathist, Traditional Chinese Medicine (TCM), osteopath) Please specify: _____	<input type="checkbox"/> _____ times
10	Other, please specify: _____	<input type="checkbox"/> _____ times

B2 Day care services

B2.1 Have you used any day care services in the past 3 months?

Day care services are usually used only for part of the day and do not involve an overnight stay.

- Yes Please go to question B2.2
- No Please go to question B3
- I don't know/I would rather not say Please go to question B3

B2.2 How many times did you use any of the following day care services in the past 3 months?

Please tick all answers that apply and indicate the number of days you used a given service for. If you are unsure, please tick 'Other' and provide details.

- 1 Medical day care (e.g. day patient in hospital) ____ days
- 2 Non-medical day care (e.g. day care centre) ____ days
- 3 Other, please specify: _____ ____ days

B3 Support/self-help groups

B3.1 Have you participated in any support/self-help groups in the past 3 months?

A support/self-help group is a group of people that meet to discuss their condition and provide each other with emotional support or advice.

- Yes, I participated in a support/self-help group _____ times
- No Please go to question B4
- I don't know/I would rather not say Please go to question B4

B4 Emergency care services

B4.1 Have you used any emergency care services for yourself in the past 3 months?

Emergency care services include: a ride in an emergency ambulance, a visit to an Accident and Emergency (A&E) department, a visit from paramedics, or contact with an emergency doctor on call.

Yes Please go to question B4.2

No Please go to question B5

I don't know/I would rather not say Please go to question B5

B4.2 How many times have you used any of the following emergency care services for yourself in the past 3 months?

Please tick all answers that apply and indicate the number of contacts you had with a given service. If you are unsure, please tick 'Other' and provide details.

		Number of face-to-face contacts	Number of online or telephone contacts
1	Emergency ambulance (e.g. paramedics)	<input type="checkbox"/> ___ contacts	___ contacts
2	Out-of-hours medical service (e.g. night care)	<input type="checkbox"/> ___ contacts	___ contacts
3	Accident and Emergency (A&E) department	<input type="checkbox"/> ___ contacts	___ contacts
4	Fire brigade	<input type="checkbox"/> ___ contacts	___ contacts
5	Other rescue services (e.g. mountain rescue) Please specify: _____	<input type="checkbox"/> ___ contacts	___ contacts

B5 Helplines

B5.1 Have you contacted a helpline (phone/online) regarding health or other life problems in the past 3 months?

Yes *Please go to question B5.2*

No *Please go to question B6*

I don't know/I would rather not say *Please go to question B6*

B5.2 How many times have you contacted a helpline (phone/online) regarding health or other life problems in the past 3 months?

Please tick all answers that apply and indicate the number of contacts you had with a given service. If you are unsure, please tick 'Other' and provide details.

- | | | | |
|---|--|--------------------------|----------------|
| 1 | For information (e.g. pharmacy, health hotline) | <input type="checkbox"/> | _____ contacts |
| 2 | For support (e.g. mental health support hotline) | <input type="checkbox"/> | _____ contacts |
| 3 | Other, please specify: _____ | <input type="checkbox"/> | _____ contacts |



B6 Vocational services

B6.1 Have you used any vocational services in the past 3 months?

Vocational services are services that help people get back into work. These might include job-specific training or support for people with disabilities to develop work-related skills.

Yes Please go to question B6.2

No Please go to question B7

I don't know/I would rather not say Please go to question B7

B6.2 How many times have you used any of the following vocational services in the past 3 months?

Please tick all answers that apply and indicate the number of days you used a given service. If you are unsure, please tick 'Other' and provide details.

- | | | |
|---|--|------------------------------------|
| 1 | Vocational training
(training for a specific type of job that provides the trainee with a qualification (e.g. a diploma) that allows them to work in a specific profession, e.g. as an electrical technician) | <input type="checkbox"/> ____ days |
| 2 | Sheltered workshop
(place of work specially designed to provide a safe environment for people with (mental) disability, unpaid or very low paid) | <input type="checkbox"/> ____ days |
| 3 | Integration workplace
(place of work promoting the integration and inclusion of people with (mental) disability into a work environment, low paid) | <input type="checkbox"/> ____ days |
| 4 | Supported employment programmes
(supporting people with some (mental) disability to secure and retain paid employment, normally paid) | <input type="checkbox"/> ____ days |
| 5 | Other, please specify: _____ | <input type="checkbox"/> ____ days |

B7 Non-emergency transport

B7 Have you received any non-emergency transport for your health and social care needs in the past 3 months?

Please consider any special transport service you needed to reach your non-emergency inpatient or outpatient appointments. These transports could include for instance a ride in an ambulance, or a specially equipped taxi.

Yes *Please go to question B7.2*

No *Please go to the next section*

I don't know/I would rather not say *Please go to the next section*

B7.1 How many times have you received non-emergency transport for your health and social care needs in the past 3 months?

Please tick all answers that apply and indicate the number of times you used a given service. If you are unsure, please tick 'Other' and provide details.

1 Non-emergency ambulance ride ____ times

2 Taxi service ____ times

3 Other, please specify: _____ ____ times

SECTION C: MEDICATION

In this section, we ask you about any **prescribed medication** you have taken to treat your illness in the **past 3 months**. This could include tablets, capsules, liquids or injections.

C1.1 Have you used any prescribed medication in the past 3 months?

Yes *Please go to question C1.2*

No *Please go to the next section*

I don't know/I would rather not say *Please go to the next section*

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C1.2 Please list below any prescribed medications you have taken in the past 3 months.

If you have taken the same medication at different doses, please list each dose in a separate row and indicate the duration for each dose if known.

	Medication name	Medication type	Dose	Unit	How often have you taken the given medication?	For how long have you taken the given medication in the <u>past 3 months</u> ?
	<i>Example: Zoloft</i>	<input checked="" type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection Other: _____	50	<input checked="" type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml Other: _____	2 _____ times	<input checked="" type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed Other: _____ 12 <input type="checkbox"/> day(s) <input type="checkbox"/> week(s) <input type="checkbox"/> month(s)
1	<input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection Other: _____	_____	<input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml Other: _____	_____ times	<input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed Other: _____ _____ day(s) _____ week(s) _____ month(s)
2	<input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection Other: _____	_____	<input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml Other: _____	_____ times	<input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed Other: _____ _____ day(s) _____ week(s) _____ month(s)
3	<input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection Other: _____	_____	<input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml Other: _____	_____ times	<input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed Other: _____ _____ day(s) _____ week(s) _____ month(s)
4	<input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection Other: _____	_____	<input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml Other: _____	_____ times	<input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed Other: _____ _____ day(s) _____ week(s) _____ month(s)

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C1.2 Please list below any prescribed medications you have taken in the past 3 months.

If you have taken the same medication at different doses, please list each dose in a separate row and indicate the duration for each dose if known.

	Medication name	Medication type	Dose	Unit	How often have you taken the given medication?	For how long have you taken the given medication in the <u>past 3 months</u> ?
5	<input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml <input type="checkbox"/> Other: _____	_____ times <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
6	<input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml <input type="checkbox"/> Other: _____	_____ times <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
7	<input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml <input type="checkbox"/> Other: _____	_____ times <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
8	<input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml <input type="checkbox"/> Other: _____	_____ times <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

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SECTION D: UNPAID HELP (INFORMAL CARE)

In this section, we ask you about any **unpaid help** (informal care) you received from your partner, family, friends, neighbours and/or volunteers in the **past 3 months**. The giver of such care is **not expected to be paid for providing this help**. When answering the questions, please consider the following help:

- Food preparation
- Eating and drinking
- Mobility around the house
- Moving or travelling outside the house
- Walking
- Washing
- Bathing
- Dressing
- Hair care
- Shaving
- Toileting and grooming
- Housekeeping
- Medication
- Prevention of dangerous/risky behaviours (to oneself and/or others)

D1 How many hours of unpaid help (informal care) have you received because of your health in the past 3 months?

_____ hours per week *Please go to the next section*

I don't know/I would rather not say *Please go to the next section*

SECTION E: EDUCATION

In this section, we ask you about your **education**, any difficulties you have faced in completing your education (e.g. missing school or repeating a year) and your use of any education support services (e.g. tutoring or remedial teaching) in the **past 3 months**.

E1	What is the highest level of education you have completed?
<input type="checkbox"/>	Primary education or lower
<input type="checkbox"/>	Lower secondary education
<input type="checkbox"/>	Upper secondary education
<input type="checkbox"/>	Post-secondary non-tertiary education
<input type="checkbox"/>	Short-cycle tertiary education
<input type="checkbox"/>	Bachelor's degree or equivalent level (e.g. BSc, BA)
<input type="checkbox"/>	Master's degree or equivalent level (e.g. MSc, MA, Mag)
<input type="checkbox"/>	Doctoral degree or equivalent level (e.g. Dr, PhD)
<input type="checkbox"/>	Other, please specify: _____

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E2 Have you been a student in the past 3 months?

Being a student means that you are enrolled in an educational facility (either full-time or part-time) and receive education on a regular basis.

Special education refers to the practice of educating students in a way that addresses their individual needs (e.g. learning/physical/developmental disabilities).

Yes, in a special education day school *Please go to question E3*

Yes, in a day school *Please go to question E3*

Yes, in a special education boarding school *Please go to question E3*

Yes, in a boarding school *Please go to question E3*

Yes, in a higher education school (e.g. university, college, vocational school)

Please go to question E3

No *Please go to question E6*

I don't know/I would rather not say *Please go to question E6*

Other, please specify: _____ *Please go to question E3*

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E3 Have you had problems with completing your education because of your health in the past 3 months?

Please tick every applicable box below.

Yes, I had to stop my education

Yes, I had a study delay (e.g. I had to repeat a year)

Yes, I had to change to a lower education level

No

I don't know/I would rather not say

Other, please specify: _____

E4 Have you missed any days of education because of your health in the past 3 months?

Please only consider the days when you were not able to participate in classes.

Yes, I have missed _____ school days

No

I don't know/I would rather not say

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E5 Have there been days when you were bothered by physical or mental health problems at school in the past 3 months?

Yes, _____ days

No

I don't know/I would rather not say

E6 Have you used education support services in the past 3 months?

This includes any additional educational support you have received, such as tutoring, additional lessons, etc.

Yes Please go to question E6.1

No Please go to question E7.1

I don't know/I would rather not say Please go to question E7.1

E6.1 How much did you use other education support services in the past 3 months?

		Average number of hours per week
1	Education support at your place of study	<input type="checkbox"/> _____ hours
2	Education support in a private setting (e.g. private tutoring)	<input type="checkbox"/> _____ hours
3	Other, please specify: _____	<input type="checkbox"/> _____ hours

E7 Have you received any special transport to attend education in the past 3 months?

Please consider any special transport service you needed to reach your educational appointments. These transports could include for instance a ride in a specially equipped taxi.

Yes *Please go to question E7.2*

No *Please go to the next section*

I don't know/I would rather not say *Please go to the next section*

E7.1 How many times have you received special transport to attend education in the past 3 months?

Please tick all answers that apply and indicate the number of times you used a given service. If you are unsure, please tick 'Other' and provide details.

1 Specialized taxi service ____ times

2 Other, please specify: _____ ____ times

SECTION F: EMPLOYMENT AND PRODUCTIVITY

In this section, we ask you about your **paid and unpaid work** (e.g. household tasks) and any difficulties you might have faced at work because of your health (e.g. missing work days or not being able to do as much work as you normally would). Please note that the questions in this section are about the **past 3 months**.

F1 What do you do? Choose the option that is closest to what you usually do.

Please indicate your current employment status.

- I go to school, I am studying
- I am employed (part-time or full-time)
- I am self-employed
- I volunteer
- I am a homemaker or stay-at-home parent
- I am unemployed
- I am unable to work for ____%
- I am retired or on a pre-pension plan
- Other, please specify: _____

F2 Do you have a paying job?

- Yes *Please go to question F3*
- No *Please go to question F9, but first read the explanation above question F9*



F3-F8 Paid work

The following questions refer to your work. This is work that you get paid for.

F3 What is your occupation?

Please indicate the occupation for which you get paid.

F4 How many **hours** a week do you work?

Please indicate the number of hours below.

_____ hours per week

F5 How many **days** a week do you work?

Please indicate the number of days below.

_____ days per week

F6 Have you missed any work because of your health in the past 3 months? *This can be due to minor or severe physical or mental health problems.*

Yes, I have missed _____ work days in the past 3 months *Please go to question F7*

No *Please go to question F8*

F7 Did you miss any work because of your health prior to the past 3 months? *This can be due to minor or severe physical or mental health problems.*

This refers to one whole uninterrupted period of missed work as a result of being sick.

Yes *Please go to question F7.1*

No *Please go to question F8*

F7.1 When did you call in sick?

Please fill in the date below.

Day		Month		Year			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please go to question F9, but first read the explanation above question F9

F8 Were there days on which you worked but were bothered by physical or mental health problems during the past 3 months?

Yes *Please go to question F8.1*

No *Please go to question F9, first read the explanation above question F9*

F8.1 How many days at work were you bothered by physical or mental health problems? **Only count the days at work in the past 3 months.**

Please indicate the number of days below.

_____ working days



F8.2 On the days that you were bothered by these problems, was it difficult to get as much work done as you normally do? On these days, how much work could you do on average?

Look at the figures below. A '10' means that you were able to do as much work as you normally do. A '0' means that you were unable to do any work on these days.

Please circle the figure that fits best below.

On these days I
could not do
anything

0

1

2

3

4

5

6

7

8

9

10

I was able to do half as
much as I normally do

I was able to do
just as much as I
normally do

F9 Unpaid work

Even for unpaid work, you can be bothered by your health. Sometimes as a result you might do less. For example, you have trouble doing household tasks, caring for your children, doing voluntary work, or you are unable to run errands, pick up groceries or work in the garden. The following questions refer to this.

F9 Were there days on which you did less unpaid work because of your health?

Only consider the past 3 months.

Yes Please go to question F9.1

No Please go to the next section

F9.1 How many days did this happen?

Only count the days in the past 3 months.

_____ days

F9.2 Imagine that somebody, e.g. your partner, family member or a friend helped you on those days, and he or she did all the unpaid work that you were unable to do for you. How many hours on average would that person spend doing this on those days?

_____ hours on those days

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SECTION G: SAFETY AND JUSTICE SYSTEM

In this section, we ask you about your contacts with professionals working in the safety and justice sector (e.g. police, lawyers) in the **past 3 months**. It can be that, because of your health, you have been in contact with one of these persons. As this can sometimes be associated with high costs, we would like to know more about these contacts.

Please note that your answers will be treated confidentially and will only be used for research purposes.

G1 Have you had any contact with the police in the past 3 months?

Please only consider a face-to-face contact either at a police station or somewhere. Emergency phone calls (e.g. 112 or 999) are excluded.

Yes, number of contacts: _____

No

I don't know/I would rather not say

G2 Have you used legal services (e.g. contact with a lawyer) in the past 3 months?

This could be a face-to-face meeting, an online consultation or a phone call with someone working in legal services.

Yes, number of times: _____

No

I don't know/I would rather not say

G3 Have you been to court in the past 3 months?

Please note that this could be in any role (e.g. victim, witness or defendant).

Yes, _____ time(s) for civil law (e.g. for a divorce)

Yes, _____ time(s) for criminal law

No

I don't know/I would rather not say

G4 Have you been confined anywhere involuntarily (e.g. in a prison, police station or secure psychiatric hospital) in the past 3 months?

This means that you were not free to leave.

Yes *Please go to question G4.1*

No *Please go to question G5*

I don't know/I would rather not say *Please go to question G5*

G4.1 How many nights were you confined involuntarily in the past 3 months?

		Number of nights
1	Police station/place of detention (e.g. prison)	<input type="checkbox"/> _____ nights
2	Secure hospital/secure psychiatric institution	<input type="checkbox"/> _____ nights
3	Other, please specify: _____	<input type="checkbox"/> _____ nights

G4.2 How many hours did you spend in confinement on days where you were only confined for part of the day (i.e. did not spend the night there)?

Please note that we are only asking about times when you were confined and then released on the same day.

		Number of hours
1	Police station/place of detention (e.g. prison)	<input type="checkbox"/> _____ hours
2	Other, please specify: _____	<input type="checkbox"/> _____ hours

G5 Affected by crimes

In the next section, we ask you about any crimes that have affected you as a victim and/or any crimes that you have committed. As this can sometimes be associated with high costs, we would like to know more about this.

Please note that your answers will be treated confidentially and will only be used for research purposes.

G5.1 Have you been a victim of, or involved in, theft in the past 3 months?

- Yes *Please go to question G5.2*
- No *Please go to question G5.3*
- I don't know/I would rather not say *Please go to question G5.3*

G5.2 How often did the following happen in the past 3 months?

	Number of times	I was involved as...
1 Stealing without violence (e.g. theft, pickpocketing)	_____ times	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> I would rather not say
2 Stealing with violence (e.g. robbery)	_____ times	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> I would rather not say

G5.3 Have you been affected by property damage (vandalism) in the past 3 months?

Yes *Please go to question G5.4*

No *Please go to question G6*

I don't know/I would rather not say *Please go to question G6*

G5.4 How often have you been affected by the following acts of property damage in the past 3 months?

		Number of times	I was involved as...
1	Damage to a car (e.g. it was scraped with a key or the windows were smashed)	_____ times	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> I would rather not say
2	Minor damage to a home (e.g. graffiti)	_____ times	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> I would rather not say
3	Major damage to a home (e.g. it was burned down)	_____ times	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> I would rather not say
4	Other, please specify: _____	_____ times	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> I would rather not say

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G6.1 Have you received any special transport for your legal appointments (e.g. court session) in the past 3 months?

Please consider any special transport service you needed to reach your legal appointments (e.g. court sessions). These transports could include for instance a ride in a specially equipped taxi.

Yes Please go to question G6.2

No Please go to the next section

I don't know/I would rather not say Please go to the next section

G6.2 How many times have you received special transport to reach your legal appointments (e.g. court sessions) in the past 3 months?

Please tick all answers that apply and indicate the number of times you used a given service. If you are unsure, please tick 'Other' and provide details.

1 Ride in a police car ____ times

2 Inmate transport ____ times

3 Other, please specify: _____ ____ times

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SECTION H: OUT-OF-POCKET AND OTHER EXPENSES

In this section, we ask you about expenses you and your family have incurred because of your health in the **past 3 months**. These could include paying for private health insurance, health and social care out-of-pocket payments, paying for help with something you were not able to do on your own, such as cleaning or personal care, buying something (e.g. a wheelchair or walking frame), or modifying your home to help with mobility.

H1.1 How was your health and social care paid for in the past 3 months?

Please tick all answers that apply. If you are unsure, please tick 'Other' and provide details.

- Public or national health service (e.g. UK NHS)
- Public or social health insurance
- Private health insurance
- I paid for these services myself out-of-pocket
- Other, please specify: _____
- I don't know/I would rather not say

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H1.2 How much have you (and/or your family on your behalf) spent on using the services listed before in the past 3 months?

Please estimate your total expenses over the past 3 months.

Please only consider private expenses that were paid for using your own funds and where you have not been and will not be reimbursed.

Please enter '0' if no expenses were incurred.

Out-of-pocket expenses		Estimate of total expenses	
		Total	Currency
1	Private health insurance	_____	€ (EUR)
2	Residential health and social care services	_____	€ (EUR)
3	Non-residential health and social care services	_____	€ (EUR)
3	Prescription medication	_____	€ (EUR)
4	Education services	_____	€ (EUR)
5	Safety and justice system	_____	€ (EUR)

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H1.3 In addition to the expenses for the goods and services already mentioned, what other expenses have you or your family incurred because of your health in the past 3 months?

Please estimate your total expenses over the past 3 months.

Please only consider private expenses that were paid for using your own funds and where you have not been and will not be reimbursed.

Please enter '0' if no expenses were incurred.

Expenses	Estimate of total expenses	
	Total	Currency
1 Cleaning or housekeeping assistance required because of your illness	_____	€ (EUR)
2 Paid childcare while you are attending appointments or temporarily away due to your health	_____	€ (EUR)
3 Complementary approaches to healthcare, such as <ul style="list-style-type: none"> • (Online) self-help • Diet and nutrition • Expressive therapies (dance, drama, music or poetry therapy) • Stress reduction and relaxation techniques (gym, yoga, mindfulness meditation) 	_____	€ (EUR)
4 Other (holistic) healing activities from someone other than a qualified healthcare professional, such as <ul style="list-style-type: none"> • Ayurveda treatment • Ceremonies • Chanting • Faith healing 	_____	€ (EUR)

H1.3 In addition to the expenses for the goods and services already mentioned, what other expenses have you or your family incurred because of your health in the past 3 months?

Please estimate your total expenses over the past 3 months.

Please only consider private expenses that were paid for using your own funds and where you have not been and will not be reimbursed.

Please enter '0' if no expenses were incurred.

Expenses	Estimate of total expenses	
	Total	Currency
<p>5 Durable goods such as</p> <ul style="list-style-type: none"> • Wheelchairs, rollators or walkers • Bathroom accessories (e.g. non-slip mat, bathing chairs, shower handrails, safety bars) • Nightlights • Emergency alarms • Adjustable beds • Special telephones 	_____	€ (EUR)
<p>6 Non-durable goods (intended to be used for a short period of time), such as</p> <ul style="list-style-type: none"> • (Disposable) swabs • Dressing material 	_____	€ (EUR)

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H1.4 In addition to the expenses for the goods and services already mentioned in this questionnaire, what other expenses have you or your family incurred because of your health in the past 3 months?

Please estimate your total expenses over the past three months.

Please only consider private expenses that were paid for using your own funds and where you have not been and will not be reimbursed.

Please enter '0' if no expenses were incurred.

	Expenses	Estimate of total expenses	
		Total	Currency
1	Refurbishment of your home because of your health	_____	€ (EUR)
2	Change of your residence/living arrangements or change to your type of accommodation (such as moving from an independent house in the community to an institutional care setting) because of your health. Please consider all relevant costs	_____	€ (EUR)
3	Cancelling or postponing your holiday because of your health. Please consider all relevant costs	_____	€ (EUR)
4	Informal carer's hotel costs when they accompany you when you travel, or the cost of respite care when those normally assisting you are away or otherwise unavailable	_____	€ (EUR)
5	Over-the-counter medication	_____	€ (EUR)
6	Therapeutic pets (e.g. guide dog)	_____	€ (EUR)
7	Transport expenses <i>Please consider only transport that concerns activities not listed before in the questionnaire</i>	_____	€ (EUR)
8	Other, please specify: _____ _____ _____	_____	€ (EUR)

SECTION I: FINAL REMARKS

11 You have reached the final section of the questionnaire. Please tell us how easy it has been for you to complete.

1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10
Very easy Very difficult

12 If you have any comments regarding completing this questionnaire, please share them with us below.

Thank you for helping us by completing this questionnaire

