PHYSICIANS REACH OUT APPLICATION

PROGRAM OVERVIEW
Physicians Reach Out (PRO) is a Care Ring program that provides primary and specialist healthcare to eligible uninsured residents of Mecklenburg County.

- Only eligible uninsured low-income residents of Mecklenburg County who have no access to health insurance can apply for the program.
- Participating primary care doctors, specialists, and dentists donate their time to see patients at no cost to the patient.
- Diagnostic testing such as labs and tests and hospital-based care, including ER visits, are billed on a sliding scale fee based on the patient’s household income.
- PRO is primarily funded through grants and donations. It is not health insurance.

HOW TO APPLY
1. Review the eligibility requirements on page 2 before you apply.

2. Schedule an appointment for an enrollment interview. Make sure you allow enough time to gather all the documents listed on pages 2-4 that must be attached to the application. Write your interview date and time in the box at the top of this page.

3. Complete Application and gather ALL documents needed.

4. Bring $25.00 Cash or Money Order made out to Care Ring (non-refundable).
   - Payment does not guarantee that you will be approved for PRO.

TIPS FOR A SUCCESSFUL INTERVIEW
- Allow one hour for the interview and orientation.
- Arrive and sign-in on time. (You will be rescheduled if you arrive more than 15 minutes late.)
- Bring all of the required documents listed on pages 2-4.
  - If you do not have all of your documents, you will be rescheduled.
  - If you need more time to gather your documents, please call 704-375-0172 at least 24 hours before your appointment to reschedule your interview.

- Foreign language translation: If you do not speak English, you must bring your own adult translator to the enrollment interview.
  - You may not bring a child as your translator.
  - If you do not bring a translator and you cannot complete the interview in English, you will be rescheduled.

Thank you for your interest in Physicians Reach Out. For more information on Physicians Reach Out, please visit www.careringnc.org or call 704-375-0172.
PHYSICIANS REACH OUT ELIGIBILITY CRITERIA

☐ You must be a resident of Mecklenburg County (minimum of 3 months).

☐ You cannot be eligible for health insurance through your job or your spouse’s job, your school, or any other program, even if you missed open enrollment or did not enroll because of the cost.

☐ You cannot be eligible for Medicaid, Medicare, Veterans Administration health care benefits, or worker’s compensation health benefits. (Exception: Family Planning Medicaid recipients can apply.) Medicaid Denial Letter may be needed.

☐ Your household income must be within 0-200% of the Federal Poverty Level. The full chart is available at www.careringnc.org.

<table>
<thead>
<tr>
<th>Household Size*</th>
<th>Maximum Annual Income</th>
<th>Maximum Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$23,340</td>
<td>$1,945</td>
</tr>
<tr>
<td>2</td>
<td>$31,460</td>
<td>$2,621</td>
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<tr>
<td>3</td>
<td>$39,580</td>
<td>$3,298</td>
</tr>
<tr>
<td>4</td>
<td>$47,700</td>
<td>$3,975</td>
</tr>
</tbody>
</table>

*Definition of Household: Mom, Dad, and children under 18 living with parents*

☐ You cannot be pregnant.

☐ You cannot have more than $6,000 in bank accounts, savings/checking, or CDs.

☐ You cannot have been enrolled in CMC’s sliding scale program at CMC Myers Park, CMC North Park, CMC Biddle Point, or Elizabeth Family Medicine within the past 24 months.

☐ If you have been a patient of any free clinic in Mecklenburg County in the last two years, you must have a current, valid referral for specialty care from that clinic in order to enroll in PRO. This includes but is not limited to Charlotte Community Health Clinic, C.W. Williams, and Matthews Free Medical Clinic.

YOU WILL BE RESCHEDULED for another day IF:

- You arrive 15 minutes late to your enrollment interview.
- You did not bring a translator and you cannot complete interview in English.
- You do not have all of your supporting documents at time of interview. Please check off each document needed on page 2-4 that applies to you.
- You did not make copies of your documents and you do not have the 25 cents per copy for office staff to make them.

Remember: You must be certain that you meet eligibility criteria because your $25 fee is non-refundable.
SUPPORTING DOCUMENTS NEEDED

Photocopies of each document are required. We cannot accept originals. Office staff can make copies for 25 cents per copy at time of interview.

1. **Proof of Identity** *(Both items are required for each applicant)*
   - □ Valid Photo ID: copy of valid driver’s license or state identification card or passport or identification from home country
   - □ Copy of Social Security card or W-7

2. **Proof of Citizenship or Legal Residency** *(One is required for each applicant)*
   - □ Copy of birth certificate or valid US passport or voter registration card
   - □ Valid Permanent Resident (Green) Card or valid Employment Authorization Card
   - □ Copies of birth certificates for all dependents listed on the application

3. **Proof of Mecklenburg County Residency** *(Choose One Below)*
   - □ NC Driver’s License or learner’s permit or NC ID with current address
   - □ A bill (that is at least 3 months old) with your name and current address.
   - □ A lease agreement or mortgage statement with your name and current address.
   - □ If you are homeless, your shelter must provide a letter, on letterhead, stating you stay there and the date you moved in.
   - □ If you are using Urban Ministry services, you can get a letter, on letterhead stating that you are homeless and use their services.

4. **Proof of Income** *(Provide All That Apply)*
   - □ Earned Income:
     - □ The 2 most recent consecutive pay stubs for each job for each household member. (If you are not paid with paystubs, your employer can write an income letter stating how many hours per week you work and your pay.)
     - □ All pages of all current bank statements for each person in household (includes all checking, savings, CD’s,)
   - □ Self-Employed APPLICANTS and SPOUSES:
     - □ Current IRS 1040 w/Schedule C (prior year forms permitted until April 15 of current year)
     - □ W-2 (s) and Form 1099-Misc Income
     - □ IRS Form 4506-T: If you did not file taxes last year, you MUST complete Form 4506-T (Download at [www.irs.gov](http://www.irs.gov); Available at PRO interview.)
     - □ Itemized Income and Expense Chart for 3 months. One chart for each month listing each check or cash received in one column and another column listing each expense for that month. Receipts or corresponding
deposits or debits/charges MUST be provided for each month.
(Each month’s income minus the expenses will equal your profit. The
profit will be added together and then divided by 3 to arrive at your
average monthly income. This will be compared to the Income Chart.)

#1 Month: Income $________ Expenses $__________ Profit $______
#2 Month: Income $________ Expenses $__________ Profit $______
#3 Month: Income $________ Expenses $__________ Profit $______

☐ All business and personal bank statements for the 3 months that
correspond with the income and expenses months above.

☐ **Unearned Income**: Social Security (Retirement, Survivors, Disability),
unemployment, child support, alimony, Workman’s Compensation, pension,
welfare, or TANF (Temporary Assistance for Needy Families)/Work First, etc.

**Provide all that apply**:

☐ Provide all pages of current awards letter or Benefits Statement for each
benefit received. Social Security awards letter must indicate type of social
security (Retirement, Survivors, Disability) you are receiving.

☐ Court Document for child support for each child and the alimony being
received.

☐ All pages of statements reflecting income received from a pension or
retirement account (401K, IRA, etc.) from the US or another country.

☐ **No Income/Financial Support**: If you receive financial support (payment of
bills or room & board) from a friend or family member or organization such as a
church, etc., you must have each one complete a Letter of Support (page 11).

**Provide both**:

☐ Attach Letter(s) of Support

☐ Complete the Statement of Zero Income (page 10)

5. **Proof That You Are Not Eligible for Health Insurance**:  
You must provide proof that each applicant is not eligible for health insurance
through his/her job or spouse’s job or college.

☐ Health Insurance Information Request Form (page 12): Each adult applicant
must have their employer complete this form and attach a business card or
business stamp.

If you need assistance in completing your application, please call 704-375-0172.
<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>SSN or W7</th>
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<tr>
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<th>Age</th>
<th>Gender</th>
<th>E-mail Address</th>
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<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>□ Male</td>
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<thead>
<tr>
<th>Street Address</th>
<th>PO Box (only if you use it to receive your mail)</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<th>Cell Phone</th>
<th>Work Phone</th>
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<tr>
<th>Race</th>
<th>Language spoken at home:</th>
<th>Do you need an interpreter?</th>
<th>Which interpreter language?</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
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<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Household Size (#)</th>
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</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>□ Legally Separated</td>
<td></td>
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<tr>
<td>□ Married</td>
<td></td>
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<tr>
<td>□ Divorced</td>
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<tr>
<td>□ Civil Union</td>
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<tr>
<td>□ Widowed</td>
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<thead>
<tr>
<th>If married, is your spouse applying for PRO?</th>
<th>If no, please give reason:</th>
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<tbody>
<tr>
<td>□ Yes</td>
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<td>□ No</td>
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<table>
<thead>
<tr>
<th>Applicant’s Primary Care Physician</th>
<th>Applicant’s Specialist(s)</th>
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<table>
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<tr>
<th>Spouse’s Primary Care Physician</th>
<th>Spouse’s Specialist(s)</th>
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<tr>
<th>Children’s Primary Care Physician</th>
<th>Children’s Specialist(s)</th>
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<tr>
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<th>Relationship</th>
<th>Contact Phone Number</th>
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<th>Lived in Mecklenburg County for:</th>
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<td>□ Own</td>
<td>Years _______Months</td>
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<tr>
<td>□ Rent</td>
<td></td>
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<tr>
<td>□ Shelter/Homeless</td>
<td></td>
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<tr>
<td>□ Staying with family/friends</td>
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</tbody>
</table>
### List ALL Household Members (Only spouse and children under 18 yrs of age. Include a child that is enrolled in High School even if he/she is over 18 yrs of age.)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relationship to you</th>
<th>Date of Birth mm/dd/yy</th>
<th>Gender Female or Male</th>
<th>Marital Status</th>
<th>SSN or W-7</th>
<th>Applying for PRO?</th>
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<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
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**How did you hear about Care Ring Physicians Reach Out (PRO)?** Check one.

- □ Doctor ____________________________
- □ Hospital __________________________
- □ Other Clinic _______________________
- □ Health Dept ________________________
- □ Family or Friend ___________________
- □ School/College _____________________
- □ Newspaper, TV, Radio, Website _______
- □ Flyer (From Where?) _______________

Everything I have stated in this application is correct to the best of my knowledge. I understand that this application and the supporting documentation I have provided is required to enroll in Physicians Reach Out (PRO) and I authorize PRO to check my bank statement, employment history or any other information requested in this application. If I provided false, misleading, or incomplete information, I will not be eligible for services through PRO. By signing this form, I authorize the use of my social security number and my dependents’ social security numbers for the purpose of verifying information.

Patient/Guardian’s Signature: __________________________Date: __________
ACKNOWLEDGMENT

I authorize Physicians Reach Out (PRO), a Care Ring program, to contact me and all applicants and leave a detailed message if not available for the purpose of providing information regarding my care by the following methods:

- Home Phone Answering Machine □ Yes □ No
- Cell Phone Voicemail □ Yes □ No
- Work Phone Voicemail □ Yes □ No
- Email Notification □ Yes □ No
- Emergency Contact Voicemail □ Yes □ No

The following persons are permitted to receive my health information:

Name: ___________________ Relationship: _________ Phone: ________
Name: ___________________ Relationship: _________ Phone: ________
Name: ___________________ Relationship: _________ Phone: ________
Name: ___________________ Relationship: _________ Phone: ________
Name: ___________________ Relationship: _________ Phone: ________
Name: ___________________ Relationship: _________ Phone: ________

_____________________________________                    ___________________
Patient’s /Guardian’s Signature                                              Date
NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

Physicians Reach Out’s Legal Duty

Physicians Reach Out (PRO), a Care Ring program, is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described here.

Uses and Disclosures of Health Information

Physicians Reach Out (PRO) uses your personal health information primarily for allowing you access to treatment; obtaining payment for your treatment; conducting internal administrative activities; and evaluating the quality of care provided. For example, PRO may use your personal health information to contact you to provide information on program responsibilities, medication limits or other health-related benefits that could be of interest to you.

PRO may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, PRO’s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later cancel that at any time.

PRO may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted. You may also request an updated copy of our Notice of Information Practices at any time.

Client’s Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. PRO will consider all such requests on a case by case basis, but PRO is not legally required to accept them.

Concerns and Complaints

If you are concerned that PRO may have violated your privacy rights or if you disagree with any decisions we have made regarding access or release of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on PRO’s health information practices or if you have a complaint, please contact the following person:

Katie Benston, Chief Program Officer
601 E. 5th Street, Suite 150, Charlotte, NC 28202
Telephone: 704-248-3723
Fax: 704-943-3748

Patient/Guardian’s Signature:____________________________ Date:__________________
PATIENT ACCEPTANCE OF PROGRAM GUIDELINES

About Physicians Reach Out (PRO):
I understand that:
• Physicians Reach Out (PRO) is a Care Ring program that offers qualified enrollees access to medical services available through our program. PRO is not a health insurance plan.
• PRO may change the nature of the program at any time, including eligibility requirements (page 2).
• Health services are provided by local physicians and allied health professionals who agree to participate in PRO and donate their services.
• There is no guarantee that all health services will be available to me through PRO.
• PRO will not change the doctor assigned to me unless the doctor is no longer participating in PRO.
• To continue receiving services through PRO, I must remain eligible and follow the program guidelines. If I do not follow these guidelines, my enrollment in PRO may be terminated.
• My PRO ID card will be accepted only by the doctors and hospital system assigned to me by PRO.

Initial: _____

Physicians Reach Out (PRO) General Guidelines:
I will:
• Contact PRO at 704-375-0172 immediately with any changes in my address, phone number, or number of household members (Definition on page 2).
• Report all income and health information accurately and completely.
• Apply for Medicaid or other assistance if PRO asks me to.
• Supply any information requested by my doctor or PRO as soon as possible.
• Allow my PRO doctor to share my medical information with PRO staff to coordinate my health care.
• Remain aware of when my enrollment ends and apply for renewal before my expiration date.
• Not seek treatment through PRO after my enrollment ends; if I do, I am responsible for all charges.
• Immediately contact PRO at 704-375-0172 if I become eligible for or covered by any health insurance plan (including Medicare, Medicaid, employer-based coverage, school-based coverage, or private insurance).
• Treat all doctors, office staff, and volunteers with respect.
• Not use illegal substances. Illegal behaviors may be cause for dismissal from PRO.
• Follow instructions from PRO staff and those that provide me my healthcare. If I do not follow those instructions, it may be grounds for dismissal from PRO.

Initial: _____

Physicians Reach Out (PRO) Doctor Appointments:
I agree to:
• Show my PRO ID card each time I see a doctor or receive services.
• See only medical providers and use only the hospital system assigned to me for emergency room and hospitalizations, in order for my services to be covered by PRO.
• Give at least 24 hour notice of cancellation of any appointment, otherwise it may be counted as a No-Show. Two No-Shows are grounds for dismissal from PRO.
• Call my PRO doctor for all questions about my care. I must call my PRO doctor (even after hours) before going to the emergency room, unless I have a life-threatening emergency.
• Follow my treatment plan. For example, get prescribed medicines and take as directed.
• Pay all required fees and bills I receive or make payment arrangements with the provider before I receive treatment.
• Pay all past due fees or make payment arrangements with the providers before I receive treatment.

Initial: _____

I agree to follow the above guidelines also written in my Patient Guidebook given to me at my enrollment interview. If I do not follow the guidelines, I may be dismissed from Physicians Reach Out (PRO).

Patient/Guardian’s Signature: __________________________ Date:___________________
STATEMENT OF ZERO INCOME

The applicant must submit a LETTER OF SUPPORT (page 11) if you complete this form.

You have stated on your application that you have no income, assets or resources. Use this form to please document how you meet your basic needs. Basic needs include how you pay for your rent, utilities, transportation, food, phone and any other bills.

Applicant Name: ______________________________ Date: ________________

1. Monthly rent payment: $ _______
   • How do you pay your rent? ______________________________________

2. Amount of monthly utility bills: $ _______
   • How do you pay your utility bills? _________________________________

3. What is/are your usual method(s) of transportation? ________________
   • How do you pay for gas or bus passes? ____________________________

4. How do you pay for food? _________________________________________

5. How do you pay for your home phone/cell phone? _____________________

The information that I have given above is correct to the best of my knowledge. I understand that if I have given false, misleading or incomplete information, I may be disqualified from Physicians Reach Out (PRO).

Print Name: ______________________________

Signature: ______________________________ Date: ________________
PHYSICIANS REACH OUT
LETTER OF SUPPORT

The applicant must complete the STATEMENT OF ZERO INCOME (page 10) along with this form

I, ________________________________ (name of person providing support), pay rent and utilities on behalf of or for ________________________________ (Physicians Reach Out (PRO) applicant).

I am not financially responsible for his /her bills or able to buy his /her medications.

I provide room and board in the amount selected below per month (dollar value of support).

Please select one:

- $ 250/month
- $ 500/month
- $ 750/month
- $1000/month
- $1500/month
- $2000/month or more

____________________________________  ______________________
Signature (Person providing support.) Date

____________________________________  ______________________
Printed Name (Person providing support.) Relationship to Applicant

____________________________________
Address

____________________________________
Phone Number
PHYSICIANS REACH OUT
HEALTH INSURANCE INFORMATION REQUEST

TO BE COMPLETED BY THE EMPLOYER ONLY

Employee Name: ___________________________ Hire date: ___________________________

Please answer the following questions regarding the employee:

1. Does your company offer health insurance to its employees? □ Yes □ No
   *If No, please skip questions 2—6 and sign and date the bottom of the form.*

2. Is this employee eligible to purchase coverage through your company (even if he/she would not be able to enroll until the next open enrollment period or qualifying event)? □ Yes □ No

3. Is health insurance also available for his/her family members? □ Yes □ No

4. If he/she is not eligible, will he/she be eligible in the future? □ Yes □ No
   *If yes, on what date would coverage take effect? _____/_____/_____*

5. Is employee currently enrolled in a Health Insurance Program? □ Yes □ No

6. When is Open Enrollment Season for health insurance through the company? _____/_____/_____

For employers who do offer health insurance (for which the above employee is eligible):

1. How much is the monthly premium? Provide information for the least expensive plan if you offer more than one plan.
   *Individual $__________ Family $__________*

2. How much is the annual deductible? Provide information for the least expensive plan if you offer more than one plan.
   *Individual $__________ Family $__________*

Company Name

Manager’s Name: _________________________ Manager’s Phone: _________________________

Manager’s Signature: _____________________ Date: _____________________

Please attach your business card or imprint your business stamp HERE.
SHARE YOUR STORY

Care Ring would like to know how being enrolled in Physicians Reach Out has made a
difference in your health and whether improved health has made a difference in your life
or economic situation. Please write a few sentences about your health care experience
with Physicians Reach Out. We may share your story with the doctors, nurses and others
who make PRO possible. Thank you.
How Do You Rate Your Health?
New Patient Survey

Name: ______________________________ Date of Birth: ___ / ___ / ___

Please answer the following questions about your health. Your answers will not affect your eligibility for Physicians Reach Out renewal.

1. In general, would you say your health is
   - □ Excellent (1)
   - □ Very Good (2)
   - □ Good (3)
   - □ Fair (4)
   - □ Poor (5)

2. How true or false is each of the following statements for you? (Circle one number on each line)

<table>
<thead>
<tr>
<th>(Circle one number on each line)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I seem to get sick a little easier than other people.</td>
</tr>
<tr>
<td>b. I am as healthy as anybody I know.</td>
</tr>
<tr>
<td>c. I expect my health to get worse.</td>
</tr>
<tr>
<td>d. My health is excellent.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitely True</th>
<th>Mostly True</th>
<th>Don’t Know</th>
<th>Mostly False</th>
<th>Definitely False</th>
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<tbody>
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<td>4</td>
<td>5</td>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
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</table>

3. Compared to one year ago, how would you rate your health in general now?
   - □ Much better now than one year ago (1)
   - □ Somewhat better now than one year ago (2)
   - □ About the same (3)
   - □ Somewhat worse now than one year ago (3)
   - □ Much worse now than one year ago (4)

   *Survey questions from RAND SF-36 Health Survey Version 1.0*