APPLICANT SCREEN

Mathematica Policy Research, Inc.

December 1981

This instrument was developed for the National Long-Term Care Channeling Demonstration. This project was conducted by Mathematica Policy Research, Inc. and Temple University under contract #HHS-100-80-0157 for the Department of Health and Human Services' Office of Social Services Policy (now the Office of Disability, Aging and Long-Term Care Policy). For additional information about this project, visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov. The Project Officer was Robert Clark.

OMB APPROVAL NO: 0990-0074
EXPIRES: 9/30/84

NATIONAL LONG TERM CARE DEMONSTRATION
APPLICANT SCREEN

This report is authorized by law (Older Americans Act, Section 421; Social Security Act, Sections 1110, 1115, 1875 and 1881; and Public Health Service Act, Sections 1526 and 1533d). While you are not required to respond, your cooperation is needed to make the results of the survey comprehensive, accurate and timely.

SCREENER ID: |__|__|-|__|__|__|__|

APPLICANT ID: |__|__|-|__|__|__|__|__|-|__|

STATUS:

S1. FINAL STATUS:

COMPLETE 01

INCOMPLETE . . . . 02 → COMPLETE A13

S2. CURRENT SCREEN:

APPROPRIATE. . . . 01

INAPPROPRIATE. . . 02 → COMPLETE A13

ASSIGNMENT:

S3. NEW ASSIGNMENT 01

PREVIOUS ASSIGNMENT . . . 02

S4. CLIENT 01

CONTROL . . . . . 02 → COMPLETE A13

S5. SUBSAMPLE STATUS

	YES	NO
a. CAREGIVER	01	02
b. PROVIDER	01	02

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This questionnaire was prepared for the Department of Health and Human Services under Contract No. HHS-100-80-0157.

THERE ARE NO RESTRICTIONS ON RESPONDENTS FOR SECTION A.

INTEREST, ELIGIBILITY AND REFERRAL

A1. APPLICANT'S AGE: |__|__|__|

A2. APPLICANT'S DATE OF BIRTH: |__|__| |__|__| |__|__|__|__| NO INFORMATION . . . -1
MONTH DAY YEAR

A3. RESIDENCE WITHIN CATCHMENT AREA: YES . . . . 01 NO 02

A4. IS A CURRENTLY INSTITUTIONALIZED?

NO 01 (A9)

YES, ACUTE HOSPITAL. . 02

YES, CHRONIC HOSPITAL. 03

YES, NURSING HOME . . 04

|__| SKILLED

|__| INTERMEDIATE

A5. IS A CURRENTLY CERTIFIED AS LIKELY TO BE DISCHARGED TO A NONINSTITUTIONAL SETTING WITHIN 3 MONTHS?

YES . . 01 ⟶ A6. EXPECTED DISCHARGE DATE:

NO. . . 02 (A7) |__|__| |__|__| |__|__|
MONTH DAY YEAR

Certified by: _____

Position: _____

A7. IF IN ACUTE HOSPITAL, IS A CERTIFIED FOR DISCHARGE AND HOSPITALIZED PENDING APPROPRIATE PLACEMENT?

YES. . . . . 01 ⟶ A8. FOR HOW LONG HAS A BEEN CERTIFIED FOR DISCHARGE, BUT HOSPITALIZED PENDING PLACEMENT?

NO 02 (A9)

NO INFORMATION . . . . -1 (A9)

DAYS . . . .|__|__|__|

NO INFORMATION . . . . . -1

A9. HAS THE PROGRAM BEEN DESCRIBED TO A AND IS A INTERESTED IN PARTICIPATING IN THE SCREENING PROCESS?

YES. 01

NO 02

CONTINUE SCREENING PROCESS ONLY IF APPLICANT:

- IS AT LEAST 65 YEARS OLD

AND

- RESIDES IN CATCHMENT AREA

AND

- IS NOT INSTITUTIONALIZED OR IS CERTIFIED FOR DISCHARGE

AND

- IS INTERESTED IN PARTICIPATING IN THE SCREENING PROCESS

IF THESE FOUR CONDITIONS HOLD, CONTINUE WITH IDENTIFICATION SHEET

COMPLETE ID1-ID8 BEFORE PROCEEDING WITH A10 BELOW.

A10. DATE OF REFERRAL: |___|___| |___|___| |___|___|
MONTH DAY YEAR

A11. REFERRAL SOURCE

CHANNELING OUTREACH 01
ACUTE/REHAB HOSPITAL DISCHARGE 02
NURSING HOME DISCHARGE. . . . 03
NURSING HOME SCREEN 04
NURSING HOME WAITING LIST . . 05
PHYSICIAN 06
HOME HEALTH AGENCY. . . 07
HOME-MAKING SERVICE . . 08
HOME DELIVERED MEALS. . 09
SR CENTER/NUTRITION . . 10
PSYCHIATRIC FACILITY. . 11
COUNSELING SERVICE. . . 12
INFORMATION AND REFERRAL 13
LEGAL/ADVOCACY 14
PUBLIC WELFARE DEPARTMENT. 15
MEDICAID DEPARTMENT. 16
CASEWORK/CASE MANAGEMENT AGENCY. . 17
ADULT DAY CARE 18
FAMILY MEMBER. 19
FRIEND OR NEIGHBOR 20
SELF 21
OTHER (SPECIFY) _____
_____ . . 22

A12. PRESENTING PROBLEMS/REASONS FOR REFERRAL

(AS DESCRIBED BY REFERRAL SOURCE AND APPLICANT. NOTE SOURCE OF DESCRIPTION)

A. DESCRIPTION

_____
_____
_____
_____
_____

PROBLEM/REFERRAL CODE: (CIRCLE ALL THAT APPLY)

CHANGE IN FUNCTIONAL CAPACITY DUE TO ILLNESS/INJURY. 01
EMOTIONAL OR BEHAVIOR PROBLEMS 02
DISORIENTATION 03
EXISTING SERVICES INADEQUATE/UNSATISFACTORY (APART FROM CHANGE IN APPLICANT FUNCTIONING) . . 04
PERMANENT LOSS OF CAREGIVER. 05
CAREGIVER EXHAUSTION 06
TEMPORARY ABSENCE OR INABILITY OF CAREGIVER. 07

EXPECTED DURATION OF ABSENCE. . |___|___| → WEEKS . . . 01; MONTHS. . . 02
NO INFORMATION . . -1

OTHER (SPECIFY) _____ . . 08

A13. IF INCOMPLETE, INAPPROPRIATE OR CONTROL GROUP MEMBER, DESTINATION TO WHICH A WAS REFERRED:

NAME: _____ → |___|___| USE CODES FROM A11 ABOVE

SCREENING WORKSHEET ON FUNCTIONAL IMPAIRMENT

A. ACTIVITIES OF DAILY LIVING (ADL)	LEVEL OF IMPAIRMENT			
	SLIGHT OR NONE(I)	MODERATE(M)	SEVERE(S)	NO INFORMATION
Eating	01	02	03	-1
Bed and/or chair transfer	01	02	03	-1
Dressing	01	02	03	-1
Bathing	01	02	03	-1
Toileting	01	02	03	-1
Continence	01	02	03	-1

B. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)	NOT SEVERELY IMPAIRED	SEVERELY IMPAIRED(S)	NO INFORMATION
Meal preparation	01	02	-1
Housekeeping/shopping*	01	02	-1
Medications	01	02	-1
Telephone/travel/money management*	01	02	-1
Functional impairment associated with cognitive or behavioral problems*	01	02	-1

*Severe impairment in one or more areas within this category is to be counted as severely impaired.

THIS SECTION IS NOT TO BE ASKED OF A SELF-RESPONDENT. SECTION C BEGINS ON PAGE 5.

B1. Does A display:

	YES	NO	NO INFORMATION
a. disorientation, confusion, impairment of judgment, or memory loss?	01	02	-1
b. inappropriate behaviors?	01	02	-1

B2. IF EITHER B1a OR B1b ANSWERED "YES":

Is A's ability to perform daily activities affected nearly every day or is daily supervision required to ensure personal safety?

YES, ACTIVITIES AFFECTED OR SUPERVISION REQUIRED . . . . . 01 S

NO 02

NO INFORMATION. . . . . -1

IF ACTIVITIES AFFECTED OR SUPERVISION REQUIRED, COUNT AS ONE SEVERE IADL IMPAIRMENT.

B3. Does A have a legal guardian?

YES . . . . . 01 → RECORD NAME, ADDRESS, AND TELEPHONE IN ID10.

NO. 02

NO INFORMATION. . . -1

B4. In your judgment, will A's family and friends be able to continue to give (him/her) the amount of help they do now?

YES 01

NOT SURE. 02

NO. . . . . 03 (B6) F

NO HELP AT PRESENT. . . . 04

NO INFORMATION. . . . . -1

SUPPORT SYSTEM IS FRAGILE IF NOT ABLE TO MAINTAIN CURRENT HELP.

B5. In your judgment, will A's family and friends be able to give (him/her) (more) help if it is needed?

YES 01

NOT SURE. 02

NO. . . . . 03 F

NO INFORMATION. . . . . -1

SUPPORT SYSTEM IS FRAGILE IF NOT ABLE TO HELP MORE OR NO CURRENT HELP AND NOT ABLE TO HELP.

B6. Would A need someone to assist or translate in an in-person interview?

YES . . . . . 01 ⟶ RECORD NAME, ADDRESS, AND TELEPHONE IN ID9.

NO . . . . . 02 HELP REQUIRED/LANGUAGE: _____

NO INFORMATION. . -1 _____

_____

B7. Is A able to communicate in English over the telephone?

YES 01

NO . . . . . 02 ⟶ COMMUNICATION PROBLEM/LANGUAGE: _____

NO INFORMATION. . -1 _____

_____

THERE ARE NO RESTRICTIONS ON RESPONDENTS FOR SECTION C.

C1. LIVING ARRANGEMENT:

IF INSTITUTIONALIZED, PRIOR LIVING ARRANGEMENT.

CIRCLE ALL THAT APPLY

- ALONE 01 (C3)
- WITH SPOUSE 02
- WITH A'S CHILD(REN) 03
- WITH OTHER RELATIVES 04
- WITH NON-RELATIVES. 05
- NO INFORMATION. . . . . -1 (C3)

C2. OTHER HOUSEHOLD MEMBERS 65 OR OLDER?

IF INSTITUTIONALIZED, PRIOR HOUSEHOLD MEMBERS.

- YES . . . . . 01 → RECORD FULL NAMES IN ID11.
- NO 02
- NO INFORMATION. . . . . -1

C3. RESIDENCE IN PERSONAL CARE HOME?

PROBE: Do **you** live in a special place where **you** can get help taking care of yourself, like LOCAL TERMS FOR HOMES PROVIDING PERSONAL CARE?

- YES 01
- NO 02
- NO INFORMATION. . . . . -1

IF INSTITUTIONALIZED, PRIOR RESIDENCE.

C4. IS BIRTHDATE COMPLETED IN A2?

- YES 01
- NO . . . . . 02 → ASK AND RECORD IN A2.

C5. APPLICANT'S SEX:

- MALE. 01
- FEMALE. 02

C6. RACIAL OR ETHNIC BACKGROUND:

PROBE: **Are you** of Spanish origin?

- AMERICAN INDIAN OR ALASKAN NATIVE . . . 01
- ASIAN OR PACIFIC ISLANDER 02
- BLACK, NOT OF HISPANIC ORIGIN 03
- HISPANIC 04
- WHITE, NOT OF HISPANIC ORIGIN 05
- NO INFORMATION. . . . . -1

C7. APPLICANT'S HEALTH INSURANCE COVERAGE:

	YES	NO	NO INFORMATION
a. MEDICARE, PLAN A FOR HOSPITAL BILLS . .	01	02	-1
b. MEDICARE, PLAN B FOR DOCTOR BILLS . . .	01	02	-1
c. MEDICAID	01	02	-1
d. PRIVATE INSURANCE	01	02	-1

PROBE: Is something deducted from **your** Social Security check for Medicare?

PROBE: **Do you** have a SITE COLOR (Medicaid) card?

IF MEDICARE AND/OR MEDICAID, COMPLETE NUMBERS IN ID6-ID7, AS NECESSARY.

C8. IS A CURRENTLY INSTITUTIONALIZED?

YES . . . . . 01 (SECTION D)

NO 02

C9. DOES A REGULARLY HAVE HELP NOW WITH--

	YES	NO	NO INFORMATION
a. MEAL PREPARATION?	01	02	-1
b. HOUSEWORK OR SHOPPING?	01	02	-1
c. TAKING MEDICINE?	01	02	-1
d. MEDICAL TREATMENTS AT HOME?	01	02	-1
e. PERSONAL CARE (EATING, GETTING OUT OF BED OR A CHAIR, DRESSING, BATHING AND USING THE TOILET)?.	01	02	-1

C10. NAMES OF ORGANIZATIONS OR AGENCIES PROVIDING HELP REGULARLY:

D. PHYSICAL ACTIVITIES OF DAILY LIVING

QUESTIONS IN SECTION D ARE TO BE ASKED ONLY OF SELF-RESPONDENTS, SIGNIFICANT OTHERS, REGULAR CAREGIVERS, OR SOMEONE WHO HAS RECENTLY ASSESSED THE APPLICANT IN A FACE-TO-FACE SITUATION. SECTION E BEGINS ON PAGE 14.

INSTRUCTIONS:

ASK ABOUT APPLICANT'S USUAL ABILITY TO PERFORM ACTIVITIES DURING THE PAST WEEK. (USUAL = HALF THE TIME OR MORE) INCLUDE SUPERVISION IN THE SAME ROOM (OR NEARBY ROOM FOR TOILETING), AS HUMAN ASSISTANCE.

The next few questions are about the things **you** do by **yourself** and the help other people give. Please tell me if someone stays in the room in case **you need** help with any of the things we talk about.

Please answer these questions in terms of **your** activities during the past week.

EATING

D1a. First, I'd like to talk about eating.

Does someone help **you** eat?

DO NOT INCLUDE HELP WITH CUTTING MEAT OR BUTTERING BREAD.

YES, SOMEONE HELPS.	|___|	
NO, BY SELF	|___|	(D1) I
DID NOT EAT AT ALL IN PAST WEEK (IV, TUBES) . .	|___|	(D1) S_1
NO INFORMATION.	|___|	(D1)

D1b. Does someone feed **you**?

PROBE: For most of the meal?

YES	|___|	S_2
NO	|___|	M
NO INFORMATION.	|___|	

D1. EATING, EXCLUDING CUTTING MEAT AND BUTTERING BREAD

DID NOT EAT AT ALL IN PAST WEEK (IV, TUBES) . . .	01	S_1
IS FED BY OTHERS	02	S_2
OTHER HUMAN ASSISTANCE . . .	03	M
NO HUMAN ASSISTANCE	04	I
NO INFORMATION	-1	

BED/CHAIR TRANSFER

D2a. Does someone help **you** get out of bed or a chair?

IF HELP WITH BED AND/OR CHAIR, CODE "YES."

YES, SOMEONE HELPS	|___|		
NO, BY SELF	|___|	(D2)	I
BEDBOUND (DID NOT GET OUT OF BED AT ALL IN PAST WEEK)	|___|	(D2)	S_1
NO INFORMATION.	|___|	(D2)	

D2b. Does someone lift **you?**

YES	|___|	S_2
NO	|___|	M
NO INFORMATION.	|___|	

D2. BED/CHAIR TRANSFER

BEDBOUND (DID NOT GET OUT OF BED AT ALL IN PAST WEEK). . 01		S_1
IS LIFTED FOR BED AND/OR CHAIR TRANSFER. 02		S_2
OTHER HUMAN ASSISTANCE IN BED AND/OR CHAIR TRANSFER. . 03		M
NO HUMAN ASSISTANCE FOR EITHER. 04		I
NO INFORMATION . . . . . -1		

D3a. The next questions are about dressing--that is, getting clothes and putting them on.

Does someone help **you** to get dressed or to change **your** night clothes?

DO NOT INCLUDE HELP WITH TYING SHOES OR GROOMING.

YES, SOMEONE HELPS	|___|	
NO, BY SELF	|___|	(D3) I
DID NOT CHANGE CLOTHES AT ALL IN PAST WEEK . . .	|___|	S_1
NO INFORMATION.	|___|	(D3)

D3b. Does someone (dress **you**/change **your** night clothes for **you**)?

YES	|___|	S_2
NO	|___|	M
NO INFORMATION.	|___|	

D3. DRESSING, INCLUDING GETTING CLOTHING

DID NOT CHANGE CLOTHES AT ALL IN PAST WEEK.	01	S_1
DRESSED BY OTHERS/OTHERS CHANGE NIGHT CLOTHES . . .	02	S_2
OTHER HUMAN ASSISTANCE IN DRESSING/CHANGING NIGHT CLOTHES	03	M
NO HUMAN ASSISTANCE	04	I
NO INFORMATION	-1	

BATHING

D4a. The next questions are about bathing--including turning on the water.

Does someone help **you** bathe?

COUNT HELP WITH TUB/ SHOWER TRANSFER AS HELP.

IF MULTIPLE METHODS USED, PROBE: Which **do you** usually use for a full bath?

YES, SOMEONE HELPS . . . . |___|

NO, BY SELF . . . . . |___| (D4) I_1

BEDBATHS (DID NOT BATHE AT ALL IN PAST WEEK) . . . |___| (D4) S_1

NO INFORMATION. . . . . |___| (D4)

D4b. IS A CURRENTLY INSTITUTIONALIZED?

YES 01

NO 02 (D4d)

D4c. IF INSTITUTIONALIZED:
Does someone help **you** or just stay near **you** in case **you need** help?

SOMEONE HELPED WITH WASHING OR TRANSFER . . . |___|

SOMEONE JUST STAYED NEAR. . |___| (D4) I_2

NO INFORMATION. . . . . |___|

D4d. Does someone help **you** wash more than **your** back or feet?

HELP WITH BACK AND FEET ONLY CONSIDERED MODERATE IMPAIRMENT.

EXCLUDE HELP WITH SHAMPOOING.

YES . . . . . |___| S_2

NO . . . . . |___| M

NO INFORMATION. . . . . |___|

D4. BATHING, AT A SINK OR BASIN OR IN A TUB OR SHOWER, INCLUDING TURNING ON WATER AND TUB/SHOWER TRANSFER.

BEDBATHS (DID NOT BATHE AT ALL IN PAST WEEK) . . . . 01 S_1

HUMAN HELP WITHING MORE THAN BACK AND/OR FEET . . . . 02 S_2
(EXCLUDE SHAMPOOING)

OTHER HUMAN ASSISTANCE . . . . . 03 M

NO HUMAN ASSISTANCE . . . . . 04 I_1

IF INSTITUTIONALIZED, SUPERVISION ONLY . . . . . 05 I_2

NO INFORMATION . . . . . -1

TOILETING

D5a. The next questions are about personal care. The first one is about using the toilet.

Does someone help **you** get to the bathroom to use the toilet?

PROBE: Or **don't you** use a toilet for either **your** bowel or bladder functions?

YES, SOMEONE HELPS.	|___|	**M**
NO, BY SELF	|___|	**I**
DID NOT USE TOILET AT ALL IN PAST WEEK (BEDPAN, BEDSIDE COMMODE, CATHETER, COLOSTOMY) . .	|___|	**S**
NO INFORMATION.	|___|	

D5. TOILETING, INCLUDING GETTING TO BATHROOM

DID NOT USE TOILET AT ALL IN PAST WEEK (BEDPAN, BEDSIDE COMMODE, CATHETER, COLOSTOMY).	01	**S**
HUMAN ASSISTANCE IN USING TOILET	02	**M**
NO HUMAN ASSISTANCE	03	**I**
NO INFORMATION	-1	

CONTINENCE

D6a. **Do you** use a device such as a catheter bag or colostomy bag?

YES	|___|	
NO	|___|	(D6c)
NO INFORMATION.	|___|	(D6c)

D6b. **Do you** change (this/your DEVICE) by **yourself**?

YES, SELF CARE.	|___|		
NO, HELP WITH CARE.	|___|	(D6)	S_2
NO INFORMATION.	|___|		

D6c. During the past week, did **you** accidently wet or soil **yourself**, either day or night?

PROBE: At least once?

YES	|___|	S_1
NO	|___|	I
NO INFORMATION.	|___|	

D6. CONTINENCE

INCONTINENT AT LEAST ONCE DURING PAST WEEK.	01	S_1
HUMAN ASSISTANCE WITH CHANGING DEVICE (E.G., CATHETER BAG OR COLOSTOMY BAG).	02	S_2
SELF CARE OF DEVICE (E.G., CATHETER BAG OR COLOSTOMY BAG AND NOT INCONTINENT DURING PAST WEEK	03	M
NOT INCONTINENT AT ALL DURING PAST WEEK.	04	I
NO INFORMATION	-1	

D7. TYPE OF RESPONDENT FOR SECTION D:

SELF 01

SIGNIFICANT OTHER/REGULAR CAREGIVER 02

RECENT ASSESSOR 03

D8. DOES APPLICANT HAVE AT LEAST 2 MODERATE ADL IMPAIRMENTS?

YES 01 (F1)

NO 02

D9. IS APPLICANT BEDBOUND (DOES NOT GET OUT OF BED OR ONLY IF LIFTED)? (SEE D2.)

YES 01

NO . . . . . 02 (SECTION E)

NO INFORMATION IN D2. . . . . 03 (SECTION E)

D10. For how long **have you** been unable to get out of bed -- has it been more than one month?

YES, MORE THAN ONE MONTH. . . 01 (E5)

NO, ONE MONTH OR LESS 02

NO INFORMATION. . . . . -1

E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

QUESTIONS IN SECTION E SHOULD BE ASKED ONLY OF SELF-RESPONDENTS, SIGNIFICANT OTHERS, REGULAR CAREGIVERS, OR SOMEONE WHO HAS RECENTLY ASSESSED THE APPLICANT IN A FACE-TO-FACE SITUATION. SECTION F BEGINS ON PAGE 16.

INSTRUCTIONS:

The next questions are about activities that are usually done in a household, such as shopping, cooking, and cleaning. I know that not everyone does these things. I would like to find out whether **you are** able to do them.

ASK ABOUT APPLICANT'S CURRENT CAPACITY (USUAL CAPACITY DURING LAST WEEK). USUAL = HALF THE TIME OR MORE.

E1. Can **you** prepare a light meal, such as a sandwich, by **yourself**?

PROBE: If the rules permitted/If someone else didn't do it/ If **you** had a kitchen,

YES 01
NO . . . . . 02 **S**
NO INFORMATION. . . . . -1

E2. Can **you** do light work around the house, such as washing dishes, by **yourself**?

PROBE: If someone else didn't do it/ If the rules permitted/If **you** wanted to,

YES 01
NO . . . . . 02 **S**
NO INFORMATION. . . . . -1

E3. Can **you** shop for groceries if someone goes with **you** to help **you** manage?

PROBE: If **you** had transportation/If someone else didn't do it,

YES 01
NO . . . . . 02 **S**
NO INFORMATION. . . . . -1

E4. Can **you** travel in a van, taxi, or car if someone goes with **you** to help **you** manage?

IF DOES NOT TRAVEL AT ALL, PROBE: What about trips to the doctor?

YES 01
NO . . . . . 02 **S**
DOES NOT TRAVEL AT ALL. . . . 03 **S**
NO INFORMATION. . . . . -1

E5. The next question is about taking medicine. If someone measures out the amount of medicine beforehand and reminds **you** to take it, can **you** do the rest by **yourself**?

YES 01
NO . . . . . 02 **S**
NO INFORMATION. . . . . -1

E6. Can **you** take care of money for day-to-day purchases by **yourself**?

YES 01
NO . . . . . 02 **S**
NO INFORMATION. . . . . -1

E7. Can **you** answer the telephone and call the operator by **yourself**?

IF CAN DO WITH AN AMPLIFIED OR OTHER SPECIALLY EQUIPPED TELEPHONE, CODE AS ABLE TO DO.

CAN DO ONE 01
BOTH 02
NEITHER . . . . . 03 **S**
NO INFORMATION. . . . . -1

E8. TYPE OF RESPONDENT FOR SECTION E:

SELF. 01
SIGNIFICANT OTHER/REGULAR CAREGIVER 02
RECENT ASSESSOR 03

E9. DOES APPLICANT HAVE 3 SEVERE IADL IMPAIRMENTS OR 2 SEVERE IADL IMPAIRMENTS AND 1 SEVERE ADL IMPAIRMENT?

YES 01
NO 02 (F2)

THE QUESTIONS IN SECTION F ARE TO BE ASKED ONLY OF SELF-RESPONDENTS OR SIGNIFICANT OTHERS.

F1. (When **you leave** the (hospital/nursing home)), do you feel that **you** (will) need more help with --

PROBE: Not counting help **you have**,

	YES	NO	NO INFORMATION
a. meal preparation?	01	02	-1
b. housework or shopping?	01	02	-1
c. taking **your** medicine?	01	02	-1
d. medical treatments at home?	01	02	-1
e. personal care, that is, eating, getting in and out of bed, dressing, bathing, and using the toilet?	01	02	-1

F2. Finally, we need to know **your** income to help us understand what kind of people are interested in our program. It does not affect whether **you** can participate in the program or not.

Before taxes and deductions, about how much income did **you** (and **your** (husband/wife)) have last month from all sources?

PROBE: Your best estimate will be fine.

MONTHLY INCOME. . $|___|___|___|___| (END)
NO INCOME . . . . . 00 (END)
NO INFORMATION. . . . . -1

F3. Could you give me an idea of the range? Was it --

less than $500, ... 01
between $500 and $1,000, ... 02
or $1,000 or more a month? 03
NO INFORMATION . . . . . -1

F4. IS A CURRENTLY INSTITUTIONALIZED?

YES . . . 01 ⟶ ASCERTAIN INTEREST
NO . . . 02

F5. **Are you** now on a waiting list to go to a nursing home or have you applied in the last two months?

ON WAITING LIST OR HAS APPLIED . . 01
NEITHER 02
NO INFORMATION . . . . . -1

ASCERTAIN INTEREST FROM APPLICANT. IF APPLICANT CANNOT COMMUNICATE, ASCERTAIN INTEREST FROM LEGAL GUARDIAN OR WITNESS.

THANK RESPONDENT

END INTERVIEW

COMPLETE ID12 - ID15

LEVEL OF ADL IMPAIRMENT

	SEVERE	MODERATE
EATING	DID NOT EAT (IV,TUBES) IS FED	OTHER HUMAN ASSISTANCE
BED/CHAIR TRANSFER	BEDBOUND LIFTED IN BED AND/OR CHAIR TRANSFER	OTHER HUMAN ASSISTANCE IN BED AND/OR CHAIR TRANSFER
DRESSING	DID NOT CHANGE CLOTHES IS DRESSED	OTHER HUMAN ASSISTANCE (EXCLUDING SHOE TYING AND GROOMING)
BATHING	BEDBATHS/DID NOT BATHE HELP IN WASHING MORE THAN BACK OR FEET (EXCLUDING SHAMPOOING)	OTHER HUMAN ASSISTANCE (EXCEPT SUPERVISION, IF INSTITUTIONALIZED)
TOILETING	DID NOT USE TOILET	ANY HUMAN ASSISTANCE
CONTINENCE	INCONTINENT AT LEAST ONCE IN PAST WEEK HUMAN ASSISTANCE WITH EQUIPMENT	EQUIPMENT USE WITH SELF CARE