CLINICAL BASELINE ASSESSMENT INSTRUMENT:
Community Version

Mathematica Policy Research, Inc.

June 22, 1983

This instrument was developed for the National Long-Term Care Channeling Demonstration. This project was conducted by Mathematica Policy Research, Inc. under contract #HHS-100-80-0157 and Temple University under contract #HHS-100-80-0133 for the Department of Health and Human Services' Office of Social Services Policy (now Office of Disability, Aging and Long-Term Care Policy). Additional funding was provided by the Administration on Aging and Health Care Financing Administration (now CMS). 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

Client Name

|__|__| - |__|__|__|__|__|__| - |__|
I.D. Number

Assessment Date(s)

Birth Date

Sex: M F

Respondent: Client Proxy

Assessment Interviewer

NATIONAL LONG TERM CARE DEMONSTRATION

CLINICAL BASELINE ASSESSMENT INSTRUMENT

COMMUNITY VERSION

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.

CLINICAL NOTES FROM THE SCREEN

Mathematica Policy Research and Temple University
June 22, 1983

This questionnaire was prepared for the Department of Health and Human Services under Contract No. HHS-100-80-0157 and Contract No. HHS 100-80-0133.

COMPLETE INFORMED CONSENT FORMS

First I'd like to find out a little about **you** and **your** living situation.

You may have recently answered a few questions similar to the ones I am going to ask now. It is important that I ask them again so that we will have the same information on everyone.

A1. **Are you** married, widowed, divorced or separated, or **have you** never been married?

MARRIED	01
WIDOWED	02
DIVORCED	03
SEPARATED	04
NEVER MARRIED	05
NOT ANSWERED	-1

[HOW LONG] _____

A2. **Do you** live alone?

YES, ALONE	01	(A6)
NO, WITH OTHERS	02	
NO, IN GROUP HOME, NOT WITH RELATIVES	03	(A6)
NOT ANSWERED	-1	

[TYPE OF RESIDENCE]

A3. Please tell me the names of everyone who usually lives with **you** .

A4. How old is NAME?

A5. How is NAME related to **you** ? NOT ANSWERED. . . . . -1

NAME	AGE	RELATIONSHIP

A6. **Do you** have any children (who do not live with **you**)?

INCLUDE ONLY LIVING CHILDREN.

YES——>How many? . . . . . |_|_|
NO. 00 (A8)
NOT ANSWERED. . . . . -1 (A8)

[NAME]	[ADDRESS]	[TELEPHONE]

A7. (Do any of these children/Does this child) live within one-half hour travel time of **you?**

YES——>How many? . . . . . |_|_|
NO. 00
NOT ANSWERED. . . . . -1

A8. Could you please tell me the name, address, and phone number of someone we might contact in case we have trouble getting in touch with you?

NAME	ADDRESS	TELEPHONE

A9. What is the highest grade or year **you** finished in school?

IF UNGRADED OR FOREIGN SCHOOL, PROBE: About what grade would that be equal to (in this country)?

NO SCHOOLING. 00

ELEMENTARY (01-08). . . | _ | _ |

HIGH SCHOOL (09-12) . . | _ | _ |

COLLEGE/GRADUATE (13-18+). . . . . | _ | _ |

NOT ANSWERED. . . . . -1

A10. READ CATEGORIES IF NECESSARY.

What is **your** 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

NOT ANSWERED . . . . . -1

B. PHYSICAL HEALTH

The next questions are about **your** physical health.

B1. How would **you** rate **your** overall health at the present time--would **you** say

excellent,. 01
good, ... 02
fair, ... 03
or poor? 04
NOT ANSWERED. . . . . -1

B2. **Do you** have a regular source of medical care, like a family doctor or a clinic?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[NAME] [ADDRESS] [TELEPHONE]

[LAST VISIT]

[NEXT APPOINTMENT]

B3. In the last year, how many times **were you** admitted to any kind of hospital?

ADMISSIONS. . . . . | _ | _ |

TRANSFER BETWEEN HOSPITALS= MULTIPLE ADMISSIONS.

NONE. 00

NOT ANSWERED. . . . . -1

[HOSPITAL] [DATE] [REASON]

_____

_____

_____

_____

_____

_____

B4. In the last year, **were you** a resident in a nursing home, convalescent home or similar place?

YES 01

NO. 02

NOT ANSWERED. . . . . -1

[NURSING HOME] [DATE] [REASON]

_____

_____

_____

B5. **Have you** applied to get into a nursing home?

YES 01

NO. 02

NOT ANSWERED. . . . . -1

[WHERE]

_____

[ATTITUDE TOWARD NURSING HOME] _____

_____

_____

B6. Now I am going to read you a list of health conditions and illnesses. Please tell me if **you have** any of them at the present time.

	IF YES → B7. **Are you** currently being treated for this condition?					
	YES	NO	NA	YES	NO	NA
a. First, **do you** have anemia (tired blood, iron-poor blood)?	01	02	-1	01	02	-1
b. High blood pressure?	01	02	-1	01	02	-1
c. Angina or heart trouble, e.g., heart attacks?	01	02	-1	01	02	-1
d. Effects of a stroke?	01	02	-1	01	02	-1
e. Diabetes?	01	02	-1	01	02	-1
f. Arthritis or pain in **your** joints?	01	02	-1	01	02	-1
g. Cancer, leukemia, or a tumor?	01	02	-1	01	02	-1
h. Nerve or muscle problems like neuralgia, Parkinson's disease or seizures?	01	02	-1	01	02	-1
i. Respiratory problems like asthma, emphysema, or bronchitis?	01	02	-1	01	02	-1
j. Skin problems like a rash, eczema, or bed sores	01	02	-1	01	02	-1
k. Broken or dislocated bones?	01	02	-1	01	02	-1
l. Paralysis?	01	02	-1	01	02	-1
m. **Do you** have any (other) health conditions or illnesses we haven't talked about (SPECIFY)	01	02	-	01	02	-1
PROBE: Anything else?						
_____	01	02	-1	01	02	-1
_____						

[DETAILS OF HEALTH CONDITIONS/RISK FACTORS. INCLUDE SMOKING, ALCOHOL CONSUMPTION, COMPLIANCE WITH DOCTOR'S ORDERS.]

B8. I would like some information about the medicines **you take** regularly now. Let's start with **your** prescriptions. (May I see them?)

AFTER PRESCRIPTIONS NOTED,
Are there any other medicines **you keep** in a special place, for example in the refrigerator, or any special medicines like eyedrops, suppositories or injections?

AFTER ANY SPECIAL MEDICINES NOTED.
Are there any non-prescription medicines **you take** regularly like vitamins, aspirin, or laxatives?

MEDICINE	DOSAGE	FREQUENCY	DOCTOR	DATE

B9. **Do you** have any medical treatments <u>at home</u> like injections, therapies, oxygen or changing of bandages?

[TREATMENTS] _____

_____

[WHO DOES IT] _____

[FREQUENCY] _____

YES 01

NO. 02 (B11)

NOT ANSWERED. . . . . -1 (B11)

B10. Do you feel that **you are** getting enough help to carry out these treatments at home or **do you** need more help with them?

ENOUGH HELP/NO HELP NEEDED. . 01

NEED MORE HELP. 02

NOT ANSWERED. . . . . -1

[HELP NEEDED] _____

_____

B11. Often what you eat is important to your health. Could you please tell me what **you** usually eat?

READ CATEGORIES IF NECESSARY

<u>CIRCLE ALL THAT APPLY</u>

[DETAILS]

_____

_____

_____

_____

_____

_____

_____

DAIRY PRODUCTS, SUCH AS MILK, CHEESE OR YOGURT 01

"PROTEIN FOODS", SUCH AS MEAT, POULTRY, FISH, EGGS, OR DRIED BEANS. 02

FRUITS OR VEGETABLES - EITHER RAW, COOKED OR CANNED. 03

FOODS MADE FROM GRAINS, SUCH AS BREAD, CEREAL, NOODLES, OR RICE 04

DOES NOT EAT AT ALL (IV TUBES) . 06

NOT ANSWERED . . . . . -1

B12. **Are you** on a special diet?

YES. 01
NO 02
NOT ANSWERED . . . . . -1

[TYPE] _____

[WHO PRESCRIBED] _____

B13. Now, I'd like to talk about special equipment **you** may use. **Do you** use any of the following special equipment or aids?

	YES	NO	NOT ANSWERED
a. Dentures?.	01	02	-1
b. A cane?.	01	02	-1
c. A walker?.	01	02	-1
d. A wheelchair?.	01	02	-1
e. A brace?	01	02	-1
f. A pacemaker (for **your** heart)?.	01	02	-1
g. A hearing aid?	01	02	-1
h. Glasses or contact lenses?	01	02	-1
i. Any other special equipment that I haven't mentioned? (SPECIFY).	01	02	-1

_____

_____

[EQUIPMENT USE] _____

_____

_____

IF THE CLIENT HAS BEEN UNABLE TO GET OUT OF BED FOR MORE THAN ONE MONTH, OR WHEN LIFTED OUT STILL CANNOT AMBULATE, SKIP TO B16.

INDOOR MOBILITY

B14. The next questions are about getting around indoors, (inside **this** house/apartment/on **this** floor).

How **do you** usually get around inside?

(SPECIFY) _____

_____

_____

[PROBLEMS WITH MOBILITY/AMBULATION] _____

_____

_____

B15. IF IN WHEELCHAIR, CODE WITHOUT ASKING.
How difficult is it for **you** to climb one flight of stairs -- is it

PROBE: If there were stairs here, how difficult would it be for you to climb them?

not difficult, ... 01

somewhat difficult,. 02

very difficult, or 03

can't you do it at all?. . . . 04

IN WHEELCHAIR. 05

NOT ANSWERED . . . . . -1

[# OF FLIGHTS:
STREET TO DWELLING UNIT _____
INSIDE DWELLING UNIT _____]

B16. Do you feel that **you need** (help/more help) with getting around inside?

YES. 01

NO 02

NOT ANSWERED . . . . . -1

[HELP NEEDED]

_____

OUTDOOR MOBILITY

B17. What about outdoors? How **do you** usually get around when you go outdoors?

DOES NOT GO OUTDOORS ☐

(SPECIFY) _____

_____

_____

B18. (With **your** glasses or lenses) can **you** see well enough to read the labels on **your** medicine bottles or see the numbers on a telephone?

IF FOREIGN, PROBE:
Could **you** read a
CLIENT'S NATIVE LANGUAGE
newspaper?

YES 01

NO. 02

NOT ANSWERED. . . . . -1

_____

_____

_____

_____

B19. CAN THE CLIENT HEAR WELL ENOUGH TO UNDERSTAND NORMAL CONVERSATION (WITH A HEARING AID IF USUALLY WORN)?

YES 01

NO. 02

NOT ANSWERED. . . . . -1

_____

_____

_____

_____

B20. WHICH OF THE FOLLOWING BEST DESCRIBES THE CLIENT'S SPEECH?

PARTIALLY IMPAIRED (CAN USUALLY BE UNDERSTOOD BUT HAS DIFFICULTY WITH SOME WORDS). 01

SEVERELY IMPAIRED (CAN BE UNDERSTOOD ONLY WITH DIFFICULTY AND CANNOT CARRY ON A NORMAL CONVERSATION 02

COMPLETELY IMPAIRED (SPEECH IS UNINTELLIGIBLE OR CANNOT SPEAK). 03

C. PHYSICAL ACTIVITIES OF DAILY LIVING

EATING

C1. The next questions are about taking care of yourself.

First, I'd like to ask you about help with eating.

During the past week, did someone usually help **you** eat or stay in the room in case **you** needed help eating?

DO NOT CODE HELP WITH CUTTING MEAT OR BUTTERING BREAD.

YES, USUALLY HELPED 01
NO, NOT USUALLY HELPED. . . . 02 (C3)
IV, TUBES 03 (C4)
NOT ANSWERED. . . . . -1 (C3)

USUALLY = HALF THE TIME OR MORE DURING THE PAST WEEK.

[WHO HELPS] [HOW]

_____

_____

_____

C2. Did someone usually feed **you?**

YES 01
NO. 02
NOT ANSWERED. . . . . -1

C3. Do you feel that **you need** (help/more help) with eating?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[HELP NEEDED] _____

_____

BED AND CHAIR TRANSFER

C4. During the past week, did someone usually help **you** get out of bed or a chair or stay in the room in case **you** needed help?

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

YES, USUALLY HELPED 01

NO, NOT USUALLY HELPED. 02 (C6)

DID NOT GET OUT OF BED AT ALL . . 03 (C6)

NOT ANSWERED. . . . . -1 (C6)

[WHO HELPS] [HOW]

_____

_____

_____

C5. Did someone usually lift **you** out of bed or a chair?

[SPECIAL EQUIPMENT USED]

_____

_____

YES 01

NO. 02

NOT ANSWERED. . . . . -1

C6. Do you feel that **you need** (help/more help) with getting out of bed or a chair?

IF NO, PROBE: What about special equipment, **do you** need that?

YES 01

NO. 02

NOT ANSWERED. . . . . -1

[HELP NEEDED]

_____

DRESSING

C7. The next questions are about dressing -- that is, getting clothes and putting them on (including **your** brace).

During the past week, did **you** usually get dressed for the day or did **you** stay in night clothes?

GOT DRESSED 01

STAYED IN NIGHT CLOTHES 02

DID NOT CHANGE CLOTHES AT ALL . . 03 (C10)

NOT ANSWERED. . . . . -1 (C10)

C8. Did someone help **you** (dress/change **your** night clothes) or stay in the room in case **you** needed help?

DO NOT CODE HELP IN TYING SHOES OR GROOMING.

YES, USUALLY HELPED 01

NO, NOT USUALLY HELPED. . . . 02 (C10)

NOT ANSWERED. . . . . -1 (C10)

[WHO HELPS] [HOW]

_____

_____

_____

C9. Did someone usually (dress **you** /change **your** night clothes for **you**)?

YES 01

NO. 02

NOT ANSWERED. . . . . -1

C10. Do you feel that **you need** (help/more help) with (getting dressed/ changing **your** night clothes)?

YES 01

NO. 02

NOT ANSWERED. . . . . -1

[HELP NEEDED]

_____

BATHING

C11. The next questions are about bathing -- including turning on the water.

During the past week when you had a full bath, did **you** usually bathe in a tub or shower, at a sink or basin, or did **you** have bedbaths?

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

IN TUB OR SHOWER. 01

IN SINK OR BASIN. 02 (C13)

BEDBATHS. 03 (C16)

DID NOT HAVE FULL BATH. . . . 04 (C16)

NOT ANSWERED. . . . . -1 (C13)

[IF BEDBATH, WHO HELPS] _____

_____

C12. Did someone usually help **you** get in or out of the tub or shower or stay in the room in case **you** needed help?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

C13. During the past week, did someone usually help **you** bathe (at the sink or basin) or stay in the room in case **you** needed help?

YES, USUALLY HELPED 01
NO, NOT USUALLY HELPED. 02 (C15)
NOT ANSWERED. . . . . -1 (C15)

[WHO HELPS] [HOW]

_____

_____

_____

_____

C14. Did someone help **you** wash more than **your** back or feet?

DO NOT CODE HELP WITH SHAMPOOING HAIR.

YES 01
NO. 02
NOT ANSWERED. . . . . -1

C15. Did **you** usually use special equipment to help **you** bathe, like (a tub stool or grab bar/handle bars at the sink)?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[TYPE]

_____

C16. Do you feel that **you need** (help/more help) with bathing?

IF NO, PROBE: What about special equipment, **do you** need that?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[HELP NEEDED]

_____

_____

_____

_____

TOILETING

C17. The next questions are about personal care. The first one is about using the toilet.

During the past week, did **you** usually go to the bathroom to use the toilet?

PROBE: For either **your** bowel or bladder functions?

IF NO, PROBE: What did **you** usually use?

_____

YES, TOILET FOR AT LEAST ONE FUNCTION. 01
NO (BEDPAN, BEDSIDE COMMODE). 02 (C22)
NO (CATHETER, COLOSTOMY). . . 03 (C20)
NOT ANSWERED. . . . . -1 (C20)

[IF BEDPAN/COMMODE, WHO HELPS]

_____

C18. Did someone usually help **you** get to the bathroom to use the toilet or stay nearby in case **you** needed help?

YES, USUALLY HELPED 01
NO, NOT USUALLY HELPED. . . . 02
NOT ANSWERED. . . . . -1

[WHO HELPS]

[HOW]

_____

_____

_____

C19. During the past week, did **you** usually use special equipment like a grab bar or raised toilet seat to help **you** use the toilet?

[TYPE]

_____

_____

YES 01
NO. 02
NOT ANSWERED. . . . . -1

C20. **Do you** use a device such as a catheter bag or colostomy bag?

[TYPE]

_____

_____

YES 01
NO. 02 (C22)
NOT ANSWERED. . . . . -1

C21. **Do you** change (this/ **your** DEVICE) by **yourself?**

[WHO HELPS]

_____

SELF CARE 01
HELP WITH CARE. 02
NOT ANSWERED. . . . . -1

C22. During the past week, did **you** accidently wet or soil **yourself**, either day or night?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

C23. Do you feel that **you need** (help/more help) with (using the toilet/caring for **your** bladder and bowel functions)?

IF NO, PROBE: What about special eqiupment, **do you** need that?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[HELP NEEDED]

_____

_____

D. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

IF CLIENT HAS BEEN UNABLE TO GET OUT OF BED FOR MORE THAN ONE MONTH, OR WHEN LIFTED OUT STILL CANNOT AMBULATE, ASK ONLY THE QUESTIONS MARKED WITH A STAR ★.

MEAL PREPARATION

D1. These next questions are about things done in a household, such as cleaning and cooking.

Do you usually prepare **your** own meals by **yourself?**

USUALLY = HALF THE TIME OR MORE DURING THE PAST MONTH.

YES, USUALLY BY SELF. 01 (D4)

NO, USUALLY HAS HELP/NO MEALS PREPARED. 02

NOT ANSWERED. . . . . -1 (D3)

[WHO HELPS] [HOW]

D2. What is the reason **you (get** help preparing/ **don't** prepare) meals?
(SPECIFY)

D3. **Are you** able to prepare light meals, such as a sandwich, by **yourself?**

CAN PREPARE LIGHT MEALS . . . 01

CANNOT. 02

NOT ANSWERED. . . . . -1

★ D4. Do you feel that **you need** (help/more help) with meal preparation?

YES 01

NO. 02

NOT ANSWERED. . . . . -1

[HELP NEEDED]

HOUSEKEEPING

D5. **Do you** usually do the work around the house, like washing dishes and cleaning floors, by **yourself?**

YES, USUALLY BY SELF 01 (D7)
NO, USUALLY HAS HELP 02
NO WORK DONE AROUND THE HOUSE. . . 03
NOT ANSWERED . . . . . -1

[WHO HELPS] [HOW]

[REASON]

D6. **Are you** able to do light work around the house, such as washing dishes, by **yourself?**

CAN DO LIGHT HOUSEWORK 01
NOT AT ALL 02
NOT ANSWERED . . . . . -1

★ D7. Do you feel that **you need** (help/more help) with work around the house?

YES. 01
NO 02
NOT ANSWERED . . . . . -1

[HELP NEEDED]

SHOPPING

D8. **Do you** usually shop for most of **your** groceries by **yourself?**

YES, USUALLY BY SELF 01 (D10)
NO, USUALLY HAS HELP 02
NOT ANSWERED . . . . . -1

[WHO HELPS] [HOW]

_____

_____

_____

_____

[REASON]

_____

D9. **Are you** <u>able</u> to go grocery shopping if someone goes with **you** to help **you** manage?

PROBE: If **you** had transportation,

YES, CAN WITH HELP 01
NO, CANNOT GO AT ALL 02
NOT ANSWERED . . . . . -1

* D10. Do you feel **you need** (help/more help) with grocery shopping?

YES. 01
NO 02
NOT ANSWERED . . . . . -1

[HELP NEEDED]

_____

_____

_____

TAKING MEDICINE

★D11. The next questions are about taking medicine.

Does someone usually help **you** to take the correct amounts of medicine at the proper time?

PROBE: When **you take** medicine,

YES, USUALLY HAS HELP . . . 01
NO, USUALLY BY SELF 02 (D14)
NOT ANSWERED. . . . . -1 (D13)

[WHO HELPS] [HOW]

_____

_____

_____

_____

★D12. What is the reason **you get** help with taking medicine?

(SPECIFY)

_____

★D13. If someone measures out the amount of medicine beforehand and reminds you to take it, **are you** able to do the rest by **yourself?**

IF NEEDS REMINDER AND/OR PREMEASURED AMOUNT, BUT CAN DO REST, CODE "YES".

YES 01
NO. 02
NOT ANSWERED. . . . . -1

★D14. Do you feel **you need** (help/more help) when **you take** medicine?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[HELP NEEDED]

_____

_____

_____

TRAVEL/TRANSPORTATION

D15. What kind of transportation do **you** usually use?

PROBE: What about going to the doctor?

BUS/SUBWAY. 01 (D17)
CAR/VAN/TAXI. 02
AMBULANCE ONLY. 03
DOES NOT TRAVEL AT ALL. . . 04 (D18)
NOT ANSWERED. . . . . -1 (D18)

D16. Can **you** travel in a car, van or taxi if someone goes with **you** to help **you** manage?

[ESCORT NEEDED] _____

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[WHO HELPS] [HOW]

_____

_____

_____

D17. **Do you** have help with transportation from an agency or organization, like LOCAL NAME?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[AGENCY NAME] _____

_____

★ D18. Do you feel that **you need** (help/more help) with transportation?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[HELP NEEDED] _____

_____

_____

MONEY MANAGEMENT

★D19. The next questions are about managing **your** money, regardless of how much or little **you have.**

Do you usually write checks or pay bills by **yourself?**

YES, USUALLY BY SELF . . . 01 (D22)
NO, USUALLY HAS HELP . . . 02
NO, HAS NO BILLS 03
NOT ANSWERED . . . . . -1

[WHO HELPS] [HOW]

_____

_____

[REASON HAS HELP/NO BILLS]

_____

★D20. **Do you** have a legal guardian, conservator, or payee?

[NAME] _____

_____

[TYPE] _____

[ADDRESS] _____

[PHONE #] _____

YES 01
NO. 02
NOT ANSWERED. . . . . -1

★D21. **Are you** able to take care of money for day-to-day purchases by **yourself?**

YES 01
NO. 02
NOT ANSWERED. . . . . -1

★D22. Do you feel that **you need** (help/more help) with managing **your** money?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[HELP NEEDED]

_____

_____

_____

TELEPHONE

The next questions are about using the telephone.

★D23. Can **you** get telephone numbers and place the calls by **yourself?**

PROBE: Can **you** do both?

ONE ONLY 01
BOTH. 02 (D25)
NEITHER 03
NOT ANSWERED. . . . . -1

[USES SPECIAL EQUIPMENT] _____

_____

[NEEDS SPECIAL EQUIPMENT] _____

_____

★D24. Can **you** answer the telephone and call the operator by **yourself?**

PROBE: Can **you** do both?

ANSWER ONLY 01
CALL OPERATOR ONLY. 02
BOTH. 03
NEITHER 04
NOT ANSWERED. . . . . -1

D25. DOES CLIENT LIVE ALONE (SEE A2 AND A3)?

THOSE IN GROUP QUARTERS DO NOT LIVE ALONE.

YES 01 (E7)
NO. 02
A2 OR A3 NOT ANSWERED 03

E. SERVICES AND SUPPORT
HOUSEHOLD SUPPORT SYSTEM

E1. Now I have some more questions about the people who help **you**. First, please tell me who <u>lives</u> with **you** who <u>regularly</u> helps **you** to take care of **yourself** or who does things around the house.

ASK E2-E6 FOR EACH HOUSEHOLD CAREGIVER	NAME 1 _____ NO HOUSEHOLD CARE-GIVERS . . . . . -4 (E7)	NAME 2 _____	NAME 3 _____
E2. How is <u>NAME</u> related to **you**?	_____ NOT ANSWERED . . . . -1	_____ NOT ANSWERED . . . . -1	_____ NOT ANSWERED. . . . . -1
E3. When is <u>NAME</u> generally at home to help **you** if **you need** it? CIRCLE ALL THAT APPLY	WEEK NIGHTS. . . . . 01 WEEK DAYS. . . . . 02 WEEKENDS . . . . . 03 NOT ANSWERED . . . . -1	WEEK NIGHTS. . . . . 01 WEEK DAYS. . . . . 02 WEEKENDS . . . . . 03 NOT ANSWERED . . . . -1	WEEK NIGHTS . . . . . 01 WEEK DAYS . . . . . 02 WEEKENDS. . . . . 03 NOT ANSWERED. . . . . -1
E4. Is <u>NAME</u> employed?	YES. . . . . 01 NO . . . . . 02 NOT ANSWERED . . . . -1	YES. . . . . 01 NO . . . . . 02 NOT ANSWERED . . . . -1	YES . . . . . 01 NO. . . . . 02 NOT ANSWERED. . . . . -1
E5. What does <u>NAME</u> regularly help **you** with? PROBE: Anything else? IF NO MENTION OF PERSONAL CARE, PROBE: Does Name help **you** with eating, getting out of bed or a chair, dressing, bathing, or using the toilet?	PERSONAL CARE . . . . 01 PREPARING MEALS . . . 02 HOUSEWORK, LAUNDRY, SHOPPING, CHORES. . 03 TAKING MEDICINE . . . 04 MEDICAL TREATMENTS. . 05 TRANSPORTATION. . . . 06 MANAGING MONEY. . . . 07 MONITORING. . . . . 08 OTHER (SPECIFY) _____ 09 _____ _____ _____ NOT ANSWERED . . . . -1	PERSONAL CARE . . . . 01 PREPARING MEALS . . . 02 HOUSEWORK, LAUNDRY, SHOPPING, CHORES. . 03 TAKING MEDICINE . . . 04 MEDICAL TREATMENTS. . 05 TRANSPORTATION. . . . 06 MANAGING MONEY. . . . 07 MONITORING. . . . . 08 OTHER (SPECIFY) _____ 09 _____ _____ _____ NOT ANSWERED . . . . -1	PERSONAL CARE . . . . 01 PREPARING MEALS . . . 02 HOUSEWORK, LAUNDRY, SHOPPING, CHORES. . 03 TAKING MEDICINE . . . 04 MEDICAL TREATMENTS. . 05 TRANSPORTATION. . . . 06 MANAGING MONEY. . . . 07 MONITORING. . . . . 08 OTHER (SPECIFY) _____ 09 _____ _____ _____ NOT ANSWERED. . . . . -1
E6. WAS ANOTHER HOUSEHOLD CAREGIVER NAMED?	YES .(Repeat E2-E6). 01 NO. .(GO TO E7). . . 02	YES .(Repeat E2-E6). 01 NO. .(GO TO E7). . . 02	GO TO E7

INFORMAL SUPPORT SYSTEM

E7. Next, please tell me the names of friends, neighbors or family members (who do not live with **you**) who regularly help **you**. Please do not include people who help **you** as part of their paid or volunteer work.

ASK E8-E13 FOR EACH HOUSEHOLD CAREGIVER	NAME 1 ______ NO HOUSEHOLD CAREGIVERS . . . . . -4 (E14)	NAME 2 ______	NAME 3 ______
E8. How is NAME related to **you?**	______ NOT ANSWERED . . . . . -1	______ NOT ANSWERED . . . . . -1	______ NOT ANSWERED . . . . . -1
E9. IF RELATIVE, is NAME employed?	YES. . . . . 01 NO . . . . 02 NOT RELATIVE . . . . . -4 NOT ANSWERED . . . . . -1	YES. . . . . 01 NO . . . . 02 NOT RELATIVE . . . . . -4 NOT ANSWERED . . . . . -1	YES. . . . . 01 NO . . . . 02 NOT RELATIVE . . . . . -4 NOT ANSWERED . . . . . -1
E10. About how often does NAME come to help **you** ? PROBE: In the avg. week or month?	__ __ VISITS PER WEEK. . . . 01 PER MONTH . . . 02 NOT ANSWERED . . . . . -1	__ __ VISITS PER WEEK. . . . 01 PER MONTH . . . 02 NOT ANSWERED . . . . . -1	__ __ VISITS PER WEEK. . . . 01 PER MONTH . . . 02 NOT ANSWERED . . . . . -1
E11. About how long does NAME usually stay each visit? PROBE: On the avg?	______ HOURS MINS. NOT ANSWERED . . . . . -1	______ HOURS MINS. NOT ANSWERED . . . . . -1	______ HOURS MINS. NOT ANSWERED . . . . . -1
E12. What does NAME regularly help **you** with? PROBE: Anything else? IF NO MENTION OF PERSONAL CARE, PROBE: Does Name help **you** with eating, getting out of bed or a chair, dressing, bathing, or using the toilet?	PERSONAL CARE . . . . 01 PREPARING MEALS . . . 02 HOUSEWORK, LAUNDRY, SHOPPING, CHORES. . 03 TAKING MEDICINE . . . 04 MEDICAL TREATMENTS. . 05 TRANSPORTATION. . . . 06 MANAGING MONEY. . . . 07 MONITORING. . . . . . 08 OTHER (SPECIFY) ______ 09 ______ ______ ______ NOT ANSWERED . . . . . -1	PERSONAL CARE . . . . 01 PREPARING MEALS . . . 02 HOUSEWORK, LAUNDRY, SHOPPING, CHORES. . 03 TAKING MEDICINE . . . 04 MEDICAL TREATMENTS. . 05 TRANSPORTATION. . . . 06 MANAGING MONEY. . . . 07 MONITORING. . . . . . 08 OTHER (SPECIFY) ______ 09 ______ ______ ______ NOT ANSWERED . . . . . -1	PERSONAL CARE . . . . 01 PREPARING MEALS . . . 02 HOUSEWORK, LAUNDRY, SHOPPING, CHORES. . 03 TAKING MEDICINE . . . 04 MEDICAL TREATMENTS. . 05 TRANSPORTATION. . . . 06 MANAGING MONEY. . . . 07 MONITORING. . . . . . 08 OTHER (SPECIFY) ______ 09 ______ ______ ______ NOT ANSWERED . . . . . -1
E13. WAS ANOTHER INFORMAL CAREGIVER NAMED?	YES .(Repeat E8-E13).01 NO. .(GO TO E14) . . 02	YES .(Repeat E8-E13).01 NO. .(GO TO E14) . . 02	GO TO E14

FORMAL SUPPORT SYSTEM

E14. Now, please tell me the people who regularly (come to) help **you** as part of their paid or volunteer work. These could be people who come from an agency or organization or (people **you** or **your** family hired/people on the staff here).

ASK E15-E19 FOR EACH FORMAL CAREGIVER	NAME 1 ______ NO FORMAL CAREGIVERS . . . . . -4(E20)	NAME 2 ______	NAME 3 ______
E15. **Do you** have a card or letter from the agency so that I can get the correct spelling? IF NO CARD, ASK FOR AGENCY NAME. IF CANNOT NAME AGENCY, PROBE FOR HELPER'S NAME AND TELEPHONE NUMBER.	NOT WITH AGENCY. . . . -4 NOT ANSWERED . . . . . -1	NOT WITH AGENCY. . . . -4 NOT ANSWERED . . . . . -1	NOT WITH AGENCY. . . . -4 NOT ANSWERED . . . . . -1
E16. How often does NAME come to help **you?**	_ _ VISITS PER WEEK . . . . . . 01 PER MONTH. . . . . . 02 NOT ANSWERED . . . . -1	_ _ VISITS PER WEEK . . . . . . 01 PER MONTH. . . . . . 02 NOT ANSWERED . . . . -1	_ _ VISITS PER WEEK . . . . . . 01 PER MONTH. . . . . . 02 NOT ANSWERED . . . . -1
E17. How long does NAME usually stay each visit?	______ HOURS MINS. NOT ANSWERED . . . . -1	______ HOURS MINS. NOT ANSWERED . . . . -1	______ HOURS MINS. NOT ANSWERED . . . . -1
E18. What does NAME regularly help **you** with? PROBE: Anything else? IF NO MENTION OF PERSONAL CARE, PROBE: Does Name help **you** with eating, getting out of bed or a chair, dressing, bathing, or using the toilet?	PERSONAL CARE . . . . 01 PREPARING MEALS . . . 02 HOUSEWORK, LAUNDRY, SHOPPING, CHORES. . 03 TAKING MEDICINE . . . 04 MEDICAL TREATMENTS. . 05 TRANSPORTATION. . . . 06 MANAGING MONEY. . . . 07 MONITORING. . . . . . 08 OTHER (SPECIFY) ______ 09 NOT ANSWERED . . . . -1	PERSONAL CARE . . . . 01 PREPARING MEALS . . . 02 HOUSEWORK, LAUNDRY, SHOPPING, CHORES. . 03 TAKING MEDICINE . . . 04 MEDICAL TREATMENTS. . 05 TRANSPORTATION. . . . 06 MANAGING MONEY. . . . 07 MONITORING. . . . . . 08 OTHER (SPECIFY) ______ 09 NOT ANSWERED . . . . -1	PERSONAL CARE . . . . 01 PREPARING MEALS . . . 02 HOUSEWORK, LAUNDRY, SHOPPING, CHORES. . 03 TAKING MEDICINE . . . 04 MEDICAL TREATMENTS. . 05 TRANSPORTATION. . . . 06 MANAGING MONEY. . . . 07 MONITORING. . . . . . 08 OTHER (SPECIFY) ______ 09 NOT ANSWERED . . . . -1
E19. WAS ANOTHER FORMAL CAREGIVER NAMED?	YES. (Repeat E15-19). 01 NO. . (GO TO E20) . . 02	YES. (Repeat E15-19). 01 NO. . (GO TO E20) . . 02	GO TO E20

E20. **Do you** regularly attend a social, religious, or recreational program like at a senior center or (church/temple)?

REGULARLY = ON A RECURRING BASIS OF AT LEAST ONE VISIT A MONTH AT THE PRESENT TIME.

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[WHERE] _____

_____

E21. **Do you** regularly go to a group program where people help **you** take care of **yourself** during the day like AREA PROGRAM TITLE?

REGULARLY = ON A ROUTINE BASIS OF AT LEAST ONCE A WEEK AT THE PRESENT TIME.

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[ANY MEALS THERE] _____

[DAILY ACTIVITIES] _____

_____

_____

_____

_____

_____

_____

_____

_____

F. MENTAL FUNCTIONING

*** THIS SECTION IS NOT TO BE ASKED OF A PROXY ***

F1. Now I'm going to read a list of questions to you. Please answer "Yes" or "No" for each of them.

	YES	NO	NA
a. Do you often have trouble getting to sleep or staying asleep?	01	02	-1
b. Do you often find yourself feeling unhappy or depressed?.	01	02	-1
c. Are you troubled by your heart pounding or shortness of breath?.	01	02	-1
d. Do you usually have a good appetite?.	01	02	-1
e. Have you recently had periods of days or weeks when you couldn't "get going"? (you were constantly tired)	01	02	-1
f. Have you had crying spells or problems shaking off the blues?.	01	02	-1
g. Do you often have trouble keeping your mind on what you are doing?	01	02	-1

F2. Do you find yourself feeling lonely quite often, sometimes, or almost never?

QUITE OFTEN 01
SOMETIMES 02
ALMOST NEVER. 03
NOT ANSWERED. . . . . -1

F3. Have you had any counseling or treatment for personal problems or emotional stress since DATE 6 MONTHS AGO?

[WHERE] _____
_____
_____

YES 01
NO. 02
NOT ANSWERED. . . . . -1

F4. (Besides your husband/wife), have any friends or family members you felt close to died within the past year?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

DO NOT ASK OF A PROXY RESPONDENT

F5. Sometimes when people get older, they have trouble remembering things. If you do not know the answers to some of the next questions, that's okay. It's very normal. If you do know the answers, the questions may seem obvious.

		CORRECT	INCORRECT/ NOT ANSWERED
a.	What is the date today?	01	02
b.	What day of the week is it?	01	02
c.	What is the name of this place? . . . . . PROBE: This neighborhood? This apartment (house/project)?	01	02
d.	What is your telephone number? IF CLIENT DOES NOT HAVE A PHONE, What is your street address?	01	02
e.	How old are you?	01	02
f.	When were you born? . . . . . MO: DAY: YR: CHECK COVER	01	02
g.	What is the name of the President of the United States?	02	
h.	Who was President before this one?	01	02
i.	What was your mother's maiden name? . . . . . ACCEPT ANY SURNAME OTHER THAN CLIENT'S.	01	02
j.	Subtract 3 from 20 and keep subtracting 3 from each new number you get, all the way down. . . . . PROBE: Can you subtract 3 from that? 17, 14, 11, 8, 5, 2	01	02

Thank you. That's all of those questions.

| _ | _ | NUMBER CORRECT

F6. THINKING ABOUT THE CLIENT'S UNDERSTANDING OF THE QUESTIONS, MENTAL FUNCTIONING AND ABILITY TO COMMUNICATE, WOULD YOU SAY THE RESPONSES TO THE QUESTIONS ASKED OF HIM/HER WERE:

COMPLETELY RELIABLE	01
RELIABLE ON MOST ITEMS	02
RELIABLE ON SOME ITEMS	03
COMPLETELY UNRELIABLE	04
NO QUESTIONS ASKED OF SAMPLE MEMBER	-4

F7. DURING THE ASSESSMENT, DID THE CLIENT'S BEHAVIOR STRIKE YOU AS:

	YES	NO	CANNOT DETERMINE
MENTALLY ALERT AND STIMULATING	01	02	03
PLEASANT AND COOPERATIVE	01	02	03
DEPRESSED AND/OR TEARFUL	01	02	03
FEARFUL, ANXIOUS, OR EXTREMELY TENSE	01	02	03
FULL OF UNREALISTIC COMPLAINTS	01	02	03
SUSPICIOUS (MORE THAN REASONABLE)	01	02	03
BIZARRE OR INAPPROPRIATE (E.G. DISRUPTIVE, WANDERING, ABUSIVE)	01	02	03
WITHDRAWN OR LETHARGIC	01	02	03
AGITATED, QUICK, LOUD, AND EMOTIONALLY OVERRESPONSIVE	01	02	03

[BEHAVIOR AND EMOTIONAL FUNCTIONING] _____

_____

_____

_____

_____

_____

_____

G. FINANCIAL RESOURCES

G1. The next questions are about **your** insurance.

Are you covered by --

	YES	NO	NOT ANSWERED
a. Medicare? . . . . . A . . . . . B	01	02	-1
[# FROM CARD] _____			
b. Medicaid?	01	02	-1
[# FROM CARD] _____			

G2. Any (other) medical insurance or health plan such as Blue Cross, Blue Shield, VA or HMO?

[DETAILS/NUMBERS]	YES	NO	NOT ANSWERED
_____	01	02	-1
_____			
_____			
_____			
_____			
_____			

G3. The next questions are about sources of income and assets **you** may have. This information is needed to see if **you** may be able to get services **you do** not now have.

Do you (and **your** husband/wife) now have any income from --

	IF YES → YES	NO	NA	G4. What is the monthly amount of that income?	NOT ANSWERED
a. Social Security or railroad retirement, including Social Security disability payments. . . . PROBE: That is, a green check. EXCLUDE SSI.	01	02	-1	CLIENT:_____	-1
				SPOUSE:_____	-1
				BOTH: _____	-1
b. Other checks from the government such as SSI (that is, a gold check). .	01	02	-1	CLIENT:_____	-1
				SPOUSE:_____	-1
				BOTH:_____	-1
c. Veterans' disability payments?.	01	02	-1	CLIENT:_____	-1
				SPOUSE:_____	-1
				BOTH:_____	-1
d. Retirement pensions? . . .	01	02	-1	_____	-1
e. Any other income?.	01	02	-1	_____	-1

G5. Before taxes and deductions, how much is **your** (and **your** husband's/wife's) <u>total monthly</u> income?

ESTIMATE OK

$|__|__|__|__|__|

NOT ANSWERED . . . . . -1

G6. **Are you** (or is anyone in **your** household) receiving food stamps?

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[AMOUNT] _____

G7. **Do you** (and **your** husband/wife) have any assets like real estate (other than **your** usual home), savings accounts, saving certificates, stocks or bonds, or money market funds?

PROBE: **Do you** have any bank accounts?

IF OWNED BY SPOUSE, CODE "YES".

YES 01
NO. 02
NOT ANSWERED. . . . . -1

[COMMENTS ON FINANCIAL ELIGIBILITY: FOLLOW SITE-SPECIFIC PROCEDURE]

H. PHYSICAL ENVIRONMENT

H1. **Do you** (and **your** (husband/wife)) <u>own</u> or <u>rent</u> **your** (usual) home?

IF HOME OWNED BY SPOUSE, CODE "OWNS OR IS BUYING".

IF GROUP HOME, CODE AS "RENTS".

OWNS OR IS BUYING 01

RENTS 02

OCCUPIES RENT-FREE OR FOR EXCHANGE OF SERVICES. 03

OTHER (SPECIFY) 04

NOT ANSWERED. . . . . -1

[HOUSING EXPENSES] _____

H2. **Do you** receive any (other) assistance from the government in paying **your** rent?

YES 01

NO. 02

NOT ANSWERED. . . . . -1

[TYPE] _____

H3. In the past year, **have you** received any help from the federal, state or local government in paying **your** (fuel/electric) bills?

PROBE: Under (the Energy Assistance Program/ <u>LOCAL NAME</u>)?

YES 01

NO. 02

NOT ANSWERED. . . . . -1

[TYPE] _____

ASK OF CLIENT ONLY

The last questions are about how you feel about your home. The purpose of these questins is to help us understand how people feel about where they live.

H4. Is there anything about the structure of this building that makes it hard for you to go outside?

CIRCLE ALL THAT APPLY

PROBE FOR PROBLEMS RELATED TO ARCHITECTURE OR REPAIR.

YES, STAIRS 01
YES, OTHER PROBLEM. . . . 02
NO. 03
NOT ANSWERED. . . . . -1

[PROBLEMS]

_____

_____

_____

H5. How satisfied are you with the state of repairs or maintenance here? (Are you --

very satisfied, ... 01
fairly satisfied, ... 02
or not very satisfied?) . 03
NOT ANSWERED. . . . . -1

[COMMENTS] _____

_____

_____

H6. How safe do you feel inside here at night? (Would you say very safe, somewhat safe, or very unsafe?)

VERY SAFE 01
SOMEWHAT SAFE 02
VERY UNSAFE 03
NOT ANSWERED. . . . . -1

[COMMENTS] _____

_____

_____

H7. How satisfied are you with this place as a place to live? (Are you --

very satisfied, ... 01
fairly satisfied, ... 02
or not very satisfied?) . 03
NOT ANSWERED. . . . . -1

[COMMENTS] _____

_____

_____

[SATISFACTION WITH THINGS IN GENERAL]

_____

_____

H8. THE PHYSICAL ENVIRONMENT

CHECK IF A PROBLEM OBSERVED FOR EACH OF THE FOLLOWING:

A. LOOSE, SHAKY STAIRS . . . |___|

B. BROKEN WINDOWS. . . . . |___|

C. ADEQUATE HANDRAILS ON STAIRS. . . . . |___|

D. INTERIOR OR EXTERIOR IN NEED OF MAJOR REPAIRS . |___|

E. NO DEADBOLT OR OTHER SECURE LOCK ON DOOR . . . |___|

F. FREEZING IN WINTER, SWELTERING IN SUMMER. . |___|

G. FIRE HAZARDS SUCH AS UNSAFE HEATING OR LIGHTING EQUIPMENT OR BARE WIRES . . . . . |___|

H. ACCUMULATION OF TRASH OR GARBAGE IN OR AROUND DWELLING UNIT . . . . . |___|

I. RATS OR MICE OR THEIR DROPPINGS . . . . . |___|

J. PRESENCE OR STRONG ODOR OF EXCREMENT. . . . . |___|

K. FLOODING OR STANDING WATER INSIDE. . . . . |___|

L. INFESTATION WITH BUGS OR INSECTS. . . . . |___|

M. PEELING PAINT . . . . . |___|

N. NO CURTAINS OR SHADES . . |___|

O. INADEQUATE VENTILATION. . |___|

P. BLOCKED PATHWAYS/ACCESS TO FIRE EXITS . . . . . |___|

Q. SLIPPERY, STICKY OR CLUTTERED FLOORS THAT MIGHT CAUSE SLIPPING OR TRIPPING . . . . . |___|

R. EVIDENCE OF SPOILED FOOD. |___|

S. DIRTY FOOD PREPARATION SURFACES. . . . . |___|

T. MORE THAN ONE DAY'S DIRTY DISHES IN SINK. . |___|

U. BEDDING NOT FRESH . . . . |___|

V. TOILET AREA FILTHY OR ODOROUS . . . . . |___|

W. NO GRAB BARS NEAR TOILET AND/OR TUB. . . . . |___|