FACILITY QUESTIONNAIRE

FQ1. Which one of the categories on this card best describes the ownership of your facility?

+--------+	FOR PROFIT (AN INDIVIDUAL, PARTNERSHIP OR CORPORATION).....	1
¦ SHOW ¦	PRIVATE NONPROFIT (RELIGIOUS GROUP, NONPROFIT CORPORATION, ETC.).....	2
¦ CARD ¦	CITY/COUNTY GOVERNMENT.....	3
¦ FQ1 ¦	STATE GOVERNMENT.....	4
+--------+	VETERANS ADMINISTRATION.....	5
FACOWNED	OTHER FEDERAL AGENCY (SPECIFY)_____	91
FACOWNOS		

FQ2. Which category best describes your facility?

+--------+	HOSPITAL.....	1
¦ SHOW ¦	NURSING HOME.....	2
¦ CARD ¦	RETIREMENT HOME.....	3
¦ FQ2 ¦	DOMICILIARY OR PERSONAL CARE FACILITY....	4
+--------+	MENTAL HEALTH FACILITY.....	5
	INSTITUTION FOR THE MENTALLY RETARDED/ DEVELOPMENTALLY DISABLED.....	6
FACDISC	MENTAL HEALTH CENTER.....	7
FACDISOS	SOME OTHER PLACE (SPECIFY)_____	8

FQ3. Does this facility provide long-term care for any of its residents?

FACLONGT	Yes.....	1	(FQ4)
	No.....	2	BOX FQ3

FQ4. Can the long-term care residents of this facility be identified separately from those of the institution as a whole: that is, are the long-term care facility residents a distinct unit of the facility?

FACLONGD	Yes.....	1	(FQ5)
	No.....	2	BOX FQ3

FQ5. How many beds (in this unit) are regularly maintained for long-term care residents? Include all beds staffed and set up for residents. Do not include beds used by staff or owners or beds used only for day care patients or emergency care.

FACLTBED _____

BEDS

FQ6. How many beds are there in the entire facility?

FACTOBED _____
BEDS

FQ7. Does this facility provide different levels of care to its residents?

PROVLEVL
Yes..... 1
No..... 2 (FQ9)

FQ8. What are the different levels of care provided at this facility? (That is, how are the levels of care classified?)

Skilled.....	1	**LEVLSKIL**
Intermediate.....	2	**LEVLINTR**
Other (SPECIFY).....	3	**LEVLOTH1**
_____		**LEVLOS1**
Other (SPECIFY).....	4	**LEVLOTH2**
_____		**LEVLOS2**
Other (SPECIFY).....	5	**LEVLOTH3**
_____		**LEVLOS3**

FQ9. Does this (facility/unit) have any beds certified by Medicare as SNF (that is, Skilled Nursing Facility) beds?

MCARCERT
Yes..... 1 (FQ10)
No..... 2 (FQ11)

FQ10. How many beds are certified under Medicare as SNF beds?

SNFBEDN _____
BEDS

FQ11. Does this (facility/unit) have any beds certified by Medicaid as SNF beds?

MCADCERT
Yes..... 1 (FQ12)
No..... 2 (FQ13)

FQ12. How many beds are certified under Medicaid as SNF beds?

MDSNFN _____
BEDS

FQ13. Does this (facility/unit) have any beds certified by Medicaid as either ICF (that is, Intermediate Care Facility) beds, or ICF-MR (that is, Intermediate Care Facility for the Mentally Retarded) beds?

MCADICF

YES..... 1 (FQ14)
NO..... 2 BOX FQ1
DON'T KNOW..... -8 BOX FQ1

BOX FQ1	IF ANY MEDICARE-SNF OR MEDICAID-SNF BEDS ("YES" AT FQ9 OR FQ11), SKIP TO FQ16.
	IF NO SNF BEDS (BOTH FQ9 AND FQ11 ARE "NO"), SKIP TO FQ18.

FQ14. How many beds are certified under Medicaid as ICF beds (excluding ICF-MR beds)?
IF NO ICF BEDS, ENTER 0.

MCDICFN _____
BEDS

FQ15. How many beds are certified under Medicaid as ICF-MR beds?
IF NO ICF-MR BEDS, ENTER 0.

MCDICFMR _____
BEDS

FQ16. Do you have any beds that are not certified by either Medicare or Medicaid?

CERTMCMD

Yes..... 1 (FQ17)
No..... 2 (FQ18)

FQ17. How many of these beds does this (facility/unit) have?

CERTBEDS _____
OF UNCERTIFIED BEDS

FQ18. Does this (facility/unit) primarily or exclusively serve any of the following groups of persons? CIRCLE ALL THAT APPLY.

SHOW CARD FQ3

DEAF	1	**PRIMDEAF**
BLIND	1	**PRIMBLND**
UNWED MOTHERS	1	**PRIMUWED**
ALCOHOLICS OR DRUG ABUSERS	1	**PRIMABUS**
ORPHANS OR OTHER DEPENDENT CHILDREN	1	**PRIMORPH**
MENTALLY ILL ONLY	1	**PRIMMENT**
MENTALLY ILL AND DEAF	1	**PRIMMDEF**
MENTALLY RETARDED OR DEVELOPMENTALLY DISABLED ONLY	1	**PRIMMEDD**
MENTALLY ILL AND MENTALLY RETARDED	1	**PRIMMIMR**
OTHER NEUROLOGICALLY OR PHYSICALLY HANDICAPPED	1	**PRIMNEUR**
GERIATRIC (ELDERLY OR AGED)	1	**PRIMGERI**
SOME OTHER SPECIAL GROUP (SPECIFY)	1	**PRIMOTHR**
_____		**PRIMOS**
DOES NOT SERVE ONE GROUP PRIMARILY OR EXCLUSIVELY	1	**PRIMGRP**

BOX FQ2	IF FACILITY/UNIT IS CERTIFIED AS SNF/ICF/ICF-MR (FQ9, FQ11 OR FQ13 = 1, "YES"), SKIP TO BOX FQ4 IF FACILITY IS NOT CERTIFIED AS SNF/ICF/ICF-MR (FQ9, FQ11, AND FQ13 = 2, "NO"), GO TO FQ 19.

FQ19. In addition to room and board, does this (facility/unit) routinely provide . . .

			YES	NO
ROOMCARE	a.	Nursing or medical care?	1	2
SUPRVMED	b.	Supervision over residents who administer their own medications?	1	2
FHLPBATH	c.	Help with bathing?	1	2
FHLPDRES	d.	Help with dressing?	1	2
FHLPSHOP	e.	Help with correspondence or shopping?	1	2
FHLPWALK	f.	Help with walking or getting about?	1	2
FHLPEAT	g.	Help with eating?	1	2
FHLPCOMM	h.	Help with communication (such as hearing, speaking, sign language, writing)?	1	2

FQ20. Does this (facility/unit) provide 24-hour-a-day, seven-day-a-week supervision or nursing coverage for its residents?

FHLPNURS

Yes 1 }BOX FQ4

No 2

BOX FQ3	That completes the interview about the facility. I need to conduct an interview with the individual(s) we have listed as living here. COMPLETE COMMUNITY QUESTIONNAIRE WITH SPs. **INTETIME SPIDCNT**

	That completes the interview about the facility. I have a few questions about the individuals we have listed as living here. DOES THIS FACILITY PROVIDE <u>ONLY</u> LONG-TERM CARE? (FQ5 = FQ6) YES..... 1 BOX FQ5 NO..... 2 (FQ21)

FQ21. I have the following people listed as living at this facility. Does (SP) reside in the long-term care portion of the facility?

SPRESID

SP1
NAME:_____

Yes..... 1
No..... 2

SP2
NAME:_____

Yes..... 1
No..... 2

SP3
NAME:_____

Yes..... 1
No..... 2

SP4
NAME:_____

Yes..... 1
No..... 2

SP5
NAME:_____

Yes..... 1
No..... 2

SP6
NAME:_____

Yes..... 1
No..... 2

BOX FQ5	CONDUCT AN INSTITUTIONAL INTERVIEW FOR EACH SP LIVING IN LONG-TERM CARE PORTION OF FACILITY (BOX FQ4 OR FQ21 = YES). CONDUCT COMMUNITY INTERVIEW WITH EACH SP NOT LIVING IN LTC PORTION OF FACILITY. (FQ21 = NO)

TIME INTERVIEW ENDED: _____ am/pm