

FORM **HHCS-5**  
(3-27-2000)

U.S. DEPARTMENT OF COMMERCE  
Economics and Statistics Administration  
U.S. CENSUS BUREAU  
ACTING AS COLLECTING AGENT FOR THE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
U.S. PUBLIC HEALTH SERVICE  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
NATIONAL CENTER FOR HEALTH STATISTICS

**DISCHARGED PATIENT  
QUESTIONNAIRE**  
**2000 NATIONAL HOME AND  
HOSPICE CARE SURVEY**

**NOTICE** – Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; Paperwork Reduction Project (0920-0298) 1600 Clifton Road, MSD-24, Atlanta, GA 30333. Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

**Section A – ADMINISTRATIVE INFORMATION**

1. Field representative name	2. FR code	3. Date of interview		
		Month	Day	Year

**Section B – PATIENT INFORMATION**

1. Discharged patient line number →	2. Date of Discharge

**Section C – STATUS OF INTERVIEW**

- 01  Complete
- 02  Partial
- 03  Patient included in sampling list in error – **Explain in NOTES section.**
- 04  Incorrect sample line number selected
- 05  Refused
- 06  Assessment only
- 07  Unable to locate record – **Explain in NOTES section.**
- 08  Less than 6 discharges selected
- 09  Other noninterview – **Explain in NOTES section.**
- 10  No discharges

**NOTES**

01  Mark (X) this box if comments are written in this section or any other place on this questionnaire.

Read to each new respondent.

In order to obtain national level data about patients who are discharged from hospices and home health agencies such as this one, we are collecting information about a sample of discharges. I will be asking questions about the background, health status, treatment, social contacts, and billing information for each sampled discharge.

The information you provide will be held in strict confidence and will be used ONLY by persons involved in the survey and only for the purposes of the survey.

In answering these questions, it is especially important to locate the information in the patient's medical record. Do you have the medical file(s) and record(s) for the selected discharged patient(s)?

If not, ask the respondent to get it/them prior to beginning the interview. Fill sections A and B on the front of all the discharged patient forms while the respondent gets the records. If no record is available for a patient, try to obtain as much information as possible from whatever administrative records are available and/or from the respondent's memory.

1. What was this patient's sex?

- 01  Male  
02  Female

2. What was her/his date of birth?

Month						Day		Year		Age (at discharge)			
										OR		OR	
											Years		Months

3a. Was she/he of Hispanic or Latino origin?

- 01  Yes  
02  No  
03  Don't know

HAND FLASHCARD 1.

b. Which of these best described her/his race?

Mark (X) all that apply.

PROBE: Any others?

- 01  American Indian or Alaska Native  
02  Asian  
03  Black or African American  
04  Native Hawaiian or other Pacific Islander  
05  White  
06  Other - Specify

NOTE - Hispanic is NOT a race.

- 07  Don't know

4. What was her/his marital status at the time of discharge?

Mark (X) only one box.

- 01  Married  
02  Widowed  
03  Divorced  
04  Separated  
05  Never married  
06  Single  
07  Don't know

HAND FLASHCARD 2.

5a. During the episode of care that ended on (date of discharge), where was she/he living?

Mark (X) only one box.

- 01  Private residence (house or apartment)  
02  Rented room, boarding house  
03  Retirement home or apartment, including elderly housing  
04  Board and care, assisted living, or residential care facility  
05  Nursing home, hospital, or other inpatient health facility (including mental health facility) - SKIP to item 6 Introduction  
06  Other - Specify

b. Was she/he living with family members, nonfamily members, both family and nonfamily members, or alone?

- 01  With family members  
02  With nonfamily members  
03  With both family members and nonfamily members  
04  Alone  
05  Don't know

HAND FLASHCARD 3.

**6. Who referred her/him to this agency?**

Mark (X) all that apply.

PROBE: Any other sources?

- 01  Self/Family
- 02  Nursing home
- 03  Hospital
- 04  Physician
- 05  Health department
- 06  Social service agency
- 07  Home health agency
- 08  Hospice
- 09  Religious organization
- 10  Health maintenance organization
- 11  Friend/Neighbor
- 12  Other – Specify

\_\_\_\_\_

13  Don't know

**7. What was the date of her/his admission for the period of care which ended on (Date of discharge)?**

Month		Day		Year	

00  Only an assessment was done for this patient (patient was not provided services by this agency)

**8a. According to the medical record, what were the primary and other diagnoses at the time of her/his admission that ended with this (discharge/assessment)?**

PROBE: Any other diagnoses?

- 01  No diagnosis
- 02  Admission diagnoses unknown

Primary: 1 \_\_\_\_\_

Others: 2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

6 \_\_\_\_\_

Refer to Q7. If **ONLY** an assessment was done for this patient, END THE INTERVIEW AND MARK STATUS CODE "06" IN SECTION C ON THE COVER. THEN GO TO the next discharged patient questionnaire.

If the patient was admitted to the agency and provided services by the agency, CONTINUE this interview.

**b. According to the medical records, what were her/his primary and other diagnoses at the time of discharge – that is, on (Date of discharge)?**

PROBE: Any other diagnoses?

- 01  No diagnosis
- 02  Same as 8a
- 03  Discharge diagnoses unknown

Primary: 1 \_\_\_\_\_

Others: 2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

6 \_\_\_\_\_

**c. According to the medical record, did she/he have any diagnostic or surgical procedures that were related to her/his admission to this agency?**

- 01  Yes
- 02  No procedures

1 \_\_\_\_\_

2 \_\_\_\_\_

HAND FLASHCARD 4.

8d. Why was she/he discharged?

Mark (X) only one box.

- 01  Recovered
- 02  Stabilized
- 03  Family/friends resumed care
- 04  Services no longer needed, treatment plan completed
- 05  No longer eligible for service/no longer home bound

Transferred to inpatient care

- 06  Hospital
- 07  Nursing home
- 08  Other inpatient or residential care - Specify ↴

Blank box for specifying other inpatient or residential care.

- 09  Transferred to another form of outpatient or home care - Specify ↴

Blank box for specifying another form of outpatient or home care.

- 10  Moved out of area
- 11  Deceased
- 12  Other - Specify ↴

Blank box for specifying other reasons for discharge.

- 13  Don't know

9. What type of care was she/he receiving at the time of discharge? Was it home health care, home care, or hospice care?

- 01  Home health care or home care
- 02  Hospice care
  - 02a  In the home or usual place of residence
  - 02b  Inpatient

10a. Did she/he have a primary caregiver outside of this agency?

- 01  Yes
  - 02  No . . . . .
  - 03  Don't know
- } SKIP to item 11

b. Did she/he usually live with (her/his) primary caregiver?

- 01  Yes
- 02  No
- 03  Don't know

HAND FLASHCARD 5.

c. What was the relationship of the primary caregiver to the patient?

Mark (X) only one box.

- 01  Spouse
- 02  Parent
- 03  Child, including daughter- or son-in-law
- 04  Sister or brother, including sister- or brother-in-law
- 05  Other relative - Specify ↴

Blank box for specifying other relative.

- 06  Friend or neighbor
- 07  Paid help or staff of facility where patient resides
- 08  Other - Specify ↴

Blank box for specifying other relationship.

- 09  Don't know

HAND FLASHCARD 6.

11. During the 30 days prior to (discharge/death), which of these aids or special devices did she/he regularly use?

Mark (X) all that apply.

PROBE: Any other aids?

- 00  No aids used
- 01  Bedside commode
- 02  Blood glucose monitor
- 03  Cane, crutches
- 04  Dentures (full or partial)
- 05  Elevated/raised toilet seat
- 06  Enteral feeding equipment
- 07  Eyeglasses (including contact lenses)
- 08  Geri-chairs, lift chairs, other specialized chairs
- 09  Grab bars
- 10  Hearing aid
- 11  Hospital bed
- 12  IV therapy equipment
- 13  Mattress, special (eggcrate, foam, air, gel, etc.)
- 14  Orthotics, including braces
- 15  Overbed table
- Respiratory therapy equipment
- 16  Oxygen (including oxygen concentrator)
- 17  Other respiratory therapy equipment
- 18  Shower chair/Bath bench
- 19  Transfer equipment
- 20  Walker
- 21  Wheel chair – Manually operated
- 22  Wheel chair – Motorized (including scooter)
- 23  Other – Specify

**INSTRUCTION BOX**

For items 12 through 17, use the phrase "AT THE TIME OF DISCHARGE ON (date of discharge)" if the patient was discharged alive. Use the phrase "IMMEDIATELY PRIOR TO DEATH" if the patient was discharged dead.

For items 12a–13b, refer to item 11.

12a. (At the time of discharge on (date of discharge)/ Immediately prior to death), did she/he have any difficulty in seeing (when wearing glasses)?

- 01  Yes
  - 02  No
  - 03  Not applicable (e.g., comatose)
  - 04  Don't know
- } SKIP to item 13a

HAND FLASHCARD 7.

b. Was her/his sight (when wearing glasses) partially, severely, or completely impaired as defined on this card?

- 01  Partially impaired
- 02  Severely impaired
- 03  Completely lost, blind
- 04  Don't know

13a. (At the time of discharge on (date of discharge)/ Immediately prior to death), did she/he have any difficulty in hearing (when wearing a hearing aid)?

- 01  Yes
  - 02  No
  - 03  Not applicable (e.g., comatose)
  - 04  Don't know
- } SKIP to item 14a

HAND FLASHCARD 8.

b. Was her/his hearing (when wearing a hearing aid) partially, severely, or completely impaired, as defined on this card?

- 01  Partially impaired
- 02  Severely impaired
- 03  Completely lost, deaf
- 04  Don't know

14a. (At the time of discharge on (date of discharge)/ Immediately prior to death), did she/he have an indwelling urinary catheter or urostomy?

- 01  Yes
  - 02  No
  - 03  Don't know
- } SKIP to item 15

b. Did she/he receive assistance from your agency staff in caring for this device?

- 01  Yes
  - 02  No
  - 03  Don't know
- } SKIP to item 16a

<b>15. (At the time of discharge on (date of discharge) immediately prior to death), did she/he have any difficulty in controlling (his/her) bladder?</b>	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Infant 04 <input type="checkbox"/> Don't know																												
<b>16a. (At the time of discharge on (date of discharge) immediately prior to death), did she/he have a colostomy or ileostomy?</b>	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No ..... } <i>SKIP to item 17</i> 03 <input type="checkbox"/> Don't know ..... }																												
<b>b. Did she/he receive assistance from your agency staff in caring for this device?</b>	01 <input type="checkbox"/> Yes ..... } <i>SKIP to item 18</i> 02 <input type="checkbox"/> No ..... } 03 <input type="checkbox"/> Don't know ..... }																												
<b>17. (At the time of discharge on (date of discharge) immediately prior to death), did she/he have any difficulty in controlling (his/her) bowels?</b>	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Infant 04 <input type="checkbox"/> Don't know																												
<p><i>HAND FLASHCARD 9.</i></p> <b>18. During the 30 days prior to (discharge/death), did she/he receive personal help from this agency in any of the following activities as defined on this card -</b> <i>Mark (X) one box for each activity.</i>	<table border="1"> <thead> <tr> <th data-bbox="836 699 1023 793">Yes</th> <th data-bbox="1023 699 1209 793">No</th> <th data-bbox="1209 699 1396 793">Don't know</th> <th data-bbox="1396 699 1588 793">Not applicable (e.g., patient was bedfast)</th> </tr> </thead> <tbody> <tr> <td data-bbox="836 888 1023 930">01 <input type="checkbox"/></td> <td data-bbox="1023 888 1209 930">02 <input type="checkbox"/></td> <td data-bbox="1209 888 1396 930">03 <input type="checkbox"/></td> <td data-bbox="1396 888 1588 930">04 <input type="checkbox"/></td> </tr> <tr> <td data-bbox="836 940 1023 982">01 <input type="checkbox"/></td> <td data-bbox="1023 940 1209 982">02 <input type="checkbox"/></td> <td data-bbox="1209 940 1396 982">03 <input type="checkbox"/></td> <td data-bbox="1396 940 1588 982">04 <input type="checkbox"/></td> </tr> <tr> <td data-bbox="836 993 1023 1035">01 <input type="checkbox"/></td> <td data-bbox="1023 993 1209 1035">02 <input type="checkbox"/></td> <td data-bbox="1209 993 1396 1035">03 <input type="checkbox"/></td> <td data-bbox="1396 993 1588 1035">04 <input type="checkbox"/></td> </tr> <tr> <td data-bbox="836 1045 1023 1087">01 <input type="checkbox"/></td> <td data-bbox="1023 1045 1209 1087">02 <input type="checkbox"/></td> <td data-bbox="1209 1045 1396 1087">03 <input type="checkbox"/></td> <td data-bbox="1396 1045 1588 1087">04 <input type="checkbox"/></td> </tr> <tr> <td data-bbox="836 1098 1023 1140">01 <input type="checkbox"/></td> <td data-bbox="1023 1098 1209 1140">02 <input type="checkbox"/></td> <td data-bbox="1209 1098 1396 1140">03 <input type="checkbox"/></td> <td data-bbox="1396 1098 1588 1140">04 <input type="checkbox"/></td> </tr> <tr> <td data-bbox="836 1150 1023 1192">01 <input type="checkbox"/></td> <td data-bbox="1023 1150 1209 1192">02 <input type="checkbox"/></td> <td data-bbox="1209 1150 1396 1192">03 <input type="checkbox"/></td> <td data-bbox="1396 1150 1588 1192">04 <input type="checkbox"/></td> </tr> </tbody> </table>	Yes	No	Don't know	Not applicable (e.g., patient was bedfast)	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
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<p><i>HAND FLASHCARD 10.</i></p> <b>19. During the 30 days prior to (discharge/death), did she/he receive personal help from your agency in any of the following activities as defined on this card -</b> <i>Mark (X) one box for each activity.</i>	<table border="1"> <thead> <tr> <th data-bbox="836 1213 1023 1308">Yes</th> <th data-bbox="1023 1213 1209 1308">No</th> <th data-bbox="1209 1213 1396 1308">Don't know</th> <th data-bbox="1396 1213 1588 1308">Not applicable (e.g., patient was bedfast)</th> </tr> </thead> <tbody> <tr> <td data-bbox="836 1402 1023 1444">01 <input type="checkbox"/></td> <td data-bbox="1023 1402 1209 1444">02 <input type="checkbox"/></td> <td data-bbox="1209 1402 1396 1444">03 <input type="checkbox"/></td> <td data-bbox="1396 1402 1588 1444">04 <input type="checkbox"/></td> </tr> <tr> <td data-bbox="836 1455 1023 1497">01 <input type="checkbox"/></td> <td data-bbox="1023 1455 1209 1497">02 <input type="checkbox"/></td> <td data-bbox="1209 1455 1396 1497">03 <input type="checkbox"/></td> <td data-bbox="1396 1455 1588 1497">04 <input type="checkbox"/></td> </tr> <tr> <td data-bbox="836 1507 1023 1549">01 <input type="checkbox"/></td> <td data-bbox="1023 1507 1209 1549">02 <input type="checkbox"/></td> <td data-bbox="1209 1507 1396 1549">03 <input type="checkbox"/></td> <td data-bbox="1396 1507 1588 1549">04 <input type="checkbox"/></td> </tr> <tr> <td data-bbox="836 1560 1023 1602">01 <input type="checkbox"/></td> <td data-bbox="1023 1560 1209 1602">02 <input type="checkbox"/></td> <td data-bbox="1209 1560 1396 1602">03 <input type="checkbox"/></td> <td data-bbox="1396 1560 1588 1602">04 <input type="checkbox"/></td> </tr> <tr> <td data-bbox="836 1612 1023 1654">01 <input type="checkbox"/></td> <td data-bbox="1023 1612 1209 1654">02 <input type="checkbox"/></td> <td data-bbox="1209 1612 1396 1654">03 <input type="checkbox"/></td> <td data-bbox="1396 1612 1588 1654">04 <input type="checkbox"/></td> </tr> <tr> <td data-bbox="836 1665 1023 1703">01 <input type="checkbox"/></td> <td data-bbox="1023 1665 1209 1703">02 <input type="checkbox"/></td> <td data-bbox="1209 1665 1396 1703">03 <input type="checkbox"/></td> <td data-bbox="1396 1665 1588 1703">04 <input type="checkbox"/></td> </tr> </tbody> </table>	Yes	No	Don't know	Not applicable (e.g., patient was bedfast)	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
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NOTES

HAND FLASHCARD 11.

**20a. During the 30 days prior to (discharge/death), which of these services were provided to her/him BY YOUR AGENCY?**

Mark (X) all that apply.

**PROBE: Any other services?**

- |  |  |
|--|--|
| 00 <input type="checkbox"/> None                                   | 16 <input type="checkbox"/> Physician services   |
| 01 <input type="checkbox"/> Companion services                     | 17 <input type="checkbox"/> Psychological services                                       |
| 02 <input type="checkbox"/> Continuous home care                   | 18 <input type="checkbox"/> Referral services  |
| 03 <input type="checkbox"/> Counseling                             | 19 <input type="checkbox"/> Respiratory therapy  |
| 04 <input type="checkbox"/> Dental treatment services              | 20 <input type="checkbox"/> Respite care   |
| 05 <input type="checkbox"/> Dietary/nutritional services           | 21 <input type="checkbox"/> Skilled nursing services                                     |
| 06 <input type="checkbox"/> Durable medical equipment and supplies | 22 <input type="checkbox"/> Social services  |
| 07 <input type="checkbox"/> Enterostomal therapy                   | 23 <input type="checkbox"/> Speech therapy/Audiology                                     |
| 08 <input type="checkbox"/> Homemaker-household services           | 24 <input type="checkbox"/> Spiritual care   |
| 09 <input type="checkbox"/> IV therapy                             | 25 <input type="checkbox"/> Transportation   |
| 10 <input type="checkbox"/> Meals on Wheels                        | 26 <input type="checkbox"/> Vocational therapy   |
| 11 <input type="checkbox"/> Medications                            | 27 <input type="checkbox"/> Volunteer services   |
| 12 <input type="checkbox"/> Occupational therapy                   | 28 <input type="checkbox"/> Other high tech care (e.g., enteral nutrition, dialysis)     |
| 13 <input type="checkbox"/> Pastoral care                          | 29 <input type="checkbox"/> Other services - Specify <input checked="" type="checkbox"/> |
| 14 <input type="checkbox"/> Personal care                          |  |
| 15 <input type="checkbox"/> Physical therapy                       |  |

HAND FLASHCARD 12.

**b. During the 30 days prior to (discharge/death), which of these service providers FROM YOUR AGENCY visited her/him?**

Mark (X) all that apply.

**PROBE: Any other providers?**

- |   |   |
|---|---|
| 00 <input type="checkbox"/> None                                    | 09 <input type="checkbox"/> Physical therapists   |
| 01 <input type="checkbox"/> Chaplain                                | 10 <input type="checkbox"/> Physicians  |
| 02 <input type="checkbox"/> Dietitians/Nutritionists                | 11 <input type="checkbox"/> Registered nurses   |
| 03 <input type="checkbox"/> Home health aides                       | 12 <input type="checkbox"/> Respiratory therapists  |
| 04 <input type="checkbox"/> Homemakers/Personal caretakers          | 13 <input type="checkbox"/> Social workers  |
| 05 <input type="checkbox"/> Licensed practical or vocational nurses | 14 <input type="checkbox"/> Speech pathologists/Audiologists                              |
| 06 <input type="checkbox"/> Mental health specialists               | 15 <input type="checkbox"/> Volunteers  |
| 07 <input type="checkbox"/> Nursing aides and attendants            | 16 <input type="checkbox"/> Other providers - Specify <input checked="" type="checkbox"/> |
| 08 <input type="checkbox"/> Occupational therapists                 |   |

NOTES

HAND FLASHCARD 13.

**21. What was the PRIMARY expected source of payment for her/his entire episode of care?**

Mark (X) only one source.

For the source of payment ask:  
**Is the (source of payment) for home health care or hospice care?**

	Home Health Care	Hospice Care
01 <input type="checkbox"/> Medicare . . . . .	01 <input type="checkbox"/>	01 <input type="checkbox"/>
a. Fee-for-service Medicare . . . . .	01a <input type="checkbox"/>	01a <input type="checkbox"/>
b. Medicare HMO . . . . .	01b <input type="checkbox"/>	01b <input type="checkbox"/>
02 <input type="checkbox"/> Medicaid . . . . .	02 <input type="checkbox"/>	02 <input type="checkbox"/>
a. Fee-for-service or traditional Medicaid . . . . .	02a <input type="checkbox"/>	02a <input type="checkbox"/>
b. Privately insured through Medicaid . . . . .	02b <input type="checkbox"/>	02b <input type="checkbox"/>
03 <input type="checkbox"/> Other government medical assistance . . . . .	03 <input type="checkbox"/>	03 <input type="checkbox"/>
04 <input type="checkbox"/> Private insurance . . . . .	04 <input type="checkbox"/>	04 <input type="checkbox"/>
a. HMO or IPA . . . . .	04a <input type="checkbox"/>	04a <input type="checkbox"/>
b. Indemnity plan or PPO . . . . .	04b <input type="checkbox"/>	04b <input type="checkbox"/>
c. Other - Specify <u>      </u>		
	04c <input type="checkbox"/>	04c <input type="checkbox"/>
05 <input type="checkbox"/> Own income, family support, Social Security benefits, retirement funds, or welfare . . . . .	05 <input type="checkbox"/>	05 <input type="checkbox"/>
06 <input type="checkbox"/> Supplemental Security Income (SSI) . . . . .	06 <input type="checkbox"/>	06 <input type="checkbox"/>
07 <input type="checkbox"/> Religious organizations, foundations, agencies . . . . .	07 <input type="checkbox"/>	07 <input type="checkbox"/>
08 <input type="checkbox"/> Veterans Administration . . . . .	08 <input type="checkbox"/>	08 <input type="checkbox"/>
09 <input type="checkbox"/> CHAMPVA/CHAMPUS . . . . .	09 <input type="checkbox"/>	09 <input type="checkbox"/>
10 <input type="checkbox"/> Other military medicine . . . . .	10 <input type="checkbox"/>	10 <input type="checkbox"/>
11 <input type="checkbox"/> Other - Specify <u>      </u>		
	11 <input type="checkbox"/>	11 <input type="checkbox"/>
12 <input type="checkbox"/> Payment source not yet determined . . . . .	SKIP to item 24	
13 <input type="checkbox"/> No charge made for care . . . . .	SKIP to item 25	

NOTES



**22. What were ALL the secondary sources of payment for her/his entire episode of care?**

Mark (X) all that apply.

**PROBE: Any other sources of payment?**

For the source of payment ask:

**Was the (source of payment) for home health care or hospice care?**

	Home Health Care	Hospice Care
00 <input type="checkbox"/> No secondary sources		
01 <input type="checkbox"/> Medicare . . . . .	01 <input type="checkbox"/>	01 <input type="checkbox"/>
a. Fee-for-service Medicare . . . . .	01a <input type="checkbox"/>	01a <input type="checkbox"/>
b. Medicare HMO . . . . .	01b <input type="checkbox"/>	01b <input type="checkbox"/>
02 <input type="checkbox"/> Medicaid . . . . .	02 <input type="checkbox"/>	02 <input type="checkbox"/>
a. Fee-for-service or traditional Medicaid . . . . .	02a <input type="checkbox"/>	02a <input type="checkbox"/>
b. Privately insured through Medicaid . . . . .	02b <input type="checkbox"/>	02b <input type="checkbox"/>
03 <input type="checkbox"/> Other government medical assistance . . . . .	03 <input type="checkbox"/>	03 <input type="checkbox"/>
04 <input type="checkbox"/> Private insurance . . . . .	04 <input type="checkbox"/>	04 <input type="checkbox"/>
a. HMO or IPA . . . . .	04a <input type="checkbox"/>	04a <input type="checkbox"/>
b. Indemnity plan or PPO . . . . .	04b <input type="checkbox"/>	04b <input type="checkbox"/>
c. Other - Specify <input checked="" type="checkbox"/>		
<div style="border: 1px solid black; width: 100%; height: 40px; margin: 5px 0;"></div>		
	04c <input type="checkbox"/>	04c <input type="checkbox"/>
05 <input type="checkbox"/> Own income, family support, Social Security benefits, retirement funds, or welfare . . . . .	05 <input type="checkbox"/>	05 <input type="checkbox"/>
06 <input type="checkbox"/> Supplemental Security Income (SSI) . . . . .	06 <input type="checkbox"/>	06 <input type="checkbox"/>
07 <input type="checkbox"/> Religious organizations, foundations, agencies . . . . .	07 <input type="checkbox"/>	07 <input type="checkbox"/>
08 <input type="checkbox"/> Veterans Administration . . . . .	08 <input type="checkbox"/>	08 <input type="checkbox"/>
09 <input type="checkbox"/> CHAMPVA/CHAMPUS . . . . .	09 <input type="checkbox"/>	09 <input type="checkbox"/>
10 <input type="checkbox"/> Other military medicine . . . . .	10 <input type="checkbox"/>	10 <input type="checkbox"/>
11 <input type="checkbox"/> Other - Specify <input checked="" type="checkbox"/>		
<div style="border: 1px solid black; width: 100%; height: 40px; margin: 5px 0;"></div>		
	11 <input type="checkbox"/>	11 <input type="checkbox"/>

**23a. What was the last amount billed for her/his care, including all charges for services, drugs, special medical supplies, etc., before discounts or adjustments?**

Total amount

\$  .00

- 01  Don't know } *SKIP to item 24*  
 02  Not billed yet }

**b. What dates are covered by the amount billed?**

Month	Day	Year		to	Month	Day	Year

**24. Which best describes the way this agency (was/will be) reimbursed for the total charges?**

- 01  Based on services provided  
 02  Capitation (services provided under a capitation agreement or by salaried staff in an HMO)  
 03  Don't know

**25. When was the last time service was provided to this patient for the period of care that ended (date of discharge)?**

Month	Day	Year

**FR Date Check** - Prior to leaving the agency, you must verify the dates you entered in other sections of this questionnaire. Copy the dates below to the space provided. Check that the dates go from the oldest to the newest and are logical. Correct errors by referring to the patient records and/or agency staff.

Date of Birth - Question 2 on page 2

Month		Day		Year			

Date of Admission - Question 7 on page 3

Month		Day		Year			

Date last time service provided - Question 25 on page 9

Month		Day		Year			

Date of Discharge - Item B2 on cover

Month		Day		Year			

Date of Interview - Item A3 on cover

Month		Day		Year			

NOTES

[Area for handwritten notes with horizontal lines]

**FILL SECTION C ON THE COVER OF THIS FORM AND CONTINUE WITH THE NEXT DISCHARGED PATIENT QUESTIONNAIRE.**