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FORM **NNHS-3**
(1-25-95)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
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

1995

CURRENT RESIDENT QUESTIONNAIRE

NATIONAL NURSING HOME SURVEY

NOTICE – Public reporting burden of 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to PHS Reports Clearance Officer; ATTN: PRA (0920-0353); Hubert H. Humphrey Bldg., Rm. 737-F; 200 Independence Ave., SW; Washington, DC 20201. 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 – RESIDENT INFORMATION

1. Resident name or other identifier
First | M.I. | Last

2. Resident line number

Section C – STATUS OF INTERVIEW

01 ☐ Complete
02 ☐ Partial
03 ☐ Resident included in sampling list in error
04 ☐ Incorrect sample line number selected
05 ☐ Refused
06 ☐ Unable to locate record
07 ☐ Less than 6 residents selected
08 ☐ Other noninterview – *Specify* _____
09 ☐ No current residents

Notes

Read to each new respondent.

In order to obtain national level data about the residents of nursing homes such as this one, we are collecting information about a sample of current residents. I will be asking questions about the background, health status, and charges for each sampled resident.

The identifying 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.

Do you have the medical file(s) and record(s) for *(Read name's) of selected current resident(s))*? **If you have a Health Care Finance Administration Minimum Data Set for Nursing Home Resident Assessment form in the records, you may use it while we complete this questionnaire.**

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 current resident forms while the respondent gets the records. If no record is available for a resident, try to obtain as much information as possible from whatever administrative records are available and/or from the respondent's memory.

1. What is . . .'s sex?

01 ☐ Male
02 ☐ Female

2. What is . . .'s date of birth?

Current age

Month		Day		Year			

OR _____ Years

HAND FLASHCARD 1.

3a. Which of these best describes . . .'s race?

Mark (X) only one box.

01 ☐ White
02 ☐ Black
03 ☐ American Indian, Eskimo, Aleut
04 ☐ Asian, Pacific Islander
05 ☐ Other – *Specify* _____
06 ☐ Don't know

b. Is . . . of Hispanic origin?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

4. What is . . .'s current marital status?

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. Where was . . . staying immediately before entering this facility?

Mark (X) only one box.

01 ☐ Private residence
02 ☐ Rented room, boarding house
03 ☐ Retirement home
04 ☐ Board and care or residential care facility
05 ☐ Nursing home
06 ☐ Hospital
07 ☐ Mental health facility

SKIP to item 6 Introduction

08 ☐ Other – *Specify* _____
09 ☐ Don't Know

b. At that time, was . . . 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

Read the introductory paragraph for the Social Security Number only once for each respondent.

As part of this survey, we would like to have . . .'s Social Security Number. Provision of this number is voluntary and providing or not providing the number will have no effect in any way on . . .'s benefits. This number will be useful in conducting future followup studies. This number will be used to match against the vital statistics records maintained by the National Center for Health Statistics. This information is collected under the authority of Section 306 of the Public Health Service Act.

6. What is . . .'s Social Security Number?

Social Security Number

☐☐☐ – ☐☐ – ☐☐☐☐

01 ☐ Refused
02 ☐ Don't know

7. What was the date of . . .'s most recent admission with your facility, that is, the date on which . . . was admitted for the current episode of care?

Month	Day	Year
☐☐	☐☐	☐☐

8. Has . . . previously been a resident in this facility?

01 ☐ Yes
02 ☐ No

9a. According to . . .'s medical record, what were the primary and other diagnoses at the time of admission on *(date in item 7)*?

PROBE: **Any other diagnoses?**

Primary: 1 _____

Others: 2 _____

3 _____

4 _____

5 _____

6 _____

b. According to . . .'s medical record, what are . . .'s CURRENT primary and other diagnoses?

PROBE: **Any other diagnoses?**

00 ☐ Same as 9a

Primary: 1 _____

Others: 2 _____

3 _____

4 _____

5 _____

6 _____

10. What level of care is . . . currently receiving from your facility? Is it skilled care, intermediate care or residential care?

01 ☐ Skilled care
02 ☐ Intermediate care
03 ☐ Residential care

Notes

HAND FLASHCARD 3.

11. Which of these aids does . . . currently use?

Mark (X) all that apply.

PROBE: **Any other aids?**

00 ☐ No aids used
01 ☐ Eye glasses (including contact lenses)
02 ☐ Hearing aid
03 ☐ Transfer equipment
04 ☐ Wheelchair
05 ☐ Cane
06 ☐ Walker
07 ☐ Crutches
08 ☐ Brace (any type)
09 ☐ Oxygen
10 ☐ Hospital bed
11 ☐ Commode
12 ☐ Other aids or devices – *Specify* ✍

_____

13 ☐ Don't know

For items 12a-13b, refer to item 11.

12a. Does . . . have any difficulty in seeing (when wearing glasses)?

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

HAND FLASHCARD 4.

b. Is . . .'s 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. Does . . . have any difficulty in hearing (when wearing a hearing aid)?

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

HAND FLASHCARD 5.

b. Is . . .'s 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. Does . . . have trouble biting or chewing any kinds of food, such as firm meats or apples?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

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b. Has . . . lost ALL of (his/her) upper permanent natural teeth?

01 ☐ Yes
02 ☐ No – *SKIP to item 14d*
03 ☐ Don't know

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c. Does . . . have an upper denture or plate?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

---

d. Has . . . lost ALL of (his/her) lower permanent natural teeth?

01 ☐ Yes
02 ☐ No – *SKIP to item 14f*
03 ☐ Don't know

14e. Does . . . have a lower denture or plate?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

Ask only if item 14 c = Yes ***OR*** *item 14e = Yes, otherwise skip to item 14h*

f. How often does . . . wear the dentures?

01 ☐ All the time
02 ☐ Usually
03 ☐ About half the time
04 ☐ Seldom
05 ☐ Never – *SKIP to item 14h*
06 ☐ Don't know

g. Does . . . usually wear dentures when eating?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

h. How would you describe the condition of . . .'s teeth and gums; excellent, very good, good, fair or poor?

If resident DOES NOT have any teeth then ask the following:

How would you describe the condition of . . .'s gums or soft tissue; excellent, very good, good, fair or poor?

01 ☐ Excellent
02 ☐ Very good
03 ☐ Good
04 ☐ Fair
05 ☐ Poor
06 ☐ Don't know

15a. Does . . . currently receive any assistance in bathing or showering?

01 ☐ Yes
02 ☐ No – *SKIP to item 16a*

b. Does . . . bathe or shower with the help of:

	Yes	No
(1) Special equipment?	01 ☐	02 ☐
(2) Another person?	01 ☐	02 ☐

16a. Does . . . currently receive any assistance in dressing?

01 ☐ Yes
02 ☐ No – *SKIP to item 17a*

b. Does . . . dress with the help of:

	Yes	No
(1) Special equipment?	01 ☐	02 ☐
(2) Another person?	01 ☐	02 ☐

17a. Does . . . currently receive any assistance in eating?

01 ☐ Yes
02 ☐ No – *SKIP to item 18a*

b. Does . . . eat with the help of:

	Yes	No
(1) Special equipment?	01 ☐	02 ☐
(2) Another person?	01 ☐	02 ☐

18a. Is . . . bedfast?

01 ☐ Yes – *SKIP to item 22a*
02 ☐ No

b. Is . . . chairfast?

01 ☐ Yes – *SKIP to item 22a*
02 ☐ No

19a. Does . . . currently receive any assistance in transferring in and out of bed or a chair?	01 ☐ Yes 02 ☐ No . . . . . } *SKIP to item 20a* 03 ☐ Don't know
b. Does . . . require the help of:	Yes No
(1) Special equipment?	01 ☐ 02 ☐
(2) Another person?	01 ☐ 02 ☐
20a. Does . . . currently receive any assistance in walking?	01 ☐ Yes 02 ☐ No – *SKIP to item 21a*
b. Does . . . walk with the help of:	Yes No
(1) Special equipment?	01 ☐ 02 ☐
(2) Another person?	01 ☐ 02 ☐
21a. Does . . . go outside the grounds of this facility?	01 ☐ Yes 02 ☐ No – *SKIP to item 22a*
b. When . . . goes outside the grounds, does . . . require the help of:	Yes No
(1) Special equipment?	01 ☐ 02 ☐
(2) Another person?	01 ☐ 02 ☐
22a. Does . . . have an ostomy, an indwelling catheter or similar device?	01 ☐ Yes 02 ☐ No – *SKIP to item 22c*
b. Does . . . receive any help from another person in caring for this device?	01 ☐ Yes 02 ☐ No
c. Does . . . currently receive any assistance using the toilet room?	01 ☐ Yes 02 ☐ No – *SKIP to item 23* 03 ☐ Does not use toilet room (ostomy patient, chairfast, etc.) – *SKIP to item 23*
d. Does . . . require the help of:	Yes No
(1) Special equipment?	01 ☐ 02 ☐
(2) Another person?	01 ☐ 02 ☐
23. Does . . . currently have any difficulty in controlling (his/her) bowels?	01 ☐ Yes 02 ☐ No 03 ☐ Not applicable (e.g., infant, had a colostomy)
24. Does . . . currently have any difficulty in controlling (his/her) bladder?	01 ☐ Yes 02 ☐ No 03 ☐ Not applicable (e.g., infant, has an indwelling catheter, had an ostomy)
Notes	

HAND FLASHCARD 6.

25. Does . . . currently receive personal help or supervision in any of the following activities:

	Yes	No
a. Care of personal possessions?	01 ☐	02 ☐
b. Managing money?	01 ☐	02 ☐
c. Securing personal items such as newspapers, toilet articles, snack food?	01 ☐	02 ☐
d. Using the telephone (dialing or receiving calls)?	01 ☐	02 ☐

26. During the past 12 months, has . . . had a flu shot at this facility or any other location?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

27. Has . . . EVER had a pneumococcal vaccine, that is, pneumonia vaccination?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

INSTRUCTION BOX

For questions 28, 30, 31, 32, and 33, use the phrase "LAST MONTH" *if the resident was admitted last month or earlier. Use the phrase* "SINCE ADMISSION" *if the resident was admitted this month.*

HAND FLASHCARD 7.

28. (Last month/since admission) which of these services were received by . . ., either inside or outside this facility?

Mark (X) all that apply.

PROBE: **Any other services?**

00 ☐ None
01 ☐ Dental care
02 ☐ Equipment or devices
03 ☐ Hospice services
04 ☐ Medical services
05 ☐ Mental health services
06 ☐ Nursing services
07 ☐ Nutritional services
08 ☐ Occupational therapy
09 ☐ Personal care
10 ☐ Physical therapy
11 ☐ Prescribed medicines or nonprescribed medicines
12 ☐ Sheltered employment
13 ☐ Social services
14 ☐ Special education
15 ☐ Speech or hearing therapy
16 ☐ Transportation
17 ☐ Vocational rehabilitation
18 ☐ Other – *Specify* _____

HAND FLASHCARD 8.

29. What was the PRIMARY source of payment for . . .'s care for the month of *(Month and year of admission)*?

Refer to item 7 on page 3.

Mark (X) only one source.

01 ☐ Private insurance
02 ☐ Own income, family support, Social Security benefits, retirement funds
03 ☐ Supplemental Security Income (SSI)
04 ☐ Medicare
05 ☐ Medicaid
06 ☐ Other government assistance or welfare
07 ☐ Religious organizations, foundations, agencies
08 ☐ VA contract, pensions, or other VA compensation
09 ☐ Payment source not yet determined
10 ☐ Other – *Specify* _____
11 ☐ Don't know

HAND FLASHCARD 8.

30. (Last month/since admission) what was the PRIMARY source of payment for . . .'s care?

Mark (X) only one source.

01 ☐ Private insurance
02 ☐ Own income, family support, Social Security benefits, retirement funds
03 ☐ Supplemental Security Income (SSI)
04 ☐ Medicare
05 ☐ Medicaid
06 ☐ Other government assistance or welfare
07 ☐ Religious organizations, foundations, agencies
08 ☐ VA contract, pensions, or other VA compensation
09 ☐ Payment source not yet determined
10 ☐ Other – *Specify* ➶

_____

HAND FLASHCARD 8.

31. (Last month/since admission) what were all the secondary sources of payment for . . .'s care?

Mark (X) all that apply.

00 ☐ None
01 ☐ Private insurance
02 ☐ Own income, family support, Social Security benefits, retirement funds
03 ☐ Supplemental Security Income (SSI)
04 ☐ Medicare
05 ☐ Medicaid
06 ☐ Other government assistance or welfare
07 ☐ Religious organizations, foundations, agencies
08 ☐ VA contract, pensions, or other VA compensation
09 ☐ Payment source not yet determined
10 ☐ Other – *Specify* ➶

_____

32. (Last month/since admission) what were the total charges billed for . . .'s care, including all charges for services, drugs and special medical supplies?

$ _____ . 00 per ➶

01 ☐ Month
02 ☐ Day
03 ☐ Week
04 ☐ Other period – *Specify* ➶

Month	Day	Year		Month	Day	Year
			TO			

05 ☐ Not billed yet
00 ☐ No charge was made

HAND FLASHCARD 9.

33. (Last month/since admission) what was the primary source of payment for . . .'s dental care?

Mark (X) only one source.

01 ☐ Own income, family support, Social Security benefits, retirement funds
02 ☐ Medicaid
03 ☐ VA contract, pension, or other VA compensation
04 ☐ Other government assistance or welfare
05 ☐ Covered in basic patient charges
06 ☐ Payment source not yet determined
07 ☐ No dental services received last month/since admission

FILL SECTION C ON THE COVER OF THIS FORM

Notes