

FORM **NNHS-3**
(4-27-99)

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

**CURRENT RESIDENT
QUESTIONNAIRE**

1999 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. 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 (0920-0353) 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 – SAMPLE INFORMATION

Current 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/Comments section

01 Check 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 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 the resident's sex?	01 <input type="checkbox"/> Male 02 <input type="checkbox"/> Female						
2. What is (his/her) date of birth?	<table border="1" style="display: inline-table;"><thead><tr><th>Month</th><th>Day</th><th>Year</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td></tr></tbody></table> OR _____ Years	Month	Day	Year			
Month	Day	Year					
3a. Is (he/she) of Hispanic or Latino origin?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know						
HAND FLASHCARD 1. b. Which of these best describes (his/her) race? <i>Mark (X) one or more boxes.</i>	01 <input type="checkbox"/> American Indian or Alaska Native 02 <input type="checkbox"/> Asian 03 <input type="checkbox"/> Black or African American 04 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 05 <input type="checkbox"/> White 06 <input type="checkbox"/> Other – <i>Specify</i> _____ 07 <input type="checkbox"/> Don't know						
4. What is (his/her) current marital status? <i>Mark (X) only one box.</i>	01 <input type="checkbox"/> Married 02 <input type="checkbox"/> Widowed 03 <input type="checkbox"/> Divorced 04 <input type="checkbox"/> Separated 05 <input type="checkbox"/> Never married 06 <input type="checkbox"/> Single 07 <input type="checkbox"/> Don't know						
HAND FLASHCARD 2. 5a. Where was (he/she) staying immediately before entering this facility? <i>Mark (X) only one box.</i>	01 <input type="checkbox"/> Private residence (house or apartment) 02 <input type="checkbox"/> Rented room, boarding house 03 <input type="checkbox"/> Retirement home 04 <input type="checkbox"/> Board and care, assisted living or residential care facility 05 <input type="checkbox"/> Nursing home 06 <input type="checkbox"/> Hospital 07 <input type="checkbox"/> Rehabilitation facility 08 <input type="checkbox"/> Other inpatient health facility (including mental health facility) 09 <input type="checkbox"/> Other – <i>Specify</i> _____ 10 <input type="checkbox"/> Don't know } <i>SKIP to item 6</i>						
b. At that time, was (he/she) living with family members, nonfamily members, both family and nonfamily members, or alone?	01 <input type="checkbox"/> With family members 02 <input type="checkbox"/> With nonfamily members 03 <input type="checkbox"/> With both family members and nonfamily members 04 <input type="checkbox"/> Alone 05 <input type="checkbox"/> Don't know						

6. What was the date of (his/her) most recent admission with your facility, that is, the date on which (he/she) was admitted for the current episode of care?	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 15%;">Month</td> <td style="width: 15%;">Day</td> <td style="width: 70%;">Year</td> </tr> <tr> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> </table>	Month	Day	Year			
Month	Day	Year					
7. Has (he/she) previously been a resident in this facility?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No						
8a. According to (his/her) medical record, what were the primary and other diagnoses at the time of admission on (date in item 6)? <i>PROBE: Any other diagnoses?</i>	Primary: 1 _____ Others: 2 _____ 3 _____ 4 _____ 5 _____ 6 _____						
b. According to (his/her) medical record, what are (his/her) CURRENT primary and other diagnoses? <i>PROBE: Any other diagnoses?</i>	00 <input type="checkbox"/> Same as 8a Primary: 1 _____ Others: 2 _____ 3 _____ 4 _____ 5 _____ 6 _____						
9. What level of care is (he/she) currently receiving from your facility? Is it skilled care, intermediate care or residential care?	01 <input type="checkbox"/> Skilled care 02 <input type="checkbox"/> Intermediate care 03 <input type="checkbox"/> Residential care						

Notes/Comments

HAND FLASHCARD 3.

10. Which of these aids does (he/she) 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 Dentures
 - 04 Transfer equipment
 - 05 Wheelchair
 - 06 Cane
 - 07 Walker
 - 08 Crutches
 - 09 Brace (any type)
 - 10 Oxygen
 - 11 Bedside commode
 - 12 Other aids or devices – Specify
-

13 Don't know

For items 11a-12b, refer to item 10.

11a. Does (he/she) 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 12a

HAND FLASHCARD 4.

b. Is (his/her) 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

12a. Does (he/she) 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 13a

HAND FLASHCARD 5.

b. Is (his/her) 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

13a. Does (he/she) currently receive any assistance in bathing or showering?

- 01 Yes
- 02 No – SKIP to item 14a

b. Does (he/she) bathe or shower with the help of:

- (1) Special equipment?
- (2) Another person?

- | | | |
|-----|--------------------------|--------------------------|
| | Yes | No |
| (1) | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) | <input type="checkbox"/> | <input type="checkbox"/> |

14a. Does (he/she) currently receive any assistance in dressing?

- 01 Yes
- 02 No – SKIP to item 15a

b. Does (he/she) dress with the help of:

- (1) Special equipment?
- (2) Another person?

- | | | |
|-----|--------------------------|--------------------------|
| | Yes | No |
| (1) | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) | <input type="checkbox"/> | <input type="checkbox"/> |

15a. Does (he/she) currently receive any assistance in eating?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 16a</i>
b. Does (he/she) eat with the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>
16a. Is (he/she) bedfast?	01 <input type="checkbox"/> Yes – <i>SKIP to item 20a</i> 02 <input type="checkbox"/> No
b. Is (he/she) chairfast?	01 <input type="checkbox"/> Yes – <i>SKIP to item 20a</i> 02 <input type="checkbox"/> No
17a. Does (he/she) currently receive any assistance in transferring in and out of bed or a chair?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No } <i>SKIP to item 18a</i> 03 <input type="checkbox"/> Don't know }
b. Does (he/she) require the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>
18a. Does (he/she) currently receive any assistance in walking?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 19a</i>
b. Does (he/she) walk with the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>
19a. Does (he/she) go outside the grounds of this facility?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 20a</i>
b. When (he/she) goes outside the grounds, does (he/she) require the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>
20a. Does (he/she) have an ostomy, an indwelling catheter or similar device?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 20c</i>
b. Does (he/she) receive any help from another person in caring for this device?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
c. Does (he/she) currently receive any assistance using the toilet room?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 21</i> 03 <input type="checkbox"/> Does not use toilet room (ostomy patient, chairfast, etc.) – <i>SKIP to item 21</i>
d. Does (he/she) require the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>

21. Does (he/she) currently have any difficulty in controlling (his/her) bowels?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Not applicable (e.g., infant, had a colostomy)															
22. Does (he/she) currently have any difficulty in controlling (his/her) bladder?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Not applicable (e.g., infant, has an indwelling catheter, had an ostomy)															
<p><i>HAND FLASHCARD 6.</i></p> 23. Does (he/she) currently receive personal help or supervision in any of the following activities: <p>a. Care of personal possessions?</p> <p>b. Managing money?</p> <p>c. Securing personal items such as newspapers, toilet articles, snack food?</p> <p>d. Using the telephone (dialing or receiving calls)?</p>	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>a. Care of personal possessions?</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> <tr> <td>b. Managing money?</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> <tr> <td>c. Securing personal items such as newspapers, toilet articles, snack food?</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> <tr> <td>d. Using the telephone (dialing or receiving calls)?</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	a. Care of personal possessions?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	b. Managing money?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	c. Securing personal items such as newspapers, toilet articles, snack food?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	d. Using the telephone (dialing or receiving calls)?	01 <input type="checkbox"/>	02 <input type="checkbox"/>
	Yes	No														
a. Care of personal possessions?	01 <input type="checkbox"/>	02 <input type="checkbox"/>														
b. Managing money?	01 <input type="checkbox"/>	02 <input type="checkbox"/>														
c. Securing personal items such as newspapers, toilet articles, snack food?	01 <input type="checkbox"/>	02 <input type="checkbox"/>														
d. Using the telephone (dialing or receiving calls)?	01 <input type="checkbox"/>	02 <input type="checkbox"/>														
24. During the past 12 months, has (he/she) had a flu shot at this facility or any other location?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know															
25. Has (he/she) EVER had a pneumococcal vaccine, that is, pneumonia vaccination?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know															
26. During the past 10 years has (he/she) had a Tetanus-Diphtheria (Td) Toxoid booster at this facility or any other location?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know															

Notes/Comments

**INSTRUCTION
BOX**

For questions 27, 29, 30, and 31, 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.

27. (Last month/since admission) which of these services were received by (him/her), 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.

28. What was the PRIMARY source of payment for (his/her) care for the month of (Month and year of admission)?

Refer to item 6 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.

29. (Last month/since admission) what was the PRIMARY source of payment for (his/her) 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.

30. (Last month/since admission) what were all the secondary sources of payment for (his/her) care?

Mark (X) all that apply.

PROBE: Any other sources?

- 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

31. What were the total charges billed for (his/her) care, including all charges for services, drugs and special medical supplies?

Mark (X) only one box.

Put dates in the boxes shown ONLY if the charge is NOT for a month, day, or week.

\$ _____ per

00 Mark (X) if drugs and medical supplies are included in this total.

- 01 Month
- 02 Day
- 03 Week
- 04 Other period – Specify

Month	Day	Year

TO

Month	Day	Year

- 05 Not billed yet
- 00 No charge was made

FILL SECTION C ON THE COVER OF THIS FORM

FR Date Check – Prior to leaving the facility, 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 resident records and/or facility staff.

Date of Birth – Question 2 on page 2

Month	Day	Year

Date of Admission – Question 6 on page 3

Month	Day	Year

Date of Interview – Item A3 on cover

Month	Day	Year

Notes/Comments