

FORM **DFS-3**
(7-1-94)

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

DISABILITY FOLLOWBACK SURVEY
(NHIS PHASE II)
SUPPLEMENT ON AGING QUESTIONNAIRE

NOTICE - 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 only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m). Public reporting burden for this collection of information is estimated to vary from 40 to 50 minutes per response, with an average of 45 minutes per response. 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; Humphrey Building, Room 721-H, 200 Independence Avenue, SW; Washington, DC 20201; and to the Office of Management and Budget, Paperwork Reduction Project (0920-0214) Washington, DC 20503.

RT 01
3-7
8

RT 06
3-4

Part I - CALL RECORD

Mode	Date		Beginning time	Results	Ending time	Comments
	Month	Day				
5	6-7	8-9	10-14		15-19	
T P			a.m. p.m.		a.m. p.m.	
T P			a.m. p.m.		a.m. p.m.	
T P			a.m. p.m.		a.m. p.m.	
T P			a.m. p.m.		a.m. p.m.	
T P			a.m. p.m.		a.m. p.m.	

Part II - STATUS

A. Final Status 20-21		B. Mode 22		C. Respondent 64	
Interview 01 <input type="checkbox"/> Complete 02 <input type="checkbox"/> Partial (Explain in Notes) Noninterview 03 <input type="checkbox"/> SP refused 04 <input type="checkbox"/> Proxy refused 05 <input type="checkbox"/> Unable to contact 06 <input type="checkbox"/> Unable to locate 07 <input type="checkbox"/> Deceased 08 <input type="checkbox"/> Institutionalized, no proxy 09 <input type="checkbox"/> Incapable, no proxy 10 <input type="checkbox"/> Moved o/s PSU, unable to phone 11 <input type="checkbox"/> Other noninterview		1 <input type="checkbox"/> Telephone 2 <input type="checkbox"/> Personal visit		1 <input type="checkbox"/> Self 2 <input checked="" type="checkbox"/> Proxy	
(Explain in Notes)		D. Proxy		Reason for proxy 1 <input type="checkbox"/> SP incapable 2 <input type="checkbox"/> SP institutionalized 3 <input type="checkbox"/> SP unavailable 4 <input checked="" type="checkbox"/> Other - Specify	
		Name 23-63		(Fill II.D)	
		E. Field Representative's Name		Code 66-68	

Part III - NEW ADDRESS

RT 07
3-4

Notes

A. Address (Different from label)					
Number and street 5-29					
City	30-49	State	50-51	ZIP Code	52-60
B. Telephone (Different from label)					
Area code	61-63	Number	64-70	71	
()		1 <input type="checkbox"/> None		7 <input type="checkbox"/> Refused 9 <input type="checkbox"/> DK number	

INITIAL SCREENING

3-4

1. May I please speak with (sample person)?

- 1 Yes (Skip to A below)
- 2 No (Go to 2)

5

2. Why is (sample person) not available to be interviewed?

- 1 SP deceased (Skip to 6)
- 2 SP moved (Skip to 4)
- 3 SP temporarily absent/unavailable (Go to 3)
- 4 SP incapable } (Skip to 5)
- 5 Other

6

3. Will (sample person) [return/be available] before (closeout date)?

- 1 Yes (Schedule appointment)
- 2 No } (Go to 4)
- 9 DK

7

4a. Has (sample person) moved to a new residence or is [he/she] in a health facility, group home, or some other place?

- 1 SP moved (Record new address and telephone no.)
- 2 SP in health facility/group home (Go to 4b)
- 3 SP in jail (Skip to 5)
- 4 SP in prison (END interview - noninterview)
- 5 SP on vacation/visiting/temporarily absent (Skip to 4d)

8

b. What type of facility or group home is this?
Mark (X) first appropriate box.

- 01 Hospital } (Go to 4c)
 - 02 Nursing/convalescent home
 - 03 Retirement home
 - 04 Group home
 - 05 Supervised apartment
 - 06 Halfway house
 - 07 Board and Care home
 - 08 Developmental Center
 - 09 Other supervised group residence or facility
 - 10 Other
- (Record new address and telephone no.)

9-10

c. Refer to age on label.

- 1 Under 69 (Skip to 5)
- 2 69+ (Go to 4d)

11

d. Is it possible to interview (sample person) at the [facility/present location]?

- 1 Yes (Record address and telephone no.)
- 2 No (Go to 5)

12

5. Since I won't be able to interview (sample person), I need to talk to the person who knows the most about (sample person's) health. Who would that be?

- 1 Respondent (Skip to A below)
- 2 Other person (Record person's name, address, and telephone no.)
- 3 No one } (END interview - noninterview)
- 9 DK/Ref

13

6. On what date did (sample person) die?

Month	Day	Year

999999 DK } (Go to 7)

14-19

7. Did (sample person) die at home, in a hospital, in a nursing or convalescent home, or some other place?

- 1 At home
- 2 In hospital
- 3 In nursing/convalescent home } (END interview - noninterview)
- 4 Other place
- 9 DK

20

A

Begin interview by asking: **When we conducted the interview several months ago, we recorded (sample person's) age as (age from label). Is this still correct?**

- 1 Yes (Skip to Section A on page 4)
- 2 No (Correct age on label, then skip to Section A on page 4)

21

Notes

INITIAL SCREENING - Continued

NEW ADDRESS (First or only)				RT 09 3-4	Second (If appropriate)				RT 10 3-4		
Name of place (If appropriate)				5-40	Name of place (If appropriate)				5-40		
Number and street				41-64	Number and street				41-64		
City	65-84	State	85-86	ZIP Code	87-95	City	65-84	State	85-86	ZIP Code	87-95
Telephone					Telephone						
Area code	96-98	Number	99-105	<input type="checkbox"/> None <input type="checkbox"/> DK <input type="checkbox"/> Refused number	106	Area code	96-98	Number	99-105	<input type="checkbox"/> None <input type="checkbox"/> DK <input type="checkbox"/> Refused number	106
PROXY RESPONDENT				RT 11 3-4							
Name				5-40							
<input type="checkbox"/> Mark box if same address/phone as SP (Skip to A1 on page 4)				41							
Number and street				42-65							
City	66-85	State	86-87	ZIP Code	88-96						
Telephone											
Area code	97-99	Number	100-106	<input type="checkbox"/> None <input type="checkbox"/> DK <input type="checkbox"/> Refused number	107						

GENERAL INSTRUCTIONS

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. Conduct all interviews by personal visit unless the only way to get an interview is by telephone. 2. After appropriate introductions, begin all interviews with A on page 2. 3. If the sample person (or proxy) is not within your normal assignment area, call your office for instructions. 4. Make minor corrections to the sample person's address or phone number on the LABEL. Record new addresses and/or phone numbers above. 5. If a question is refused, enter "REF" in the answer space. If the respondent does not know the answer to a question, mark the "DK" box if there is one, or enter "DK" in the answer space. | <ol style="list-style-type: none"> 6. The following symbols and print types are used throughout the questionnaire to standardize the asking of the questions: <ul style="list-style-type: none"> • Long dash (—) – Insert the appropriate words or names from the list. • Underlined italics in parentheses – Insert the specified words, name, date, etc. • Regular type in parentheses – Either read or do not read the parenthetical, depending on the situation and the context of the question. • Brackets with a slash ([/]) – Choose the appropriate words or phrase for the particular interview. • Bold capitals – Emphasize the word(s) when reading the question. 7. If interviewing a proxy, substitute the sample person's name (or appropriate pronoun) for the word "You" in the questions. |
|--|---|

Notes

Section A - HOUSING AND LONG-TERM CARE SERVICES

ITEM A1	Status of Sample Person (SP).	1 <input type="checkbox"/> Institutionalized (<i>Skip to 6 on page 5</i>) 2 <input type="checkbox"/> All others (<i>Go to 1</i>)	5
These first questions are about the place you live.		00 <input type="checkbox"/> Less than 1 year _____ Years (Number) 99 <input type="checkbox"/> DK	6-7
1. How long have you been living here?			
2a. Is it NECESSARY to use any steps or stairs to get into this home from the outside?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	8
b. Counting basements and step down living areas as separate levels, does this home have more than one floor or level?		1 <input type="checkbox"/> Yes (<i>Go to 2c</i>) 2 <input type="checkbox"/> No } (<i>Skip +</i>) 9 <input type="checkbox"/> DK }	9
c. Does this home have a bathroom, bedroom, and kitchen ALL on the SAME floor or level?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	10
3. Because of a physical impairment or health problem, do you have any difficulty —		Yes No DK	
a. Entering or leaving your home?		a. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	11
b. Opening or closing any of the doors in your home?		b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	12
c. Reaching or opening cabinets in your home?		c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	13
d. Using the bathroom in your home?		d. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	14
4. Some residences have special features to assist persons who have physical impairments or health problems. Whether you use them or not, does your residence have any of these features?		5. Which special features do you NEED to get around this home, but do not have?	
		Yes No DK	Yes No DK
a. Widened doorways or hallways?		a. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	15
b. Ramps or street level entrances?		b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	16
c. Railings?		c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	17
d. Automatic or easy to open doors?		d. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	18
e. Accessible parking or drop-off site?		e. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	19
f. Bathroom modifications?		f. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	20
g. Kitchen modifications?		g. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	21
h. Elevator, chair lift, or stair glide?		h. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	22
i. Alerting devices?		i. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	23
j. Any other special features?		j. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	24
a. Widened doorways or hallways?		a. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	25
b. Ramps or street level entrances?		b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	26
c. Railings?		c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	27
d. Automatic or easy to open doors?		d. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	28
e. Accessible parking or drop-off site?		e. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	29
f. Bathroom modifications?		f. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	30
g. Kitchen modifications?		g. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	31
h. Elevator, chair lift, or stair glide?		h. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	32
i. Alerting devices?		i. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	33
j. Any other special features?		j. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	34
Notes			

Section A - HOUSING AND LONG-TERM CARE SERVICES - Continued

35-36

ASK OR VERIFY:

6a. Is this place a — *(Read all categories)*

Mark (X) only one.

- 01 **Single family house or townhouse that is not part of a retirement community, (Skip to 9 on page 6)**
- 02 **Single family house, townhouse, or apartment that is part of a retirement community, (Skip to 7)**
- 03 **Regular apartment, (Skip to 9 on page 6)**
- 04 **Supervised apartment,**
- 05 **Group home,**
- 06 **Halfway house,**
- 07 **Personal care or board and care home,**
- 08 **Developmental center,**
- 09 **Some other type of supervised group residence or facility,**
- 10 **Assisted living facility,**
- 11 **Nursing or convalescent home,**
- 12 **Retirement home,**
- 13 **Center for Independent Living, or**
- 14 **Something else?**
- 99 **DK**

(Go to 6b)

ASK OR VERIFY:

b. Does this place primarily or exclusively serve people who are elderly?

- 1 Yes
- 2 No
- 9 DK

37

**ITEM
A2**

Status of SP.

- 1 Institutionalized *(Skip to 10 on page 6)*
- 2 All others *(Go to 7)*

38

7. Whether you use them or not, does this place routinely provide services such as meals, help with housework or personal care, transportation, or recreation?

- 1 Yes *(Go to 8 on page 6)*
- 2 No } *(Skip to 9 on page 6)*
- 9 DK }

39

Notes

Section A - HOUSING AND LONG-TERM CARE SERVICES - Continued

<p>8. Whether you use them or not, does this place routinely provide —</p>	<p>Yes No DK</p>	
<p>a. Group meals for residents?</p>	<p>a. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">40</p>
<p>b. Housekeeping or maid service?</p>	<p>b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">41</p>
<p>c. Nursing or medical care?</p>	<p>c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">42</p>
<p>d. Supervision of residents who give themselves their own medication?</p>	<p>d. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">43</p>
<p>e. Help with bathing, eating, or dressing?</p>	<p>e. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">44</p>
<p>f. Help with walking or getting about?</p>	<p>f. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">45</p>
<p>g. Help with shopping?</p>	<p>g. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">46</p>
<p>h. Planned social activities or trips?</p>	<p>h. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">47</p>
<p>i. Educational or training programs?</p>	<p>i. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">48</p>
<p>j. Help with laundry?</p>	<p>j. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">49</p>
<p>k. Help with money management?</p>	<p>k. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">50</p>
<p>l. Transportation?</p>	<p>l. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">51</p>
<p>m. Protective oversight?</p>	<p>m. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p>	<p align="center">52</p>
<p>9. Are you planning a move in order to receive any (additional) personal help, assistance or services?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p align="center">53</p>
<p><i>Mark "Yes" if SP is currently living in a nursing home; otherwise ask:</i></p> <p>10a. Have you EVER been a resident or patient in a nursing home?</p>	<p>1 <input type="checkbox"/> Yes (Go to 10b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Skip to 12 on page 7)</p>	<p align="center">54</p>
<p>b. How many DIFFERENT TIMES have you been a resident or patient in a nursing home (including the current time)?</p>	<p>_____ Times (Number)</p> <p>99 <input type="checkbox"/> DK</p>	<p align="center">55-56</p>
<p>c. On what date were you admitted (the FIRST time)? <i>If date not known, ask: Was it within the past 12 months?</i></p>	<p>_____/19_____ Month Year</p> <p>0001 <input type="checkbox"/> In past 12 months 0002 <input type="checkbox"/> Not in past 12 months 9999 <input type="checkbox"/> DK</p>	<p align="center">57-60</p>
<p><i>Mark box if "Now in nursing home"; otherwise ask:</i></p> <p>d. On what date were you discharged (the LAST time)? <i>If date not known, ask: Was it within the past 12 months?</i></p>	<p>_____/19_____ Month Year</p> <p>0001 <input type="checkbox"/> In past 12 months 0002 <input type="checkbox"/> Not in past 12 months 9999 <input type="checkbox"/> DK</p>	<p align="center">61-64</p>
<p>e. How long [were you/have you been] in the nursing home (the LAST time/THIS time)?</p>	<p>00 <input type="checkbox"/> Less than 1 month</p> <p>_____ Months (Number)</p> <p>99 <input type="checkbox"/> DK</p>	<p align="center">65-66</p>
<p><i>Ask if date in 10d is within the past 12 months, including "Now in". If not within the past 12 months, skip to 12 on page 7.</i></p> <p>f. How many weeks in the past 12 months [were you/have you been] in a nursing home?</p>	<p>00 <input type="checkbox"/> Less than 1 week</p> <p>_____ Weeks (Number)</p> <p>99 <input type="checkbox"/> DK</p>	<p align="center">67-68</p>

Section A - HOUSING AND LONG-TERM CARE SERVICES - Continued

HAND CARD A1. Read categories if telephone interview.

11a. Who paid or will pay for your nursing home stays in the past 12 months?

(Anyone else?)

Mark (X) all that apply.

- 01 Self or family in household
- 02 Family NOT in household
- 03 Private health insurance
- 04 Medicare
- 05 Medicaid
- 06 Rehabilitation program
- 07 Employer
- 08 School system
- 09 VA program
- 10 Other military
- 11 Other private source
- 12 Other public source
- 13 No one/Free
- 99 DK

69-70
71-72
73-74
75-76
77-78
79-80
81-82
83-84
85-86
87-88
89-90
91-92
93-94
95-96

(Skip to 12)

Ask if more than one source in 11a. If only one source in 11a, transcribe the number of the box marked without asking.

b. Who paid or will pay the most for your nursing home stays in the past 12 months?

Record number of the main source.

Paid most
(Number)

99 DK

97-98

Ask only if box 01 marked in 11a; otherwise, skip to 12.

c. During the past 12 months, about how much did you or your family pay for your nursing home stays? Do not count any money that has been or will be reimbursed by insurance or any other source.

000000 None

\$ _____ .

999999 DK

99-104

If "Now in nursing home" marked in 10d, skip to Section D on page 10; otherwise, ask:

12. Are you currently on a waiting list to go into a nursing home?

- 1 Yes
- 2 No
- 9 DK

105

Notes

Section B - TRANSPORTATION

ITEM B1	Status of SP.	<input type="checkbox"/> Institutionalized (<i>Skip to Section D on page 10</i>) <input type="checkbox"/> All others (<i>Go to 1</i>)	5
These next questions are about getting around outside your home.			6
1. How frequently do you drive a car or other motor vehicle? Would you say — (<i>Read all categories</i>) Mark (X) only one.		<input type="checkbox"/> Everyday or almost everyday, <input type="checkbox"/> Occasionally, <input type="checkbox"/> Seldom, or <input type="checkbox"/> Never? (<i>Go to 2</i>) <input type="checkbox"/> DK (<i>Skip to 3</i>)	7
2. Is this because of an impairment or health problem?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	8
3a. During the past 12 months, have you used local public transportation, such as a regular bus line, rapid transit, subway, or street car? Mark (X) only one.		<input type="checkbox"/> No public system available (<i>Skip to Section C on page 9</i>) <input type="checkbox"/> Yes (<i>Skip to 3c</i>) <input type="checkbox"/> No (<i>Go to 3b</i>) <input type="checkbox"/> DK (<i>Go to 3b</i>)	9
b. Does an impairment or health problem prevent or limit your use of the public transportation service? Mark (X) only one.		<input type="checkbox"/> No public system available <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	10
c. During the past 12 months, how often did you use the local public transportation service? Would you say — (<i>Read all categories</i>) Mark (X) only one.		<input type="checkbox"/> Everyday or almost everyday, <input type="checkbox"/> Occasionally, or <input type="checkbox"/> Seldom? <input type="checkbox"/> DK	11
d. Because of an impairment or health problem, during the past 12 months, did you have any difficulty using the local public transportation service?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	

Notes

Section C – SOCIAL ACTIVITY

Reminder – If SP is institutionalized, skip to Section D on page 10.

These next questions are about various activities you may have participated in.

1. DURING THE PAST 2 WEEKS, did you —

Yes No DK

- | | | | | | |
|---|-----------|----------------------------|----------------------------|----------------------------|----|
| a. Get together socially with friends or neighbors? | a. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 12 |
| b. Talk with friends or neighbors on the telephone? | b. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 13 |
| c. Get together with ANY relatives not including those living with you? | c. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 14 |
| d. Talk with ANY relatives on the telephone not including those living with you? | d. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 15 |
| e. Go to church, temple, or another place of worship for services or other activities? | e. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 16 |
| f. Go to a show or movie, sports event, club meeting, class, or other group event? | f. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 17 |
| g. Go out to eat at a restaurant? | g. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 18 |

2. How many days in the past two weeks did you leave your home for any reason?

- 14 Every day
00 None

_____ Days
(Number)

99 DK

19-20

If proxy respondent, skip to Section D on page 10; otherwise ask:

3. Regarding your present social activities, do you feel that you are doing about enough, too much, or would you like to be doing more?

Mark (X) only one.

- 1 About enough
2 Too much
3 Would like to be doing more
9 DK

21

Notes

Section D - WORK HISTORY/EMPLOYMENT

<p>These next questions are about working for pay or profit, and about unpaid volunteer work.</p> <p>1. Have you EVER worked at a job or business?</p>	<p align="right">22</p> <p>1 <input type="checkbox"/> Yes (Go to 2) 2 <input type="checkbox"/> No } (Skip to 7) 9 <input type="checkbox"/> DK }</p>
<p>2. Do you NOW work at a job or business?</p>	<p align="right">23</p> <p>1 <input type="checkbox"/> Yes (Go to 3) 2 <input type="checkbox"/> No } (Skip to 4) 9 <input type="checkbox"/> DK }</p>
<p>3. About how many hours a week do you usually work at your current job? (Note: If more than one job, include all jobs.)</p>	<p align="right">24-25</p> <p>_____ Hours per week } (Skip to 5) (Number) 99 <input type="checkbox"/> DK }</p>
<p>4. In what year did you stop working at your last job?</p>	<p align="right">26-27</p> <p>19 _____ Year 99 <input type="checkbox"/> DK</p>
<p>5a. Have you retired from a job or business?</p>	<p align="right">28</p> <p>1 <input type="checkbox"/> Yes (Go to 5b) 2 <input type="checkbox"/> No } (Skip to 7) 9 <input type="checkbox"/> DK }</p>
<p>b. How old were you when you retired the last time?</p>	<p align="right">29-30</p> <p>_____ Age 99 <input type="checkbox"/> DK</p>
<p>6. Did you retire because of an ongoing health problem, impairment, or disability?</p>	<p align="right">31</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>7. DURING THE PAST 12 MONTHS, were you involved in unpaid volunteer work such as teaching or coaching, office work, or providing care?</p>	<p align="right">32</p> <p>1 <input type="checkbox"/> Yes (Go to 8) 2 <input type="checkbox"/> No } (Skip to Section E on page 11) 9 <input type="checkbox"/> DK }</p>
<p>8. How many days did you do volunteer work in the past 12 months?</p>	<p align="right">33-36</p> <p>_____ { 1 <input type="checkbox"/> Per week (Days) { 2 <input type="checkbox"/> Per month { 3 <input type="checkbox"/> Per year 9999 <input type="checkbox"/> DK</p>

Notes

Section E – ASSISTIVE DEVICES AND TECHNOLOGIES

The next questions are about medical devices and implants.

Ask all of 1a–o before going to 2.

Ask for each "Yes" in 1.

1. During the past 12 months, did you use any of the following medical devices or supplies?

2. Did you use (device) in the past two weeks?

	Yes	No	DK		Yes	No	DK	
a. A tracheotomy tube?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	5	a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	6
b. A respirator?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	7	b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	8
c. An ostomy bag?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	9	c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	10
d. Catheterization equipment?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	11	d. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	12
e. A glucose monitor?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	13	e. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	14
f. Diabetic equipment or supplies?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	15	f. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	16
g. An inhaler?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	17	g. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	18
h. A nebulizer?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	19	h. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	20
i. A hearing aid?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	21	i. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	22
j. Crutches?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	23	j. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	24
k. A cane?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	25	k. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	26
l. A walker?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	27	l. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	28
m. A wheelchair?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	29	m. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	30
n. A scooter?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	31	n. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	32
o. A feeding tube?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	33	o. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	34

3. Do you now have any of the following implants?

	Yes	No	DK	
a. Any shunt that drains away fluid?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	35
b. An artificial joint?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	36
c. Implanted lens?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	37
d. Implanted pin, screw, nail, wire, rod, or plate?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	38
e. An artificial heart valve?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	39
f. A pacemaker?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	40
g. Silicone implant?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	41
h. Infusion pump?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	42
i. Implanted catheter?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	43
j. An organ implant?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	44
k. A cochlear (kŏk'ē-ðr) implant?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	45

Notes

Section F – HEALTH INSURANCE

<p>The next questions are about health insurance coverage.</p> <p>There are several government programs that provide medical care or help pay medical bills.</p> <p>People covered by Medicare have a card that looks like this.</p> <p><i>SHOW MEDICARE CARD.</i></p> <p>1a. In (month), were you covered by Medicare?</p>	<p align="right">46</p> <p>1 <input type="checkbox"/> Yes (Go to 1b) 2 <input type="checkbox"/> No } (Skip to 2) 9 <input type="checkbox"/> DK }</p>
<p>b. How long have you been covered by Medicare?</p> <p><i>Read categories if necessary.</i></p> <p><i>Mark (X) only one.</i></p>	<p align="right">47</p> <p>1 <input type="checkbox"/> Less than 6 months 2 <input type="checkbox"/> 6 months, but less than 1 year 3 <input type="checkbox"/> 1 year, but less than 2 years 4 <input type="checkbox"/> 2 years or more 9 <input type="checkbox"/> DK</p>
<p>There is a program called MEDICAID that pays for health care for persons in need. In this state, it is also called (state name).</p> <p>2a. In (month), were you covered by MEDICAID or (state name)?</p>	<p align="right">48</p> <p>1 <input type="checkbox"/> Yes (Go to 2b) 2 <input type="checkbox"/> No } (Skip to 3) 9 <input type="checkbox"/> DK }</p>
<p>b. How long have you had MEDICAID or (state name) coverage?</p> <p><i>Read categories if necessary.</i></p> <p><i>Mark (X) only one.</i></p>	<p align="right">49</p> <p>1 <input type="checkbox"/> Less than 6 months 2 <input type="checkbox"/> 6 months, but less than 1 year 3 <input type="checkbox"/> 1 year, but less than 2 years 4 <input type="checkbox"/> 2 years, but less than 5 years 5 <input type="checkbox"/> 5 years or more 6 <input type="checkbox"/> On and off for less than 2 years 7 <input type="checkbox"/> On and off for 2 years, but less than 5 years 8 <input type="checkbox"/> On and off for 5 years or more 9 <input type="checkbox"/> DK</p>
<p>3. In (month), were you covered by any OTHER public assistance program (other than Medicaid) that pays for health care? Do NOT include use of public or free clinics if that is your ONLY source of care.</p>	<p align="right">50</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>4a. In (month), were you covered by military health care, including armed forces retirement benefits, the VA (Department of Veterans' Affairs), CHAMPUS, or CHAMP-VA?</p>	<p align="right">51</p> <p>1 <input type="checkbox"/> Yes (Go to 4b) 2 <input type="checkbox"/> No } (Skip to 5) 9 <input type="checkbox"/> DK }</p>
<p>b. Was this CHAMPUS, or CHAMP-VA?</p> <p><i>Read if necessary: CHAMPUS is a program of medical care for dependents of active duty or retired military personnel. CHAMP-VA is medical insurance for dependents or survivors of disabled veterans.</i></p>	<p align="right">52</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>c. In (month), were you covered by any other military health care, including armed forces retirement benefits, or the VA (Department of Veterans' Affairs)?</p>	<p align="right">53</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>5. In (month), were you covered by the Indian Health Service?</p>	<p align="right">54</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>6a. (Not counting the government health programs we just mentioned), in (month), were you covered by a private health insurance plan?</p> <p><i>Read if necessary: Besides government programs, people also get health insurance through their jobs or union, through other private groups, or directly from an insurance company. A variety of types of plans are available, including Health Maintenance Organizations or HMOs.</i></p>	<p align="right">55</p> <p>1 <input type="checkbox"/> Yes (Go to 6b) 2 <input type="checkbox"/> No } (Skip to Section G on page 13) 9 <input type="checkbox"/> DK }</p>
<p>b. Was any of this private health insurance obtained originally through the workplace, that is through a present or former employer or union?</p> <p><i>Mark (X) only one</i></p>	<p align="right">56</p> <p>1 <input type="checkbox"/> Employer 2 <input type="checkbox"/> Union 3 <input type="checkbox"/> Through workplace, DK which 4 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>

Section G - ASSISTANCE WITH KEY ACTIVITIES

READ TO RESPONDENT: The next questions are about how well you are able to do certain activities. Please tell me if you have ANY difficulty when you do the following.

Ask 1a-j before asking 2 and 3.

Ask 2 and 3 for each "Yes" in 1a-j.

1. By yourself and not using aids, do you have any difficulty —

2. How much difficulty do you have (activity), some, a lot, or are you unable to do it?

3. For how long have you [had some difficulty/had a lot of difficulty/been unable to] (activity)?

a. Walking for a quarter of a mile, (that is about 2 or 3 blocks)?

- 1 Yes 5
2 No
9 NA/DK

- 1 Some 6
2 A lot
3 Unable
9 DK

- 00 Less than 1 year 7-8
99 DK
_____ Number of years

b. Walking up 10 steps without resting?

- 1 Yes 9
2 No
9 NA/DK

- 1 Some 10
2 A lot
3 Unable
9 DK

- 00 Less than 1 year 11-12
99 DK
_____ Number of years

c. Standing or being on your feet for about 2 hours?

- 1 Yes 13
2 No
9 NA/DK

- 1 Some 14
2 A lot
3 Unable
9 DK

- 00 Less than 1 year 15-16
99 DK
_____ Number of years

d. Sitting for about 2 hours?

- 1 Yes 17
2 No
9 NA/DK

- 1 Some 18
2 A lot
3 Unable
9 DK

- 00 Less than 1 year 19-20
99 DK
_____ Number of years

By yourself and not using aids, do you have any difficulty —

e. Stooping, crouching, or kneeling?

- 1 Yes 21
2 No
9 NA/DK

- 1 Some 22
2 A lot
3 Unable
9 DK

- 00 Less than 1 year 23-24
99 DK
_____ Number of years

f. Reaching up over your head?

- 1 Yes 25
2 No
9 NA/DK

- 1 Some 26
2 A lot
3 Unable
9 DK

- 00 Less than 1 year 27-28
99 DK
_____ Number of years

g. Reaching out (as if to shake someone's hand)?

- 1 Yes 29
2 No
9 NA/DK

- 1 Some 30
2 A lot
3 Unable
9 DK

- 00 Less than 1 year 31-32
99 DK
_____ Number of years

h. Using your fingers to grasp or handle?

- 1 Yes 33
2 No
9 NA/DK

- 1 Some 34
2 A lot
3 Unable
9 DK

- 00 Less than 1 year 35-36
99 DK
_____ Number of years

By yourself and not using aids, do you have any difficulty —

i. Lifting or carrying something as heavy as 25 pounds, (such as two full bags of groceries)?

- 1 Yes (Go to j) 37
2 No (Skip to 2)
9 NA/DK (Go to j)

- 1 Some 38
2 A lot
3 Unable
9 DK

- 00 Less than 1 year 39-40
99 DK
_____ Number of years

j. Lifting or carrying something as heavy as 10 pounds?

- 1 Yes 41
2 No
9 NA/DK

- 1 Some 42
2 A lot
3 Unable
9 DK

- 00 Less than 1 year 43-44
99 DK
_____ Number of years

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

READ TO RESPONDENT: These questions are about some other activities and how well you are able to do them by yourself and without using special equipment.

	(A) <small>RT 16</small> <small>3-4</small>	(B) <small>RT 17</small> <small>3-4</small>	(C) <small>RT 18</small> <small>3-4</small>
	Bathing or showering?	Dressing?	Eating?
<p>4. Because of a health or physical problem, do you have ANY difficulty —</p> <p><i>Ask if "Doesn't do": Is this because of a HEALTH or PHYSICAL problem? If "Yes", mark box 1; if "No" mark box 3.</i></p>	<p>4. 5</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason</p> <p>9 <input type="checkbox"/> DK</p>	<p>4. 5</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason</p> <p>9 <input type="checkbox"/> DK</p>	<p>4. 5</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason</p> <p>9 <input type="checkbox"/> DK</p>

	(A)	(B)	(C)
	Bathing or showering	Dressing	Eating
ITEM G1	<p>G1 6</p> <p><i>Refer to question 4.</i></p> <p>1 <input type="checkbox"/> "Yes" marked (Go to 5)</p> <p>2 <input type="checkbox"/> All other (Go to G1 for next activity)</p>	<p>G1 6</p> <p><i>Refer to question 4.</i></p> <p>1 <input type="checkbox"/> "Yes" marked (Go to 5)</p> <p>2 <input type="checkbox"/> All other (Go to G1 for next activity)</p>	<p>G1 6</p> <p><i>Refer to question 4.</i></p> <p>1 <input type="checkbox"/> "Yes" marked (Go to 5)</p> <p>2 <input type="checkbox"/> All other (Go to G1 for next activity)</p>
<p>5. By yourself and without using special equipment, how much difficulty do you have (activity), some, a lot, or are you unable to do it?</p>	<p>5. 7</p> <p>1 <input type="checkbox"/> Some } (Go to 6)</p> <p>2 <input type="checkbox"/> A lot } (Go to 6)</p> <p>3 <input type="checkbox"/> Unable (G1 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 6)</p>	<p>5. 7</p> <p>1 <input type="checkbox"/> Some } (Go to 6)</p> <p>2 <input type="checkbox"/> A lot } (Go to 6)</p> <p>3 <input type="checkbox"/> Unable (G1 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 6)</p>	<p>5. 7</p> <p>1 <input type="checkbox"/> Some } (Go to 6)</p> <p>2 <input type="checkbox"/> A lot } (Go to 6)</p> <p>3 <input type="checkbox"/> Unable (G1 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 6)</p>
<p>6. When you DO NOT HAVE HELP OR USE SPECIAL EQUIPMENT, is (activity) by yourself —</p> <p>(1) Very tiring? 9</p> <p>(2) Does (activity) take a long time? 10</p> <p>(3) Is it very painful? 11</p> <p><i>(Go to G1 for next activity)</i></p>	<p>6. 8</p> <p>0 <input type="checkbox"/> Never do without help or special equipment (Go to G1 for next activity)</p> <p>(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 9</p> <p>(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 10</p> <p>(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 11</p> <p><i>(Go to G1 for next activity)</i></p>	<p>6. 8</p> <p>0 <input type="checkbox"/> Never do without help or special equipment (Go to G1 for next activity)</p> <p>(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 9</p> <p>(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 10</p> <p>(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 11</p> <p><i>(Go to G1 for next activity)</i></p>	<p>6. 8</p> <p>0 <input type="checkbox"/> Never do without help or special equipment (Go to G1 for next activity)</p> <p>(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 9</p> <p>(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 10</p> <p>(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 11</p> <p><i>(Go to G1 for next activity)</i></p>

	(A)	(B)	(C)
	Bathing or showering	Dressing	Eating
ITEM G2	<p>G2 12</p> <p><i>Refer to question 4.</i></p> <p>1 <input type="checkbox"/> Box 3 marked (Go to G2 for next activity)</p> <p>2 <input type="checkbox"/> All other (Go to 7)</p>	<p>G2 12</p> <p><i>Refer to question 4.</i></p> <p>1 <input type="checkbox"/> Box 3 marked (Go to G2 for next activity)</p> <p>2 <input type="checkbox"/> All other (Go to 7)</p>	<p>G2 12</p> <p><i>Refer to question 4.</i></p> <p>1 <input type="checkbox"/> Box 3 marked (Go to G2 for next activity)</p> <p>2 <input type="checkbox"/> All other (Go to 7)</p>
<p>7a. Do you use any special equipment or aids in (activity)?</p>	<p>7a. 13</p> <p>1 <input type="checkbox"/> Yes (Go to 7b)</p> <p>2 <input type="checkbox"/> No (Go to G2 for next activity)</p>	<p>7a. 13</p> <p>1 <input type="checkbox"/> Yes (Go to 7b)</p> <p>2 <input type="checkbox"/> No (Go to G2 for next activity)</p>	<p>7a. 13</p> <p>1 <input type="checkbox"/> Yes (Go to 7b)</p> <p>2 <input type="checkbox"/> No (Go to G2 for next activity)</p>
<p>b. What special equipment or aids do you use?</p> <p>Anything else?</p> <p><i>Mark (X) all that apply.</i></p>	<p>b.</p> <p>1 <input type="checkbox"/> Stool, seat or chair 14</p> <p>2 <input type="checkbox"/> Handbar or rail 15</p> <p>3 <input type="checkbox"/> Other 16</p> <p>9 <input type="checkbox"/> DK 17</p>	<p>b.</p> <p>1 <input type="checkbox"/> Special clothes 14</p> <p>2 <input type="checkbox"/> Special fasteners 15</p> <p>3 <input type="checkbox"/> Cord, string, zipper pull 16</p> <p>4 <input type="checkbox"/> Orthopedic shoes 17</p> <p>5 <input type="checkbox"/> Other 18</p> <p>9 <input type="checkbox"/> DK 19</p>	<p>b.</p> <p>1 <input type="checkbox"/> Oversized eating equipment 14</p> <p>2 <input type="checkbox"/> Bed or lap tray 15</p> <p>3 <input type="checkbox"/> Covered cup/modified bowl 16</p> <p>4 <input type="checkbox"/> Other 17</p> <p>9 <input type="checkbox"/> DK 18</p>
<p>c. When you USE SPECIAL EQUIPMENT AND DO NOT HAVE HELP, is (activity) —</p> <p>(1) Very tiring? 19</p> <p>(2) Does (activity) take a long time? 20</p> <p>(3) Is it very painful? 21</p> <p><i>(Go to G2 for next activity)</i></p>	<p>c. 18</p> <p>0 <input type="checkbox"/> Never do without help (Go to G2 for next activity)</p> <p>(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 19</p> <p>(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 20</p> <p>(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 21</p> <p><i>(Go to G2 for next activity)</i></p>	<p>c. 20</p> <p>0 <input type="checkbox"/> Never do without help (Go to G2 for next activity)</p> <p>(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 21</p> <p>(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 22</p> <p>(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 23</p> <p><i>(Go to G2 for next activity)</i></p>	<p>c. 19</p> <p>0 <input type="checkbox"/> Never do without help (Go to G2 for next activity)</p> <p>(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 20</p> <p>(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 21</p> <p>(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 22</p> <p><i>(Go to G2 for next activity)</i></p>

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

(D) RT 19 3-4 Getting in and out of bed or chairs?	(E) RT 20 3-4 Walking?	(F) RT 21 3-4 Getting outside?	(G) RT 22 3-4 Using the toilet, including getting to the toilet?
4. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason 9 <input type="checkbox"/> DK	4. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason 9 <input type="checkbox"/> DK	4. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason 9 <input type="checkbox"/> DK	4. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason 9 <input type="checkbox"/> DK

(D) Getting in and out of bed or chairs	(E) Walking	(F) Getting outside	(G) Using the toilet, including getting to the toilet
G1 Refer to question 4. 1 <input type="checkbox"/> "Yes" marked (Go to 5) 2 <input type="checkbox"/> All other (Go to G1 for next activity)	G1 Refer to question 4. 1 <input type="checkbox"/> "Yes" marked (Go to 5) 2 <input type="checkbox"/> All other (Go to G1 for next activity)	G1 Refer to question 4. 1 <input type="checkbox"/> "Yes" marked (Go to 5) 2 <input type="checkbox"/> All other (Go to G1 for next activity)	G1 Refer to question 4. 1 <input type="checkbox"/> "Yes" marked (Go to 5) 2 <input type="checkbox"/> All other (Skip to G2 for activity (A))
5. 1 <input type="checkbox"/> Some } (Go to 6) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Go to G1 for next activity) 9 <input type="checkbox"/> DK (Go to 6)	5. 1 <input type="checkbox"/> Some } (Go to 6) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Go to G1 for next activity) 9 <input type="checkbox"/> DK (Go to 6)	5. 1 <input type="checkbox"/> Some } (Go to 6) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Go to G1 for next activity) 9 <input type="checkbox"/> DK (Go to 6)	5. 1 <input type="checkbox"/> Some } (Go to 6) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Go to G2 for activity (A)) 9 <input type="checkbox"/> DK (Go to 6)
6. 0 <input type="checkbox"/> Never do without help or special equipment (Go to G1 for next activity) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G1 for next activity)	6. 0 <input type="checkbox"/> Never do without help or special equipment (Go to G1 for next activity) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G1 for next activity)	6. 0 <input type="checkbox"/> Never do without help or special equipment (Go to G1 for next activity) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G1 for next activity)	6. 0 <input type="checkbox"/> Never do without help or special equipment (Go to G2 for activity (A)) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G2 for activity (A))

(D) Getting in and out of bed or chairs	(E) Walking	(F) Getting outside	(G) Using the toilet, including getting to the toilet
G2 Refer to question 4. 1 <input type="checkbox"/> Box 3 marked (Go to G2 for next activity) 2 <input type="checkbox"/> All other (Go to 7)	G2 Refer to question 4. 1 <input type="checkbox"/> Box 3 marked (Go to G2 for next activity) 2 <input type="checkbox"/> All other (Go to 7)	G2 Refer to question 4. 1 <input type="checkbox"/> Box 3 marked (Go to G2 for next activity) 2 <input type="checkbox"/> All other (Go to 7)	G2 Refer to question 4. 1 <input type="checkbox"/> Box 3 marked (Skip to G3 on page 16) 2 <input type="checkbox"/> All other (Go to 7)
7a. 1 <input type="checkbox"/> Yes (Go to 7b) 2 <input type="checkbox"/> No (Go to G2 for next activity)	7a. 1 <input type="checkbox"/> Yes (Go to 7b) 2 <input type="checkbox"/> No (Go to G2 for next activity)	7a. 1 <input type="checkbox"/> Yes (Go to 7b) 2 <input type="checkbox"/> No (Go to G2 for next activity)	7a. 1 <input type="checkbox"/> Yes (Go to 7b) 2 <input type="checkbox"/> No (Skip to G3 on page 16)
b. 1 <input type="checkbox"/> Cane or walking stick 2 <input type="checkbox"/> Walker 3 <input type="checkbox"/> Extra/special cushions 4 <input type="checkbox"/> Special "raising seat" chair/lift chair 5 <input type="checkbox"/> Hospital bed 6 <input type="checkbox"/> Trapeze/sling 7 <input type="checkbox"/> Ramp 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK	b. 01 <input type="checkbox"/> Cane or walking stick 02 <input type="checkbox"/> Walker 03 <input type="checkbox"/> Crutch or crutches 04 <input type="checkbox"/> Wheelchair 05 <input type="checkbox"/> Artificial leg 06 <input type="checkbox"/> Brace 07 <input type="checkbox"/> Guide dog 08 <input type="checkbox"/> Oxygen/special breathing equipment 09 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK	b. 01 <input type="checkbox"/> Cane or walking stick 02 <input type="checkbox"/> Walker 03 <input type="checkbox"/> Crutch or crutches 04 <input type="checkbox"/> Wheelchair 05 <input type="checkbox"/> Artificial leg 06 <input type="checkbox"/> Brace 07 <input type="checkbox"/> Guide dog 08 <input type="checkbox"/> Oxygen/special breathing equipment 09 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK	b. 01 <input type="checkbox"/> Cane or walking stick 02 <input type="checkbox"/> Walker 03 <input type="checkbox"/> Crutch or crutches 04 <input type="checkbox"/> Wheelchair 05 <input type="checkbox"/> Artificial leg 06 <input type="checkbox"/> Brace 07 <input type="checkbox"/> Guide dog 08 <input type="checkbox"/> Bed pan 09 <input type="checkbox"/> Raised toilet seat 10 <input type="checkbox"/> Special toilet/portable toilet 11 <input type="checkbox"/> Hand holds/rails near toilet 12 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK
c. 0 <input type="checkbox"/> Never do without help (Go to G2 for next activity) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G2 for next activity)	c. 0 <input type="checkbox"/> Never do without help (Go to G2 for next activity) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G2 for next activity)	c. 0 <input type="checkbox"/> Never do without help (Go to G2 for next activity) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G2 for next activity)	c. 0 <input type="checkbox"/> Never do without help (Go to G3 on page 16) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G3 on page 16)

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(A) Bathing or showering RT 16	(B) Dressing RT 17	(C) Eating RT 18
ITEM G3	22 <i>Refer to question 4 on page 14.</i> 1 <input type="checkbox"/> Box 3 marked (Go to G3 for next activity) 2 <input type="checkbox"/> All other (Go to 8)	24 <i>Refer to question 4 on page 14.</i> 1 <input type="checkbox"/> Box 3 marked (Go to G3 for next activity) 2 <input type="checkbox"/> All other (Go to 8)	23 <i>Refer to question 4 on page 14.</i> 1 <input type="checkbox"/> Box 3 marked (Go to G3 for next activity) 2 <input type="checkbox"/> All other (Go to 8)
8a. Do you receive help from another person in (activity)?	23 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	25 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	24 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK
b. Is this hands-on help?	24 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	26 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	25 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK
c. When you HAVE HANDS-ON HELP FROM ANOTHER PERSON, is (activity) —	25 0 <input type="checkbox"/> Never does activity (Skip to 8e)	27 0 <input type="checkbox"/> Never does activity (Skip to 8e)	26 0 <input type="checkbox"/> Never does activity (Skip to 8e)
(1) Very tiring?	26 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	28 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	27 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(2) Does (activity) take a long time?	27 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	29 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	28 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(3) Is it very painful?	28 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	30 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	29 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
d. How often do you have hands-on help with (activity)? Would you say always, sometimes, or rarely?	29 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	31 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	30 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK
e. Do you need (more) hands-on help with (activity)?	30 1 <input type="checkbox"/> Yes } (Go to G3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	32 1 <input type="checkbox"/> Yes } (Go to G3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	31 1 <input type="checkbox"/> Yes } (Go to G3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }

	(A) Bathing or showering	(B) Dressing	(C) Eating
ITEM G4	31 <i>Refer to G3 and 8b above.</i> 1 <input type="checkbox"/> Box 1 marked in G3 (Go to G4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to G4 for next activity) 3 <input type="checkbox"/> All other (Go to 9)	33 <i>Refer to G3 and 8b above.</i> 1 <input type="checkbox"/> Box 1 marked in G3 (Go to G4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to G4 for next activity) 3 <input type="checkbox"/> All other (Go to 9)	32 <i>Refer to G3 and 8b above.</i> 1 <input type="checkbox"/> Box 1 marked in G3 (Go to G4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to G4 for next activity) 3 <input type="checkbox"/> All other (Go to 9)
9a. Do you have someone who supervises you or stays nearby when you are (activity)?	32 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK	34 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK	33 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK
b. Does this person provide —	33 (1) Supervisory help, such as making sure the activity is performed correctly when you are (activity)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	35 (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	34 (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(2) Standby help, such as observing to see if any help is needed when you are (activity)?	34 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	36 (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	35 (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
10. How often do you have supervision or standby help when you are (activity)? Would you say always, sometimes, or rarely?	35 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	37 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	36 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK
11. Do you need (more) supervision or standby help with (activity)?	36 1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	38 1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	37 1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

(D) Getting in and out of bed or chairs RT 19		(E) Walking RT 20		(F) Getting outside RT 21		(G) Using the toilet, including getting to the toilet RT 22		
G3	Refer to question 4 on page 15. 1 <input type="checkbox"/> Box 3 marked (Go to G3 for next activity) 2 <input type="checkbox"/> All other (Go to 8)	27	G3	Refer to question 4 on page 15. 1 <input type="checkbox"/> Box 3 marked (Go to G3 for next activity) 2 <input type="checkbox"/> All other (Go to 8)	38	G3	Refer to question 4 on page 15. 1 <input type="checkbox"/> Box 3 marked (Go to G3 for next activity) 2 <input type="checkbox"/> All other (Go to 8)	44
8a.	1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK }	28	8a.	1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK }	39	8a.	1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK }	45
b.	1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK }	29	b.	1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK }	40	b.	1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK }	46
c.	0 <input type="checkbox"/> Never does activity (Skip to 8e)	30	c.	0 <input type="checkbox"/> Never does activity (Go to 8e)	41	c.	0 <input type="checkbox"/> Never does activity (Skip to 8e)	47
(1)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	31	(1)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	42	(1)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	48
(2)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	32	(2)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	43	(2)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	49
(3)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	33	(3)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	44	(3)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	50
d.	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	34	d.	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	45	d.	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	51
e.	1 <input type="checkbox"/> Yes } (Go to G3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	35	e.	1 <input type="checkbox"/> Yes } (Go to G3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	46	e.	1 <input type="checkbox"/> Yes } (Go to G4 for activity (A)) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	52

(D) Getting in and out of bed or chairs		(E) Walking		(F) Getting outside		(G) Using the toilet, including getting to the toilet		
G4	Refer to G3 and 8b above. 1 <input type="checkbox"/> Box 1 marked in G3 (Go to G4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to G4 for next activity) 3 <input type="checkbox"/> All other (Go to 9)	36	G4	Refer to G3 and 8b above. 1 <input type="checkbox"/> Box 1 marked in G3 (Go to G4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to G4 for next activity) 3 <input type="checkbox"/> All other (Go to 9)	47	G4	Refer to G3 and 8b above. 1 <input type="checkbox"/> Box 1 marked in G3 (Skip to G5 on page 18) 2 <input type="checkbox"/> "Yes" in 8b (Skip to G5 on page 18) 3 <input type="checkbox"/> All other (Go to 9)	53
9a.	1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK }	37	9a.	1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK }	48	9a.	1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK }	54
b.		38	b.		49	b.		55
(1)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK		(1)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK		(1)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	
(2)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	39	(2)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	50	(2)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	56
10.	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	40	10.	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	51	10.	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	57
11.	1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	41	11.	1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	52	11.	1 <input type="checkbox"/> Yes } (Go to G5 on page 18) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	58

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(A) Bathing or showering RT 16	(B) Dressing RT 17	(C) Eating RT 18
ITEM G5	G5 <i>Refer to 8a, 8e, 9a and 11 on page 16.</i> 1 <input type="checkbox"/> Any "Yes" (Go to 12) 2 <input type="checkbox"/> All other (Go to G5 for activity (B))	G5 <i>Refer to 8a, 8e, 9a and 11 on page 16.</i> 1 <input type="checkbox"/> Any "Yes" (Go to 12) 2 <input type="checkbox"/> All other (Go to G5 for activity (C))	G5 <i>Refer to 8a, 8e, 9a and 11 on page 16.</i> 1 <input type="checkbox"/> Any "Yes" (Go to 12) 2 <input type="checkbox"/> All other (Go to G5 for activity (D))
	12a. How often do you have a complete bath? This could be a tub bath, shower, sink bath or bed bath. Would you say — (Read categories) 1 <input type="checkbox"/> Everyday, 38 2 <input type="checkbox"/> 2-3 times per week, 3 <input type="checkbox"/> Once a week, or 4 <input type="checkbox"/> Less than once a week? 9 <input type="checkbox"/> DK	12a. Do you get dressed for the day — (Read categories) 1 <input type="checkbox"/> Everyday, (Skip to 13) 40 2 <input type="checkbox"/> 2-3 times per week, 3 <input type="checkbox"/> Once a week, or 4 <input type="checkbox"/> Do you stay in night clothes? } (Go to 12b) 9 <input type="checkbox"/> DK	12a. During the past month, were there times you were unable to eat when you were hungry because no one was available to help you eat? 1 <input type="checkbox"/> Yes 39 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
	b. How often do you have a partial bath? Would you say — (Read categories) 1 <input type="checkbox"/> Everyday, 39 2 <input type="checkbox"/> 2-3 times per week, 3 <input type="checkbox"/> Once a week, or 4 <input type="checkbox"/> Less than once a week? 9 <input type="checkbox"/> DK	b. How often do you change your night clothes? Would you say — (Read categories) 1 <input type="checkbox"/> Everyday, 41 2 <input type="checkbox"/> 2-3 times per week, 3 <input type="checkbox"/> Once a week, or 4 <input type="checkbox"/> Less than once a week? 9 <input type="checkbox"/> DK	b. During the past month, have you — (1) Lost any weight because you were on a diet? 1 <input type="checkbox"/> Yes 40 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
	13a. During the past month, did you experience discomfort because you were not able to bathe as often as you would have liked? <i>If necessary: That can be either physical or emotional discomfort.</i> 1 <input type="checkbox"/> Yes 40 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	13. During the past month, did you experience discomfort because you were not able to change your clothes as often as you would have liked because you did not have help? 1 <input type="checkbox"/> Yes } (Go to G5 for activity (C)) 42 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(2) Lost weight even though you were not on a diet? 1 <input type="checkbox"/> Yes 41 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
	b. During the past month, did you experience a burn or scald caused by bathing with water that was too hot? 1 <input type="checkbox"/> Yes } (Go to G5 for activity (B)) 41 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK		(3) Been dehydrated, that is not had enough liquid in your diet? 1 <input type="checkbox"/> Yes } (Go to G5 for activity (D)) 42 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <i>If necessary: If you were dehydrated, you might have been thirsty or lost body fluids.</i>

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

(D) RT 19		(E) RT 20		(G) RT 22	
Getting in and out of bed or chairs		Walking		Using the toilet, including getting to the toilet	
G5	Refer to 8a, 8e, 9a and 11 on page 17. 42 1 <input type="checkbox"/> Any "Yes" (Go to 12) 2 <input type="checkbox"/> All other (Go to G5 for activity (E))	G5	Refer to 8a, 8e, 9a and 11 on page 17. 53 1 <input type="checkbox"/> Any "Yes" (Go to 12) 2 <input type="checkbox"/> All other (Go to G5 for activity (G))	G5	Refer to 8a, 8e, 9a and 11 on page 17. 59 1 <input type="checkbox"/> Any "Yes" (Go to 12) 2 <input type="checkbox"/> All other (Skip to G6 on page 20)
12a.	Because of a health or physical problem, do you usually stay in bed all or most of the time? 1 <input type="checkbox"/> Yes (Skip to G5 for activity (E)) 43 2 <input type="checkbox"/> No } (Go to 12b) 9 <input type="checkbox"/> DK }	12a.	How often do you move around your [house/ apartment/room]? Would you say — (Read categories) 1 <input type="checkbox"/> Whenever you want, 54 2 <input type="checkbox"/> Often enough to stretch and have a change of scenery now and then, 3 <input type="checkbox"/> Often enough to take care of toileting needs but not much more than that, or 4 <input type="checkbox"/> Not often enough even to use the bathroom? 9 <input type="checkbox"/> DK (Go to G5 for activity (G))	12a.	During the past month, did you experience discomfort because you did not have help getting to the bathroom or changing soiled clothing as often as you needed to? If necessary: That can be either physical or emotional discomfort. 1 <input type="checkbox"/> Yes 60 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
b.	Because of a health or physical problem, do you usually stay in a chair all or most of the time? 1 <input type="checkbox"/> Yes 44 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			b.	During the past month, did you wet or soil yourself because you did not have help getting to the bathroom, using a bed pan or using a commode? 1 <input type="checkbox"/> Yes (Go to 12c) 61 2 <input type="checkbox"/> No } (Skip to 12d) 9 <input type="checkbox"/> DK }
c.	How often do you get out of bed? Would you say — (Read categories) 1 <input type="checkbox"/> Everyday, 45 2 <input type="checkbox"/> 2-3 times per week, 3 <input type="checkbox"/> Once a week, or 4 <input type="checkbox"/> Less than once a week? 9 <input type="checkbox"/> DK (Go to G5 for activity (E))			c.	During the past month, did you experience skin problems such as a rash or irritation because of this? 1 <input type="checkbox"/> Yes 62 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
				d.	During the past month, did you use a commode or bed pan because no help was available? 1 <input type="checkbox"/> Yes 63 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G6 on page 20)

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

ITEM G6

Refer to question 4 for activities A-G on pages 14 and 15. Indicate the activities marked "Yes".

Insert these marked activities when asking 14.

- A. Bathing or showering
- B. Dressing
- C. Eating
- D. Getting in and out of bed or chairs
- E. Walking
- F. Getting outside
- G. Using the toilet, including getting to the toilet
- No activities marked (Skip to 15)

Insert activities marked in G6.

14a. What (other) condition causes the trouble in (activities)?

Record conditions and ask 14b.

Ask if operation:

For what condition did you have the operation?

Record up to 5 conditions.

- 00 No condition (Skip to 15)
- 01 Old age (Go to 14c)

- (a) _____ 9-10
- (b) _____ 11-12
- (c) _____ 13-14
- (d) _____ 15-16
- (e) _____ 17-18

b. Besides (condition), is there any other condition which causes this trouble in (activities)?

- 1 Yes (Reask 14a and 14b)
- 2 No } (Go to 15)
- 9 DK }

c. Is this trouble in (activities) caused by any specific condition?

- 1 Yes (Reask 14a and 14b)
- 2 No } (Go to 15)
- 9 DK }

15a. Do you have difficulty controlling your bowels?

- 1 Yes (Go to 15b)
- 2 No } (Skip to 15c)
- 9 DK }

b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week?

Mark (X) only one.

- 1 Daily
- 2 Several times a week
- 3 Once a week
- 4 Less than once a week
- 9 DK

c. Do you have a colostomy or a device to help control bowel movements?

- 1 Yes (Go to 15d)
- 2 No } (Skip to 16a on page 21)
- 9 DK }

d. Do you need help from another person in taking care of this device?

- 1 Yes
- 2 No
- 9 DK

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

READ TO RESPONDENT: These questions are about some other activities. Please tell me about doing them by yourself.

<p><i>Ask questions 17(H)-(O) before continuing to Item G8.</i></p> <p>17. Because of a health or physical problem, do you have ANY difficulty —</p> <p><i>Ask if "Doesn't do": Is this because of a HEALTH or PHYSICAL problem?</i></p> <p><i>If "Yes", mark box 1; if "No" mark box 3.</i></p>	<p>(H)</p> <p>Preparing your own meals?</p>	<p>RT 24</p>	<p>3-4</p>	<p>(I)</p> <p>Shopping for groceries and personal items, such as toilet items or medicines?</p>	<p>RT 25</p>	<p>3-4</p>	<p>(J)</p> <p>Managing your money, such as keeping track of expenses or paying bills?</p>	<p>RT 26</p>	<p>3-4</p>
	<p>17.</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/></p> <p>Does someone else regularly do this for you?</p> <p>4 <input type="checkbox"/> Yes</p> <p>5 <input type="checkbox"/> No</p>	5		<p>17.</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/></p> <p>Does someone else regularly do this for you?</p> <p>4 <input type="checkbox"/> Yes</p> <p>5 <input type="checkbox"/> No</p>	5		<p>17.</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/></p> <p>Does someone else regularly do this for you?</p> <p>4 <input type="checkbox"/> Yes</p> <p>5 <input type="checkbox"/> No</p>	5	
			6				6		6

<p>ITEM G8</p>	<p>(H)</p> <p>Preparing your own meals</p>	<p>RT 24</p>	<p>3-4</p>	<p>(I)</p> <p>Shopping for groceries and personal items</p>	<p>RT 25</p>	<p>3-4</p>	<p>(J)</p> <p>Managing your money</p>	<p>RT 26</p>	<p>3-4</p>
	<p>G8</p> <p>Refer to question 17.</p> <p>1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18)</p> <p>2 <input type="checkbox"/> All other (Go to G8 for next activity)</p>	7		<p>G8</p> <p>Refer to question 17.</p> <p>1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18)</p> <p>2 <input type="checkbox"/> All other (Go to G8 for next activity)</p>	7		<p>G8</p> <p>Refer to question 17.</p> <p>1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18)</p> <p>2 <input type="checkbox"/> All other (Go to G8 for next activity)</p>	7	
<p>18. By yourself, how much difficulty do you have (activity), — some, a lot, or are you unable to do it?</p>	<p>18.</p> <p>1 <input type="checkbox"/> Some } (Go to 19)</p> <p>2 <input type="checkbox"/> A lot } (Go to 19)</p> <p>3 <input type="checkbox"/> Unable (Go to G8 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 19)</p>	8		<p>18.</p> <p>1 <input type="checkbox"/> Some } (Go to 19)</p> <p>2 <input type="checkbox"/> A lot } (Go to 19)</p> <p>3 <input type="checkbox"/> Unable (Go to G8 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 19)</p>	8		<p>18.</p> <p>1 <input type="checkbox"/> Some } (Go to 19)</p> <p>2 <input type="checkbox"/> A lot } (Go to 19)</p> <p>3 <input type="checkbox"/> Unable (Go to G8 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 19)</p>	8	
<p>19. When you DO NOT HAVE HELP, is (activity) by yourself —</p> <p>a. Very tiring?</p> <p>b. Does (activity) take a long time?</p> <p>c. Is it very painful?</p>	<p>19a.</p> <p>0 <input type="checkbox"/> Never do without help (Go to G8 for next activity)</p> <p>Yes No DK</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/></p> <p>b.</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/></p> <p>c.</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/></p> <p>(Go to G8 for next activity)</p>	9		<p>19a.</p> <p>0 <input type="checkbox"/> Never do without help (Go to G8 for next activity)</p> <p>Yes No DK</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/></p> <p>b.</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/></p> <p>c.</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/></p> <p>(Go to G8 for next activity)</p>	9		<p>19a.</p> <p>0 <input type="checkbox"/> Never do without help (Go to G8 for next activity)</p> <p>Yes No DK</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/></p> <p>b.</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/></p> <p>c.</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/></p> <p>(Go to G8 for next activity)</p>	9	
			10				10		10
			11				11		11
			12				12		12

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(K) RT 27	3-4		(L) RT 28	3-4		(M) RT 29	3-4		(N) RT 30	3-4		(O) RT 31	3-4
	Using the telephone?			Doing heavy housework, like scrubbing floors, or washing windows?			Doing light housework, like doing dishes, straightening up, or light cleaning?			Getting to places outside of walking distance?			Managing your medication?	
17.	1 <input type="checkbox"/> Yes 5 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/>			1 <input type="checkbox"/> Yes 5 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/>			1 <input type="checkbox"/> Yes 5 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/>			1 <input type="checkbox"/> Yes 5 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/>			1 <input type="checkbox"/> Yes 5 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/>	
	Does someone else regularly do this for you? 4 <input type="checkbox"/> Yes 6 5 <input type="checkbox"/> No			Does someone else regularly do this for you? 4 <input type="checkbox"/> Yes 6 5 <input type="checkbox"/> No			Does someone else regularly do this for you? 4 <input type="checkbox"/> Yes 6 5 <input type="checkbox"/> No			Does someone else regularly do this for you? 4 <input type="checkbox"/> Yes 6 5 <input type="checkbox"/> No			Does someone else regularly do this for you? 4 <input type="checkbox"/> Yes 6 5 <input type="checkbox"/> No	

	(K)	(L)	(M)	(N)	(O)
	Using the telephone	Doing heavy housework	Doing light housework	Getting to places outside of walking distance	Managing your medication
G8	Refer to question 17. 7 1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18) 2 <input type="checkbox"/> All other (Go to G8 for next activity)	Refer to question 17. 7 1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18) 2 <input type="checkbox"/> All other (Go to G8 for next activity)	Refer to question 17. 7 1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18) 2 <input type="checkbox"/> All other (Go to G8 for next activity)	Refer to question 17. 7 1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18) 2 <input type="checkbox"/> All other (Go to G8 for next activity)	Refer to question 17. 7 1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18) 2 <input type="checkbox"/> All other (Skip to G9 on page 24)
18.	1 <input type="checkbox"/> Some } (Go to 19) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Go to G8 for next activity) 9 <input type="checkbox"/> DK (Go to 19) 8	1 <input type="checkbox"/> Some } (Go to 19) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Go to G8 for next activity) 9 <input type="checkbox"/> DK (Go to 19) 8	1 <input type="checkbox"/> Some } (Go to 19) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Go to G8 for next activity) 9 <input type="checkbox"/> DK (Go to 19) 8	1 <input type="checkbox"/> Some } (Go to 19) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Go to G8 for next activity) 9 <input type="checkbox"/> DK (Go to 19) 8	1 <input type="checkbox"/> Some } (Go to 19) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Skip to G9 on page 24) 9 <input type="checkbox"/> DK (Go to 19) 8
19a.	0 <input type="checkbox"/> Never do without help (Go to G8 for next activity) 9 Yes No DK 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 10	0 <input type="checkbox"/> Never do without help (Go to G8 for next activity) 9 Yes No DK 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 10	0 <input type="checkbox"/> Never do without help (Go to G8 for next activity) 9 Yes No DK 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 10	0 <input type="checkbox"/> Never do without help (Go to G8 for next activity) 9 Yes No DK 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 10	0 <input type="checkbox"/> Never do without help (Skip to G9 for activity (H)) 9 Yes No DK 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 10
b.	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 11	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 11	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 11	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 11	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 11
c.	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 12 (Go to G8 for next activity)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 12 (Go to G8 for next activity)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 12 (Go to G8 for next activity)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 12 (Go to G8 for next activity)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 12 (Go to G9 on page 24)

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

		(H) Preparing your own meals RT 24	(I) Shopping for groceries and personal items RT 25	(J) Managing your money RT 26
ITEM G9	G9	Refer to question 17 on page 22. RT 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)	Refer to question 17 on page 22. RT 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)	Refer to question 17 on page 22. RT 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)
20a. Do you receive help from another person in (activity)?	20a.	RT 14 1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK }	RT 14 1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK }	RT 14 1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK }
b. Is this hands-on help?	b.	RT 15 1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK }	RT 15 1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK }	RT 15 1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK }
c. When you HAVE HANDS-ON HELP FROM ANOTHER PERSON, is (activity):	c.	RT 16 0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK	RT 16 0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK	RT 16 0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK
(1) Very tiring?	(1)	RT 17 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	RT 17 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	RT 17 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>
(2) Does (activity) take a long time?	(2)	RT 18 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	RT 18 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	RT 18 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>
(3) Is it very painful?	(3)	RT 19 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	RT 19 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	RT 19 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>
d. How often do you have hands-on help with (activity)? Would you say always, sometimes, or rarely?	d.	RT 20 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	RT 20 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	RT 20 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK
e. Do you need (more) hands-on help with (activity)?	e.	RT 21 1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	RT 21 1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	RT 21 1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }

		(H) Preparing your own meals RT 24	(I) Shopping for groceries and personal items RT 25	(J) Managing your money RT 26
ITEM G10	G10	Refer to G9 and 20b: RT 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)	Refer to G9 and 20b: RT 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)	Refer to G9 and 20b: RT 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)
21a. Do you have someone who supervises you or stays nearby when you are (activity)?	21a.	RT 23 1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK }	RT 23 1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK }	RT 23 1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK }
b. Does this person provide —	b.	RT 24	RT 24	RT 24
(1) Supervisory help, such as making sure the activity is performed correctly when you are (activity)?	(1)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(2) Stand-by help, such as observing to see if any help is needed when you are (activity)?	(2)	RT 25 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	RT 25 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	RT 25 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
22. How often do you have supervision or standby help when you are (activity)? Would you say always, sometimes, or rarely?	22.	RT 26 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	RT 26 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	RT 26 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK
23. Do you need (more) supervision or standby help with (activity)?	23.	RT 27 1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	RT 27 1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	RT 27 1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(K) RT 27	(L) RT 28	(M) RT 29	(N) RT 30	(O) RT 31
	Using the telephone	Doing heavy housework	Doing light housework	Getting to places outside of walking distance	Managing your medication
G9	Refer to question 17 on page 23. 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)	Refer to question 17 on page 23. 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)	Refer to question 17 on page 23. 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)	Refer to question 17 on page 23. 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)	Refer to question 17 on page 23. 13 1 <input type="checkbox"/> Box 3 marked (Go to G10 for activity (H)) 2 <input type="checkbox"/> All others (Go to 20)
20a.	1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK
b.	1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK
c.	0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK	0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK	0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK	0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK	0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK
(1)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 17	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 17	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 17	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 17	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 17
(2)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 18	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 18	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 18	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 18	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 18
(3)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 19	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 19	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 19	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 19	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 19
d.	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK
e.	1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } (Go to G10 for activity (H)) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK

	(K) RT 27	(L) RT 28	(M) RT 29	(N) RT 30	(O) RT 31
	Using the telephone	Doing heavy housework	Doing light housework	Getting to places outside of walking distance	Managing your medication
G10	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Skip to G11 on page 26) 2 <input type="checkbox"/> "Yes" marked in 20b (Skip to G11 on page 26) 3 <input type="checkbox"/> Other (Go to 21)
21a.	1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK
b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
c.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
22.	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK
23.	1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes } (Skip to G11 on page 26 for activity (H)) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(H) Preparing your own meals	RT 24	(I) Shopping for groceries and personal items	RT 25	
ITEM G11	G11	28	G11	28	
	Refer to 20a, 20e, 21a, and 23 on page 24. 1 <input type="checkbox"/> Any "Yes" (Go to 24) 2 <input type="checkbox"/> All other (Go to G11 for activity (I))		Refer to 20a, 20e, 21a, and 23 on page 24. 1 <input type="checkbox"/> Any "Yes" (Go to 24) 2 <input type="checkbox"/> All other (Go to G11 for activity (L))		
	24a.	During the past month, did you experience discomfort because you were unable to eat when you were hungry because no one was available to prepare food? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	29	29	
	b.	During the past month, were you unable to follow a special diet because you needed help cooking? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	30	30	
	c.	During the past month, were you unable to eat the kind of food you are used to and you prefer because you needed help cooking? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	31	31	
			b.	During the past month, did you miss a meal because you were unable to shop? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	30
				(Go to G11 for activity (L))	

	(H) Prepare your own meals	RT 24	(I) Shop for groceries and personal items	RT 25	(J) Manage your money	RT 26
ITEM G12	G12	32	G12	31	G12	28
	Refer to 17 on page 22. 1 <input type="checkbox"/> Box 3 marked (Go to G12 for next activity) 2 <input type="checkbox"/> All other (Go to 25)		Refer to 17 on page 22. 1 <input type="checkbox"/> Box 3 marked (Go to G12 for next activity) 2 <input type="checkbox"/> All other (Go to 25)		Refer to 17 on page 22. 1 <input type="checkbox"/> Box 3 marked (Go to G12 for activity (L)) 2 <input type="checkbox"/> All other (Go to 25)	
25. In your household, how often do YOU (activity)? Would you say always, sometimes, rarely, or never?	25.	33	25.	32	25.	29
	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 4 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK		1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 4 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK		1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 4 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK	
		(Go to G12 for next activity)		(Go to G12 for next activity)		(Go to G12 for activity (L))

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(L) Doing heavy housework	(M) Doing light housework	(N) Getting to places outside of walking distance
	RT 28	RT 29	RT 30
	28	28	28
G11	<i>Refer to 20a, 20e, 21a, and 23 on page 25.</i> 1 <input type="checkbox"/> Any "Yes" (Go to 24) 2 <input type="checkbox"/> All other (Go to G11 for activity (M))	<i>Refer to 20a, 20e, 21a, and 23 on page 25.</i> 1 <input type="checkbox"/> Any "Yes" (Go to 24) 2 <input type="checkbox"/> All other (Go to G11 for activity (N))	<i>Refer to 20a, 20e, 21a, and 23 on page 25.</i> 1 <input type="checkbox"/> Any "Yes" (Go to 24) 2 <input type="checkbox"/> All other (Skip to G12 for activity (H))
24.	During the past month, did you experience distress because you were not able to wash clothes or clean up around the house? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Go to G11 for activity (M))	During the past month, did you experience distress because you were not able to do dishes or straighten up around the house? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Go to G11 for activity (N))	24a. During the past month, did you miss a doctor's or other medical appointment because you were unable to get there? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
	29	29	29
			b. During the past month, were you unable to go places you wanted to for fun or recreation because you did not have transportation? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
			30
			c. During the past month, did you run out of food because you were unable to get to the store? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Go to G12 for activity (H))
			31

	(L) Do heavy housework	(M) Do light housework	
	30	30	
G12	<i>Refer to 17 on page 23.</i> 1 <input type="checkbox"/> Box 3 marked (Go to G12 for next activity) 2 <input type="checkbox"/> All other (Go to 25)	<i>Refer to 17 on page 23.</i> 1 <input type="checkbox"/> Box 3 marked (Skip to G13 on page 28) 2 <input type="checkbox"/> All other (Go to 25)	
25.	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 4 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK } (Go to G12 for next activity)	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 4 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK } (Skip to G13 on page 28)	
	31	31	

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

ITEM G13

Refer to question 17 for activities H-O on pages 22 and 23. Indicate the activities marked "Yes".

Insert these marked activities when asking 26.

- H. Preparing your own meals
- I. Shopping for groceries and personal items
- J. Managing your money
- K. Using the telephone
- L. Doing heavy housework
- M. Doing light housework
- N. Getting to places outside of walking distance
- O. Managing your medication
- No activities marked (Skip to 27)

Insert activities marked in G13.

26a. What (other) condition causes the trouble in (activities)?

Record conditions and ask 26b.

Ask if operation:

For what condition did you have the operation?

Record up to 5 conditions.

- 00 No condition (Skip to 27)
- 01 Old age (Skip to 26c)

- (a) _____ 5-6
7-8
- (b) _____ 9-10
- (c) _____ 11-12
- (d) _____ 13-14
- (e) _____ 15-16
- _____ 17-18

b. Besides (condition), is there any other condition which causes this trouble in (activities)?

- 1 Yes (Reask 26a and b)
- 2 No } (Skip to 27)
- 9 DK }

c. Is this trouble in (activities) caused by any specific condition?

- 1 Yes (Reask 26a and b)
- 2 No } (Go to 27)
- 9 DK }

27a. During the past 12 months, that is, since (today's date) a year ago, have you fallen?

- 1 Yes (Go to 27b)
- 2 No } (Skip to Item G14 on page 29)
- 9 DK }

b. Have you fallen more than once during the past 12 months?

- 1 Yes
- 2 No
- 9 DK

c. Were you injured as a result of the fall(s)?

- 1 Yes (Go to 27d)
- 2 No } (Skip to 27e)
- 9 DK }

d. What kind of injuries did you have — a fracture, bruise, scrape or cut; did you lose consciousness, or did you have some other injury?

Mark (X) all that apply.

- 1 Fracture
- 2 Bruise, cut, or scrape
- 3 Lost consciousness
- 4 Other
- 9 DK

e. [Did you fall/Were any of these falls] because you did not have help getting around or because your helper could not prevent you from falling?

- 1 Yes
- 2 No
- 9 DK

f. [Did you fall/Were any of these falls] because you felt dizzy?

- 1 Yes
- 2 No
- 9 DK

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

ITEM G14	Status of SP.	1 <input type="checkbox"/> Institutionalized (<i>Skip to 40 on page 33</i>) 2 <input type="checkbox"/> All others (<i>Go to Item G15</i>)	31
ITEM G15	Refer to questions 8a, columns A, D, and G on pages 16-17. [Receives help] Mark (X) all that apply.	<input type="checkbox"/> "Yes" in 8a for A. Bathing <input type="checkbox"/> "Yes" in 8a for D. Getting in/out of bed/chairs <input type="checkbox"/> "Yes" in 8a for G. Using the toilet <input type="checkbox"/> All others (<i>Skip to 29</i>)	} (<i>Go to 28</i>) 32
28. You said that you receive help with [bathing/(and) getting in or out of a bed or chair/(and) using the toilet]. Is the person who helps you most with [this/these activities] strong enough to give you the help you need or is helping physically difficult for him or her?		1 <input type="checkbox"/> Yes, strong enough 2 <input type="checkbox"/> No, physically difficult 9 <input type="checkbox"/> DK	33
If proxy respondent, ask; otherwise, skip to Item G16. 29. Does (sample person) need supervision to ensure [his/her] personal safety or the safety of others?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	34
ITEM G16	Refer to questions 8a and 9a on pages 16-17 and questions 20a and 21a on pages 24-25. (Receives help and/or supervision) Mark (X) all that apply.	<input type="checkbox"/> "Yes" in 8a or 9a for A. Bathing <input type="checkbox"/> "Yes" in 8a or 9a for B. Dressing <input type="checkbox"/> "Yes" in 8a or 9a for C. Eating <input type="checkbox"/> "Yes" in 8a or 9a for D. Getting in/out of bed/chairs <input type="checkbox"/> "Yes" in 8a or 9a for E. Walking <input type="checkbox"/> "Yes" in 8a or 9a for F. Getting outside <input type="checkbox"/> "Yes" in 8a or 9a for G. Using the toilet <input type="checkbox"/> "Yes" in 20a or 21a for H. Preparing your own meals <input type="checkbox"/> "Yes" in 20a or 21a for I. Shopping <input type="checkbox"/> "Yes" in 20a or 21a for J. Managing your money <input type="checkbox"/> "Yes" in 20a or 21a for K. Using the telephone <input type="checkbox"/> "Yes" in 20a or 21a for L. Doing heavy housework <input type="checkbox"/> "Yes" in 20a or 21a for M. Doing light housework <input type="checkbox"/> "Yes" in 20a or 21a for N. Getting places <input type="checkbox"/> "Yes" in 20a or 21a for O. Managing your medication <input type="checkbox"/> All others (<i>Skip to 38 on page 32</i>)	} (<i>Insert marked activities when asking question 30 on page 30</i>)

Notes

Section G – ASSISTANCE WITH KEY ACTIVITIES – Continued

<p>30. Who usually helps you with (activities marked in G16)? Anyone else? Enter the name or description of each helper in separate column.</p>	30.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">RT 33</td> <td style="width:10%; text-align: center;">3-4</td> </tr> <tr> <td></td> <td style="text-align: center;">5-6</td> </tr> </table> <p>(01) _____ First helper</p>	RT 33	3-4		5-6																																																		
RT 33	3-4																																																							
	5-6																																																							
<p>Ask 31–35 for each helper in 30. ASK OR VERIFY:</p> <p>31. Which activities does (Helper) help you with? Mark (X) all that apply.</p>	31.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>01 <input type="checkbox"/> Bathing or showering</td><td style="text-align: right;">7-8</td></tr> <tr><td>02 <input type="checkbox"/> Dressing</td><td style="text-align: right;">9-10</td></tr> <tr><td>03 <input type="checkbox"/> Eating</td><td style="text-align: right;">11-12</td></tr> <tr><td>04 <input type="checkbox"/> Getting in or out of bed/chairs</td><td style="text-align: right;">13-14</td></tr> <tr><td>05 <input type="checkbox"/> Walking</td><td style="text-align: right;">15-16</td></tr> <tr><td>06 <input type="checkbox"/> Getting outside</td><td style="text-align: right;">17-18</td></tr> <tr><td>07 <input type="checkbox"/> Using or getting to the toilet</td><td style="text-align: right;">19-20</td></tr> <tr><td>08 <input type="checkbox"/> Preparing your own meals</td><td style="text-align: right;">21-22</td></tr> <tr><td>09 <input type="checkbox"/> Shopping for groceries</td><td style="text-align: right;">23-24</td></tr> <tr><td>10 <input type="checkbox"/> Managing your money</td><td style="text-align: right;">25-26</td></tr> <tr><td>11 <input type="checkbox"/> Using the telephone</td><td style="text-align: right;">27-28</td></tr> <tr><td>12 <input type="checkbox"/> Doing heavy housework</td><td style="text-align: right;">29-30</td></tr> <tr><td>13 <input type="checkbox"/> Doing light housework</td><td style="text-align: right;">31-32</td></tr> <tr><td>14 <input type="checkbox"/> Getting to places outside</td><td style="text-align: right;">33-34</td></tr> <tr><td>15 <input type="checkbox"/> Managing your medications</td><td style="text-align: right;">35-36</td></tr> <tr><td>99 <input type="checkbox"/> DK</td><td style="text-align: right;">37-38</td></tr> </table>	01 <input type="checkbox"/> Bathing or showering	7-8	02 <input type="checkbox"/> Dressing	9-10	03 <input type="checkbox"/> Eating	11-12	04 <input type="checkbox"/> Getting in or out of bed/chairs	13-14	05 <input type="checkbox"/> Walking	15-16	06 <input type="checkbox"/> Getting outside	17-18	07 <input type="checkbox"/> Using or getting to the toilet	19-20	08 <input type="checkbox"/> Preparing your own meals	21-22	09 <input type="checkbox"/> Shopping for groceries	23-24	10 <input type="checkbox"/> Managing your money	25-26	11 <input type="checkbox"/> Using the telephone	27-28	12 <input type="checkbox"/> Doing heavy housework	29-30	13 <input type="checkbox"/> Doing light housework	31-32	14 <input type="checkbox"/> Getting to places outside	33-34	15 <input type="checkbox"/> Managing your medications	35-36	99 <input type="checkbox"/> DK	37-38																						
01 <input type="checkbox"/> Bathing or showering	7-8																																																							
02 <input type="checkbox"/> Dressing	9-10																																																							
03 <input type="checkbox"/> Eating	11-12																																																							
04 <input type="checkbox"/> Getting in or out of bed/chairs	13-14																																																							
05 <input type="checkbox"/> Walking	15-16																																																							
06 <input type="checkbox"/> Getting outside	17-18																																																							
07 <input type="checkbox"/> Using or getting to the toilet	19-20																																																							
08 <input type="checkbox"/> Preparing your own meals	21-22																																																							
09 <input type="checkbox"/> Shopping for groceries	23-24																																																							
10 <input type="checkbox"/> Managing your money	25-26																																																							
11 <input type="checkbox"/> Using the telephone	27-28																																																							
12 <input type="checkbox"/> Doing heavy housework	29-30																																																							
13 <input type="checkbox"/> Doing light housework	31-32																																																							
14 <input type="checkbox"/> Getting to places outside	33-34																																																							
15 <input type="checkbox"/> Managing your medications	35-36																																																							
99 <input type="checkbox"/> DK	37-38																																																							
<p>ASK OR VERIFY: HAND CARD A5. Read answers if telephone interview.</p> <p>32a. Which of these best describes (Helper)? Mark (X) only one.</p>	32a.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>01 <input type="checkbox"/> Spouse</td><td rowspan="3" style="font-size: 2em; vertical-align: middle;">}</td><td rowspan="3" style="vertical-align: middle;">In household</td><td style="text-align: right;">39-40</td></tr> <tr><td>02 <input type="checkbox"/> Child</td><td rowspan="2" style="font-size: 2em; vertical-align: middle;">}</td><td rowspan="2" style="vertical-align: middle;">Not in household</td><td></td></tr> <tr><td>03 <input type="checkbox"/> Parent</td><td></td></tr> <tr><td>04 <input type="checkbox"/> Spouse</td><td rowspan="3" style="font-size: 2em; vertical-align: middle;">}</td><td rowspan="3" style="vertical-align: middle;">Not in household</td><td></td></tr> <tr><td>05 <input type="checkbox"/> Child</td><td></td></tr> <tr><td>06 <input type="checkbox"/> Parent</td><td></td></tr> <tr><td>07 <input type="checkbox"/> Other HH relative</td><td></td><td></td><td></td></tr> <tr><td>08 <input type="checkbox"/> Non-HH relative</td><td></td><td></td><td></td></tr> <tr><td>09 <input type="checkbox"/> HH non-relative</td><td></td><td></td><td></td></tr> <tr><td>10 <input type="checkbox"/> Friend/Neighbor</td><td></td><td></td><td></td></tr> <tr><td>11 <input type="checkbox"/> Unpaid volunteer from organization/business</td><td></td><td></td><td></td></tr> <tr><td>12 <input type="checkbox"/> Paid employee of organization/business</td><td></td><td></td><td></td></tr> <tr><td>13 <input type="checkbox"/> Paid employee of yours</td><td></td><td></td><td></td></tr> <tr><td>14 <input type="checkbox"/> Other</td><td></td><td></td><td></td></tr> <tr><td>99 <input type="checkbox"/> DK</td><td></td><td></td><td></td></tr> </table>	01 <input type="checkbox"/> Spouse	}	In household	39-40	02 <input type="checkbox"/> Child	}	Not in household		03 <input type="checkbox"/> Parent		04 <input type="checkbox"/> Spouse	}	Not in household		05 <input type="checkbox"/> Child		06 <input type="checkbox"/> Parent		07 <input type="checkbox"/> Other HH relative				08 <input type="checkbox"/> Non-HH relative				09 <input type="checkbox"/> HH non-relative				10 <input type="checkbox"/> Friend/Neighbor				11 <input type="checkbox"/> Unpaid volunteer from organization/business				12 <input type="checkbox"/> Paid employee of organization/business				13 <input type="checkbox"/> Paid employee of yours				14 <input type="checkbox"/> Other				99 <input type="checkbox"/> DK			
01 <input type="checkbox"/> Spouse	}	In household	39-40																																																					
02 <input type="checkbox"/> Child			}			Not in household																																																		
03 <input type="checkbox"/> Parent																																																								
04 <input type="checkbox"/> Spouse	}	Not in household																																																						
05 <input type="checkbox"/> Child																																																								
06 <input type="checkbox"/> Parent																																																								
07 <input type="checkbox"/> Other HH relative																																																								
08 <input type="checkbox"/> Non-HH relative																																																								
09 <input type="checkbox"/> HH non-relative																																																								
10 <input type="checkbox"/> Friend/Neighbor																																																								
11 <input type="checkbox"/> Unpaid volunteer from organization/business																																																								
12 <input type="checkbox"/> Paid employee of organization/business																																																								
13 <input type="checkbox"/> Paid employee of yours																																																								
14 <input type="checkbox"/> Other																																																								
99 <input type="checkbox"/> DK																																																								
<p>ASK OR VERIFY:</p> <p>b. Is (Helper) male or female?</p>	b.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>1 <input type="checkbox"/> Male</td><td style="text-align: right;">41</td></tr> <tr><td>2 <input type="checkbox"/> Female</td><td></td></tr> <tr><td>9 <input type="checkbox"/> DK</td><td></td></tr> </table>	1 <input type="checkbox"/> Male	41	2 <input type="checkbox"/> Female		9 <input type="checkbox"/> DK																																																	
1 <input type="checkbox"/> Male	41																																																							
2 <input type="checkbox"/> Female																																																								
9 <input type="checkbox"/> DK																																																								
<p>If parent, child, spouse, or unpaid volunteer in 32a, skip to 34; otherwise ask:</p> <p>33a. Is (Helper) paid? HAND CARD A1. Read answers if telephone interview.</p> <p>b. Who pays for this help? (Anyone else?) Mark (X) all that apply.</p>	33a.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>1 <input type="checkbox"/> Yes (Go to 33b)</td><td style="text-align: right;">42</td></tr> <tr><td>2 <input type="checkbox"/> No (Skip to 34)</td><td></td></tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>01 <input type="checkbox"/> Self and family in household</td><td style="text-align: right;">43-44</td></tr> <tr><td>02 <input type="checkbox"/> Family NOT in household</td><td style="text-align: right;">45-46</td></tr> <tr><td>03 <input type="checkbox"/> Private health insurance</td><td style="text-align: right;">47-48</td></tr> <tr><td>04 <input type="checkbox"/> Medicare</td><td style="text-align: right;">49-50</td></tr> <tr><td>05 <input type="checkbox"/> Medicaid</td><td style="text-align: right;">51-52</td></tr> <tr><td>06 <input type="checkbox"/> Rehabilitation program</td><td style="text-align: right;">53-54</td></tr> <tr><td>07 <input type="checkbox"/> Employer</td><td style="text-align: right;">55-56</td></tr> <tr><td>08 <input type="checkbox"/> School system</td><td style="text-align: right;">57-58</td></tr> <tr><td>09 <input type="checkbox"/> VA program</td><td style="text-align: right;">59-60</td></tr> <tr><td>10 <input type="checkbox"/> Other military</td><td style="text-align: right;">61-62</td></tr> <tr><td>11 <input type="checkbox"/> Other private source</td><td style="text-align: right;">63-64</td></tr> <tr><td>12 <input type="checkbox"/> Other public source</td><td style="text-align: right;">65-66</td></tr> <tr><td>13 <input type="checkbox"/> No one/Free</td><td style="text-align: right;">67-68</td></tr> <tr><td>99 <input type="checkbox"/> DK</td><td style="text-align: right;">69-70</td></tr> </table>	1 <input type="checkbox"/> Yes (Go to 33b)	42	2 <input type="checkbox"/> No (Skip to 34)		01 <input type="checkbox"/> Self and family in household	43-44	02 <input type="checkbox"/> Family NOT in household	45-46	03 <input type="checkbox"/> Private health insurance	47-48	04 <input type="checkbox"/> Medicare	49-50	05 <input type="checkbox"/> Medicaid	51-52	06 <input type="checkbox"/> Rehabilitation program	53-54	07 <input type="checkbox"/> Employer	55-56	08 <input type="checkbox"/> School system	57-58	09 <input type="checkbox"/> VA program	59-60	10 <input type="checkbox"/> Other military	61-62	11 <input type="checkbox"/> Other private source	63-64	12 <input type="checkbox"/> Other public source	65-66	13 <input type="checkbox"/> No one/Free	67-68	99 <input type="checkbox"/> DK	69-70																						
1 <input type="checkbox"/> Yes (Go to 33b)	42																																																							
2 <input type="checkbox"/> No (Skip to 34)																																																								
01 <input type="checkbox"/> Self and family in household	43-44																																																							
02 <input type="checkbox"/> Family NOT in household	45-46																																																							
03 <input type="checkbox"/> Private health insurance	47-48																																																							
04 <input type="checkbox"/> Medicare	49-50																																																							
05 <input type="checkbox"/> Medicaid	51-52																																																							
06 <input type="checkbox"/> Rehabilitation program	53-54																																																							
07 <input type="checkbox"/> Employer	55-56																																																							
08 <input type="checkbox"/> School system	57-58																																																							
09 <input type="checkbox"/> VA program	59-60																																																							
10 <input type="checkbox"/> Other military	61-62																																																							
11 <input type="checkbox"/> Other private source	63-64																																																							
12 <input type="checkbox"/> Other public source	65-66																																																							
13 <input type="checkbox"/> No one/Free	67-68																																																							
99 <input type="checkbox"/> DK	69-70																																																							
<p>34. DURING THE PAST 2 WEEKS, how many days did (Helper) help you?</p>	34.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>00 <input type="checkbox"/> None in past 2 weeks</td><td style="text-align: right;">71-72</td></tr> </table> <p>_____ Days (Number)</p> <p>99 <input type="checkbox"/> DK</p>	00 <input type="checkbox"/> None in past 2 weeks	71-72																																																				
00 <input type="checkbox"/> None in past 2 weeks	71-72																																																							
<p>35. On the days you receive help from (Helper), about how many hours per day does [he/she] usually help you?</p>	35.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>_____ Hours/day (Number)</td><td rowspan="2" style="font-size: 2em; vertical-align: middle;">}</td><td rowspan="2" style="vertical-align: middle;">(Go to 31 for next helper, or G17)</td><td style="text-align: right;">73-74</td></tr> <tr><td>99 <input type="checkbox"/> DK</td><td></td><td></td></tr> </table>	_____ Hours/day (Number)	}	(Go to 31 for next helper, or G17)	73-74	99 <input type="checkbox"/> DK																																																	
_____ Hours/day (Number)	}	(Go to 31 for next helper, or G17)	73-74																																																					
99 <input type="checkbox"/> DK																																																								
<p>ITEM G17</p> <p>Refer to 30 above. (Number of helpers)</p>	G17	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Only one helper (Skip to 37 on page 32)</td></tr> <tr><td><input type="checkbox"/> More than one helper (Go to 36 on page 32)</td></tr> </table>	<input type="checkbox"/> Only one helper (Skip to 37 on page 32)	<input type="checkbox"/> More than one helper (Go to 36 on page 32)																																																				
<input type="checkbox"/> Only one helper (Skip to 37 on page 32)																																																								
<input type="checkbox"/> More than one helper (Go to 36 on page 32)																																																								

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

30. RT 33 3-4 5-6	30. RT 33 3-4 5-6	30. RT 33 3-4 5-6
(02) _____ Second helper	(03) _____ Third helper	(04) _____ Fourth helper
31. 01 <input type="checkbox"/> Bathing or showering 7-8 02 <input type="checkbox"/> Dressing 9-10 03 <input type="checkbox"/> Eating 11-12 04 <input type="checkbox"/> Getting in or out of bed/chairs 13-14 05 <input type="checkbox"/> Walking 15-16 06 <input type="checkbox"/> Getting outside 17-18 07 <input type="checkbox"/> Using or getting to the toilet 19-20 08 <input type="checkbox"/> Preparing your own meals 21-22 09 <input type="checkbox"/> Shopping for groceries 23-24 10 <input type="checkbox"/> Managing your money 25-26 11 <input type="checkbox"/> Using the telephone 27-28 12 <input type="checkbox"/> Doing heavy housework 29-30 13 <input type="checkbox"/> Doing light housework 31-32 14 <input type="checkbox"/> Getting to places outside 33-34 15 <input type="checkbox"/> Managing your medications 35-36 99 <input type="checkbox"/> DK 37-38	31. 01 <input type="checkbox"/> Bathing or showering 7-8 02 <input type="checkbox"/> Dressing 9-10 03 <input type="checkbox"/> Eating 11-12 04 <input type="checkbox"/> Getting in or out of bed/chairs 13-14 05 <input type="checkbox"/> Walking 15-16 06 <input type="checkbox"/> Getting outside 17-18 07 <input type="checkbox"/> Using or getting to the toilet 19-20 08 <input type="checkbox"/> Preparing your own meals 21-22 09 <input type="checkbox"/> Shopping for groceries 23-24 10 <input type="checkbox"/> Managing your money 25-26 11 <input type="checkbox"/> Using the telephone 27-28 12 <input type="checkbox"/> Doing heavy housework 29-30 13 <input type="checkbox"/> Doing light housework 31-32 14 <input type="checkbox"/> Getting to places outside 33-34 15 <input type="checkbox"/> Managing your medications 35-36 99 <input type="checkbox"/> DK 37-38	31. 01 <input type="checkbox"/> Bathing or showering 7-8 02 <input type="checkbox"/> Dressing 9-10 03 <input type="checkbox"/> Eating 11-12 04 <input type="checkbox"/> Getting in or out of bed/chairs 13-14 05 <input type="checkbox"/> Walking 15-16 06 <input type="checkbox"/> Getting outside 17-18 07 <input type="checkbox"/> Using or getting to the toilet 19-20 08 <input type="checkbox"/> Preparing your own meals 21-22 09 <input type="checkbox"/> Shopping for groceries 23-24 10 <input type="checkbox"/> Managing your money 25-26 11 <input type="checkbox"/> Using the telephone 27-28 12 <input type="checkbox"/> Doing heavy housework 29-30 13 <input type="checkbox"/> Doing light housework 31-32 14 <input type="checkbox"/> Getting to places outside 33-34 15 <input type="checkbox"/> Managing your medications 35-36 99 <input type="checkbox"/> DK 37-38
32a. 01 <input type="checkbox"/> Spouse } In household 02 <input type="checkbox"/> Child } 03 <input type="checkbox"/> Parent } 04 <input type="checkbox"/> Spouse } Not in household 05 <input type="checkbox"/> Child } 06 <input type="checkbox"/> Parent } 07 <input type="checkbox"/> Other HH relative 08 <input type="checkbox"/> Non-HH relative 09 <input type="checkbox"/> HH non-relative 10 <input type="checkbox"/> Friend/Neighbor 11 <input type="checkbox"/> Unpaid volunteer from organization/business 12 <input type="checkbox"/> Paid employee of organization/business 13 <input type="checkbox"/> Paid employee of yours 14 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK 39-40	32a. 01 <input type="checkbox"/> Spouse } In household 02 <input type="checkbox"/> Child } 03 <input type="checkbox"/> Parent } 04 <input type="checkbox"/> Spouse } Not in household 05 <input type="checkbox"/> Child } 06 <input type="checkbox"/> Parent } 07 <input type="checkbox"/> Other HH relative 08 <input type="checkbox"/> Non-HH relative 09 <input type="checkbox"/> HH non-relative 10 <input type="checkbox"/> Friend/Neighbor 11 <input type="checkbox"/> Unpaid volunteer from organization/business 12 <input type="checkbox"/> Paid employee of organization/business 13 <input type="checkbox"/> Paid employee of yours 14 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK 39-40	32a. 01 <input type="checkbox"/> Spouse } In household 02 <input type="checkbox"/> Child } 03 <input type="checkbox"/> Parent } 04 <input type="checkbox"/> Spouse } Not in household 05 <input type="checkbox"/> Child } 06 <input type="checkbox"/> Parent } 07 <input type="checkbox"/> Other HH relative 08 <input type="checkbox"/> Non-HH relative 09 <input type="checkbox"/> HH non-relative 10 <input type="checkbox"/> Friend/Neighbor 11 <input type="checkbox"/> Unpaid volunteer from organization/business 12 <input type="checkbox"/> Paid employee of organization/business 13 <input type="checkbox"/> Paid employee of yours 14 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK 39-40
b. 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> DK 41	b. 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> DK 41	b. 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> DK 41
33a. 1 <input type="checkbox"/> Yes (Go to 33b) 2 <input type="checkbox"/> No (Skip to 34) 42	33a. 1 <input type="checkbox"/> Yes (Go to 33b) 2 <input type="checkbox"/> No (Skip to 34) 42	33a. 1 <input type="checkbox"/> Yes (Go to 33b) 2 <input type="checkbox"/> No (Skip to 34) 42
b. 01 <input type="checkbox"/> Self and family in household 43-44 02 <input type="checkbox"/> Family NOT in household 45-46 03 <input type="checkbox"/> Private health insurance 47-48 04 <input type="checkbox"/> Medicare 49-50 05 <input type="checkbox"/> Medicaid 51-52 06 <input type="checkbox"/> Rehabilitation program 53-54 07 <input type="checkbox"/> Employer 55-56 08 <input type="checkbox"/> School system 57-58 09 <input type="checkbox"/> VA program 59-60 10 <input type="checkbox"/> Other military 61-62 11 <input type="checkbox"/> Other private source 63-64 12 <input type="checkbox"/> Other public source 65-66 13 <input type="checkbox"/> No one/Free 67-68 99 <input type="checkbox"/> DK 69-70	b. 01 <input type="checkbox"/> Self and family in household 43-44 02 <input type="checkbox"/> Family NOT in household 45-46 03 <input type="checkbox"/> Private health insurance 47-48 04 <input type="checkbox"/> Medicare 49-50 05 <input type="checkbox"/> Medicaid 51-52 06 <input type="checkbox"/> Rehabilitation program 53-54 07 <input type="checkbox"/> Employer 55-56 08 <input type="checkbox"/> School system 57-58 09 <input type="checkbox"/> VA program 59-60 10 <input type="checkbox"/> Other military 61-62 11 <input type="checkbox"/> Other private source 63-64 12 <input type="checkbox"/> Other public source 65-66 13 <input type="checkbox"/> No one/Free 67-68 99 <input type="checkbox"/> DK 69-70	b. 01 <input type="checkbox"/> Self and family in household 43-44 02 <input type="checkbox"/> Family NOT in household 45-46 03 <input type="checkbox"/> Private health insurance 47-48 04 <input type="checkbox"/> Medicare 49-50 05 <input type="checkbox"/> Medicaid 51-52 06 <input type="checkbox"/> Rehabilitation program 53-54 07 <input type="checkbox"/> Employer 55-56 08 <input type="checkbox"/> School system 57-58 09 <input type="checkbox"/> VA program 59-60 10 <input type="checkbox"/> Other military 61-62 11 <input type="checkbox"/> Other private source 63-64 12 <input type="checkbox"/> Other public source 65-66 13 <input type="checkbox"/> No one/Free 67-68 99 <input type="checkbox"/> DK 69-70
34. 00 <input type="checkbox"/> None in past 2 weeks 71-72 _____ Days (Number) 99 <input type="checkbox"/> DK	34. 00 <input type="checkbox"/> None in past 2 weeks 71-72 _____ Days (Number) 99 <input type="checkbox"/> DK	34. 00 <input type="checkbox"/> None in past 2 weeks 71-72 _____ Days (Number) 99 <input type="checkbox"/> DK
35. _____ Hours/day } (Go to 31 for next (Number) } helper, or G17) 99 <input type="checkbox"/> DK 73-74	35. _____ Hours/day } (Go to 31 for next (Number) } helper, or G17) 99 <input type="checkbox"/> DK 73-74	35. _____ Hours/day } (Go to G17) (Number) } 99 <input type="checkbox"/> DK 73-74

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

36. You said that (Read all helpers) assist you. Who helps you the most? If 2 or more equally, ask the respondent to specify who he/she considers the main helper.

Helper No. _____

Name : _____

Ask 37 about only helper listed in 30 or main helper in 36.

37. How satisfied are you with —

Very satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied	DK
----------------	--------------------	-----------------------	-------------------	----

a. (Helper's) scheduled hours or availability when you need [him/her]? Would you say very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

7

b. The amount of assistance (helper) provides? (Would you say — (Read categories)?)

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

8

c. (Helper's) willingness to do what you ask? (Would you say — Read categories?)

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

9

d. (Helper's) ability to do what you need [him/her] to do? (Would you say — (Read categories)?)

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

10

If helper is present or related to SP, skip to 38; otherwise, ask:

How satisfied are you with —

e. (Helper's) reliability? (Would you say — (Read categories)?)

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

11

f. (Helper's) trustworthiness? (Would you say — (Read categories)?)

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

12

g. How (helper) treats you? (Would you say — (Read categories)?)

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

13

38a. Including other persons living here, is there a friend, relative, or neighbor who would take care of you for a few DAYS, if necessary?

1 Yes (Go to 38b)
 2 No } (Skip to 40 on page 33)
 9 DK }

14

b. Who is this person?

Probe for description if necessary.

Mark (X) only one.

1 HH member - Related
 2 HH member - Unrelated
 3 Non HH member - Related
 4 Non HH member - Unrelated
 9 DK

15

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

39a. Again, including other persons living here, is there a friend, relative, or neighbor who would take care of you for a few WEEKS, if necessary?	1 <input type="checkbox"/> Yes (Go to 39b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Skip to 40)	16
--	---	----

b. Who is this person? <i>Probe for description if necessary.</i> <i>Mark (X) only one.</i>	1 <input type="checkbox"/> HH member - Related 2 <input type="checkbox"/> HH member - Unrelated 3 <input type="checkbox"/> Non HH member - Related 4 <input type="checkbox"/> Non HH member - Unrelated 9 <input type="checkbox"/> DK	17
--	---	----

40a. [In the past 12 months/In the 12 months prior to moving to this (type of institution)], did you experience problems of any kind because you were home by yourself?	1 <input type="checkbox"/> Yes (Go to 40b) 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK } (Skip to Item H1 on page 34)	18
--	---	----

b. What kind of problems did you have? Anything else? <i>Read categories if necessary.</i> <i>Mark (X) all that apply.</i>	01 <input type="checkbox"/> Fall 02 <input type="checkbox"/> Other accident or injury 03 <input type="checkbox"/> Incontinence - No reminders 04 <input type="checkbox"/> Incontinence - Unable to get to toilet 05 <input type="checkbox"/> Confinement to bed or chairs 06 <input type="checkbox"/> Hunger or thirst 07 <input type="checkbox"/> Fire on stove/left stove on 08 <input type="checkbox"/> Fell asleep while smoking 09 <input type="checkbox"/> Got lost/wandered off 10 <input type="checkbox"/> Forgot medications 11 <input type="checkbox"/> Took wrong dose of medication (too much/little) 12 <input type="checkbox"/> Fear 13 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK	19-20 21-22 23-24 25-26 27-28 29-30 31-32 33-34 35-36 37-38 39-40 41-42 43-44 45-46
---	--	--

Notes

Section H - OTHER SERVICES

ITEM H1	Status of SP.	<input type="checkbox"/> Institutionalized (Skip to Section I on page 39) <input type="checkbox"/> All others (Go to 1)	5																																													
Now I would like to ask about prescription medicines. 1. How many different prescription medicines are you supposed to use? Please count ones you should use each day and those that you use regularly but not every day. Include injections, eye drops, suppositories, creams, ointments, and skin patches, but not vitamins, oxygen, or medicines you get through an IV. <i>Mark (X) only one.</i>		<input type="checkbox"/> None (Skip to 9 on page 35) <input type="checkbox"/> One or two <input type="checkbox"/> Three - five <input type="checkbox"/> Six - nine <input type="checkbox"/> Ten or more <input type="checkbox"/> DK <p style="text-align: right;">} (Go to 2)</p>	6																																													
The next questions are about these prescription medicines. 2. Would you say that you use medicine(s) as prescribed by the doctor — (Read all categories) <i>Mark (X) only one.</i>		<input type="checkbox"/> All of the time, (Skip to 6) <input type="checkbox"/> Most of the time, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Rarely, or, <input type="checkbox"/> Never? <input type="checkbox"/> DK <p style="text-align: right;">} (Go to 3)</p>	7																																													
3. Are there any prescription medicines that you are supposed to use, but — a. did not get when first prescribed because of the cost? b. did not get the entire prescription filled because of the cost? c. did not refill when you ran out because of the cost? d. use less often than prescribed in order to stretch them out because of the cost? e. sometimes forget to use? f. don't use as prescribed because of the side effects? g. cannot pick up from the drug store or get delivered? h. don't use because you think you don't need it?		<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> <td>DK</td> <td></td> </tr> <tr> <td>a.</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 9</td> <td>8</td> </tr> <tr> <td>b.</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 9</td> <td>9</td> </tr> <tr> <td>c.</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 9</td> <td>10</td> </tr> <tr> <td>d.</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 9</td> <td>11</td> </tr> <tr> <td>e.</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 9</td> <td>12</td> </tr> <tr> <td>f.</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 9</td> <td>13</td> </tr> <tr> <td>g.</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 9</td> <td>14</td> </tr> <tr> <td>h.</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 9</td> <td>15</td> </tr> </table>		Yes	No	DK		a.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	8	b.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	9	c.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	10	d.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	11	e.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	12	f.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	13	g.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	14	h.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	15	
	Yes	No	DK																																													
a.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	8																																												
b.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	9																																												
c.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	10																																												
d.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	11																																												
e.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	12																																												
f.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	13																																												
g.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	14																																												
h.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 9	15																																												
4. Have you experienced any problems because you forgot to use your medicine or didn't use your medicine as prescribed?		<input type="checkbox"/> Yes (Go to 5) <input type="checkbox"/> No <input type="checkbox"/> DK } (Skip to 6)	16																																													
5. What problems did you experience? Anything else? <i>Mark (X) all that apply.</i>		<input type="checkbox"/> 01 Pain/Discomfort <input type="checkbox"/> 02 Dizziness/Fainting <input type="checkbox"/> 03 Disorientation <input type="checkbox"/> 04 Overdose/Withdrawal <input type="checkbox"/> 05 Change in blood pressure, breathing, or other vital signs <input type="checkbox"/> 06 Condition for which medicine prescribed got worse <input type="checkbox"/> 07 Other condition(s) got worse <input type="checkbox"/> 08 Had to be admitted to hospital <input type="checkbox"/> 09 Had to go to doctor/emergency room <input type="checkbox"/> 10 Drug reaction <input type="checkbox"/> 11 Other <input type="checkbox"/> 99 DK	17-18 19-20 21-22 23-24 25-26 27-28 29-30 31-32 33-34 35-36 37-38 39-40																																													
6. Do you receive help using your medications? This includes reminding you or measuring the medicines, and setting them up for you, OR do you use ALL of your medicine completely by yourself? <i>Mark (X) only one.</i>		<input type="checkbox"/> Receive help <input type="checkbox"/> All by self <input type="checkbox"/> DK	41																																													
7. Not counting financial help, do you NEED (more) help with your medicine?		<input type="checkbox"/> Yes (Go to 8) <input type="checkbox"/> No <input type="checkbox"/> DK } (Skip to 9 on page 35)	42																																													
8. What do you NEED (more) help with? <i>Mark (X) all that apply.</i>		<input type="checkbox"/> Ordering/Shopping for/Getting medicines from pharmacy <input type="checkbox"/> Reminder/Monitoring/Measuring/Setting up/Taking medicines <input type="checkbox"/> Other <input type="checkbox"/> DK	43 44 45 46																																													

Section H - OTHER SERVICES - Continued

These next questions are about your sources of medical care.

47

9. Do you have a general practitioner, internist, or family doctor whom you see regularly?

- 1 Yes (Go to 10)
- 2 No } (Skip to 14 on page 36)
- 9 DK }

10. Which do you see most often — a general practitioner, an internist, or family doctor?

Mark (X) only one.

- 1 General practitioner
- 2 Internist
- 3 Family doctor
- 4 DK specialty/title
- 9 DK which seen most often

48

11. Have you seen this [(provider in 10)/doctor] in the past 12 months?

- 1 Yes (Go to 12)
- 2 No } (Skip to 13)
- 9 DK }

49

12. In the past 3 months, how many times have you seen this [(provider in 10)/doctor]?

- 00 None
- _____ Times
(Number)
- 99 DK

50-51

13. How would you rate this [(provider in 10)/doctor] in terms of overall quality of care and services? Would you say excellent, good, fair, or poor?

Mark (X) only one.

- 1 Excellent
- 2 Good
- 3 Fair
- 4 Poor
- 9 DK

52

Notes

Section H - OTHER SERVICES - Continued		RT 36 3-4	RT 36 3-4
		A	B
The next questions are about other services you may have received.		1	2
		A visiting nurse	A personal care attendant (other than family or a friend)
14a. During the past 12 months, did you receive any services from _____?		14a.	14a.
		1 <input type="checkbox"/> Yes (Skip to 15) 2 <input type="checkbox"/> No } (Go to 14b) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Skip to 15) 2 <input type="checkbox"/> No } (Go to 14b) 9 <input type="checkbox"/> DK
b. Did you need the services of _____ in the past 12 months?		b.	b.
		1 <input type="checkbox"/> Yes (Skip to 18) 2 <input type="checkbox"/> No } (Go to 14a for next service) 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes (Skip to 18) 2 <input type="checkbox"/> No } (Go to 14a for next service) 9 <input type="checkbox"/> DK
15a. During the past 12 months, in how many months did you receive services from _____?		15a.	15a.
		____ Months (Number) 99 <input type="checkbox"/> DK	____ Months (Number) 99 <input type="checkbox"/> DK
b. What was the total number of times you received services from _____ during [that/those] month(s)?		b.	b.
		____ Times (Number) 99 <input type="checkbox"/> DK	____ Times (Number) 99 <input type="checkbox"/> DK
HAND CARD A1. Read categories if telephone interview.			
16a. Who paid or will pay for the services received from _____ in the past 12 months? (Anyone else?) Mark (X) all that apply.		16a.	16a.
		01 <input type="checkbox"/> Self or family in household 12-13 02 <input type="checkbox"/> Family NOT in household 14-15 03 <input type="checkbox"/> Private health insurance 16-17 04 <input type="checkbox"/> Medicare 18-19 05 <input type="checkbox"/> Medicaid 20-21 06 <input type="checkbox"/> Rehabilitation program 22-23 07 <input type="checkbox"/> Employer 24-25 08 <input type="checkbox"/> School system 26-27 09 <input type="checkbox"/> VA program 28-29 10 <input type="checkbox"/> Other military 30-31 11 <input type="checkbox"/> Other private source 32-33 12 <input type="checkbox"/> Other public source 34-35 13 <input type="checkbox"/> No one/Free } (Skip to 17) 36-37 99 <input type="checkbox"/> DK 38-39	01 <input type="checkbox"/> Self or family in household 12-13 02 <input type="checkbox"/> Family NOT in household 14-15 03 <input type="checkbox"/> Private health insurance 16-17 04 <input type="checkbox"/> Medicare 18-19 05 <input type="checkbox"/> Medicaid 20-21 06 <input type="checkbox"/> Rehabilitation program 22-23 07 <input type="checkbox"/> Employer 24-25 08 <input type="checkbox"/> School system 26-27 09 <input type="checkbox"/> VA program 28-29 10 <input type="checkbox"/> Other military 30-31 11 <input type="checkbox"/> Other private source 32-33 12 <input type="checkbox"/> Other public source 34-35 13 <input type="checkbox"/> No one/Free } (Skip to 17) 36-37 99 <input type="checkbox"/> DK 38-39
b. Who paid most of the cost for the services received from _____ in the past 12 months? Record number of main source. Ask if more than one source in 16a. If only one, transcribe number of box marked without asking.		b.	b.
		<input type="checkbox"/> <input type="checkbox"/> Paid most (Number) 99 <input type="checkbox"/> DK	<input type="checkbox"/> <input type="checkbox"/> Paid most (Number) 99 <input type="checkbox"/> DK
c. During the past 12 months, about how much did you or your family pay for the services received from _____? Do not count any money that has been or will be reimbursed by insurance or any other source. Ask only if box 01 marked in 16a; otherwise, skip to 17.		c.	c.
		00000 <input type="checkbox"/> None 42-46 \$ _____ 00 99999 <input type="checkbox"/> DK	00000 <input type="checkbox"/> None 42-46 \$ _____ 00 99999 <input type="checkbox"/> DK
17. During (month) did you receive services from _____?		17.	17.
		1 <input type="checkbox"/> Yes (Skip to 14a for next service) 2 <input type="checkbox"/> No (Go to 18) 9 <input type="checkbox"/> DK (Skip to 14a for next service)	1 <input type="checkbox"/> Yes (Skip to 14a for next service) 2 <input type="checkbox"/> No (Go to 18) 9 <input type="checkbox"/> DK (Skip to 14a for next service)
HAND CARD A7. Read categories if telephone interview.			
18. Why didn't you receive services from _____ [in (month)] in the past 12 months? (Anything else?) Mark (X) all that apply.		18.	18.
		00 <input type="checkbox"/> Didn't need services 48-49 01 <input type="checkbox"/> Provider thinks no longer needed 50-51 02 <input type="checkbox"/> Too expensive/can't afford 52-53 03 <input type="checkbox"/> Insurance doesn't cover 54-55 04 <input type="checkbox"/> Insurance no longer covers 56-57 05 <input type="checkbox"/> No longer on Medicaid 58-59 06 <input type="checkbox"/> Provider not available 60-61 07 <input type="checkbox"/> Didn't like provider 62-63 08 <input type="checkbox"/> Transportation problems 64-65 09 <input type="checkbox"/> Could not take time off from work 66-67 10 <input type="checkbox"/> Other 68-69 99 <input type="checkbox"/> DK 70-71	00 <input type="checkbox"/> Didn't need services 48-49 01 <input type="checkbox"/> Provider thinks no longer needed 50-51 02 <input type="checkbox"/> Too expensive/can't afford 52-53 03 <input type="checkbox"/> Insurance doesn't cover 54-55 04 <input type="checkbox"/> Insurance no longer covers 56-57 05 <input type="checkbox"/> No longer on Medicaid 58-59 06 <input type="checkbox"/> Provider not available 60-61 07 <input type="checkbox"/> Didn't like provider 62-63 08 <input type="checkbox"/> Transportation problems 64-65 09 <input type="checkbox"/> Could not take time off from work 66-67 10 <input type="checkbox"/> Other 68-69 99 <input type="checkbox"/> DK 70-71

Notes

C		5
3 An adult day care center or day activity center		5
14a.	1 <input type="checkbox"/> Yes (Skip to 15) 2 <input type="checkbox"/> No } (Go to 14b) 9 <input type="checkbox"/> DK }	6
b.	1 <input type="checkbox"/> Yes (Skip to 18) 2 <input type="checkbox"/> No } (Skip to 19 on 9 <input type="checkbox"/> DK } page 38)	7
15a.	____ Months (Number) 99 <input type="checkbox"/> DK	8-9
b.	____ Times (Number) 99 <input type="checkbox"/> DK	10-11
16a.	01 <input type="checkbox"/> Self or family in household	12-13
	02 <input type="checkbox"/> Family NOT in household	14-15
	03 <input type="checkbox"/> Private health insurance	16-17
	04 <input type="checkbox"/> Medicare	18-19
	05 <input type="checkbox"/> Medicaid	20-21
	06 <input type="checkbox"/> Rehabilitation program	22-23
	07 <input type="checkbox"/> Employer	24-25
	08 <input type="checkbox"/> School system	26-27
	09 <input type="checkbox"/> VA program	28-29
	10 <input type="checkbox"/> Other military	30-31
	11 <input type="checkbox"/> Other private source	32-33
	12 <input type="checkbox"/> Other public source	34-35
	13 <input type="checkbox"/> No one/Free } (Skip to 17) 99 <input type="checkbox"/> DK }	36-37 38-39
b.	<input type="text"/> Paid most (Number) 99 <input type="checkbox"/> DK	40-41
c.	00000 <input type="checkbox"/> None \$ <input type="text"/> <input type="text"/> 99999 <input type="checkbox"/> DK	42-46
17.	1 <input type="checkbox"/> Yes (Skip to 19 on page 38) 2 <input type="checkbox"/> No (Go to 18) 9 <input type="checkbox"/> DK (Skip to 19 on page 38)	47
18.	00 <input type="checkbox"/> Didn't need services	48-49
	01 <input type="checkbox"/> Provider thinks no longer needed	50-51
	02 <input type="checkbox"/> Too expensive/can't afford	52-53
	03 <input type="checkbox"/> Insurance doesn't cover	54-55
	04 <input type="checkbox"/> Insurance no longer covers	56-57
	05 <input type="checkbox"/> No longer on Medicaid	58-59
	06 <input type="checkbox"/> Provider not available	60-61
	07 <input type="checkbox"/> Didn't like provider	62-63
	08 <input type="checkbox"/> Transportation problems	64-65
	09 <input type="checkbox"/> Could not take time off from work	66-67
	10 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK	68-69 70-71

Section H - OTHER SERVICES - Continued

19a. Are you currently on a waiting list for services from a visiting nurse, personal care attendant, or an adult day care or day activity center?	1 <input type="checkbox"/> Yes (Go to 19b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } Skip to 20	72
b. For which of these services are you on a waiting list? <i>Read list if necessary.</i> <i>Mark (X) all that apply.</i>	01 <input type="checkbox"/> A visiting nurse 02 <input type="checkbox"/> A personal care attendant, other than family or a friend 03 <input type="checkbox"/> An adult day care center or day activity center 09 <input type="checkbox"/> DK	73-74 75-76 77-78 79-80
20a. Do you NEED help filling out insurance forms or benefit applications? <i>Mark (X) only one.</i>	1 <input type="checkbox"/> Yes } (Go to 20b) 2 <input type="checkbox"/> No } 3 <input type="checkbox"/> Never filled forms/applications (Skip to Section I on page 39) 9 <input type="checkbox"/> DK (Go to 20b)	81
b. Who helps you fill out insurance forms or applications for public programs or benefits? <i>Mark (X) all that apply.</i>	0 <input type="checkbox"/> No one 1 <input type="checkbox"/> Household member 2 <input type="checkbox"/> Friend/Other relative not in household 3 <input type="checkbox"/> Paid caregiver 4 <input type="checkbox"/> Volunteer from organization 5 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK	82 83 84 85 86 87 88

Notes

Section I - FAMILY STRUCTURE, RELATIONSHIPS, AND LIVING ARRANGEMENTS

<p>1. Are you now married, widowed, divorced, separated, or have you never been married?</p> <p><i>If married, probe as necessary to determine if the spouse is a current household member.</i></p> <p><i>Mark (X) only one.</i></p>	<p> <input type="checkbox"/> Married - spouse in HH <input type="checkbox"/> Married - spouse not in HH } (Go to 2a) <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced } (Go to 2b) <input type="checkbox"/> Separated <input type="checkbox"/> Never married } (Skip to Item I1) <input type="checkbox"/> DK </p>
---	---

5

<p>2a. How long have you been married to your current spouse?</p>	<p> <input type="checkbox"/> Less than 1 year _____ Years (Number) <input type="checkbox"/> DK </p>
--	--

6-7

<p>b. How long have you been [widowed/divorced/separated]?</p>	<p> <input type="checkbox"/> Less than 1 year _____ Years (Number) <input type="checkbox"/> DK </p>
---	--

8-9

<p>ITEM I1</p>	<p>Status of SP.</p>	<p> <input type="checkbox"/> Institutionalized (Skip to 5 on page 40) <input type="checkbox"/> All others (Go to 3) </p>
-----------------------	----------------------	---

10

<p>3. Including yourself, how many people altogether live in this household?</p>	<p> <input type="checkbox"/> SP only (Skip to 5 on page 40) _____ Household members (Go to 4) (Number) <input type="checkbox"/> DK (Go to 4) </p>
---	--

11-12

4a. What are the names of all persons living in your household?

Enter SP on line 1, all others on subsequent lines.

If more than 9 household members, continue listing in the Notes space.

b. If necessary, ask: What is (name's) sex?

c. If necessary, ask: How is (name) related TO YOU? Record relationships to the sample person.

RT 38

Line No.	4a. Name (First/Middle initial/Last)	7-57	58	b. Sex	58	c. Relationship to Sample Person	59-60
01				<input type="checkbox"/> M <input type="checkbox"/> F		77 <input type="checkbox"/> SAMPLE PERSON	
02				<input type="checkbox"/> M <input type="checkbox"/> F			
03				<input type="checkbox"/> M <input type="checkbox"/> F			
04				<input type="checkbox"/> M <input type="checkbox"/> F			
05				<input type="checkbox"/> M <input type="checkbox"/> F			
06				<input type="checkbox"/> M <input type="checkbox"/> F			
07				<input type="checkbox"/> M <input type="checkbox"/> F			
08				<input type="checkbox"/> M <input type="checkbox"/> F			
09				<input type="checkbox"/> M <input type="checkbox"/> F			

Section I - FAMILY STRUCTURE, RELATIONSHIPS, AND LIVING ARRANGEMENTS - Continued

3-4

5a. Including step and adopted children, how many LIVING SONS do you have?

00 None
 _____ Sons
 (Number)
 99 DK

5-6

b. Including step and adopted children, how many LIVING DAUGHTERS do you have?

00 None
 _____ Daughters
 (Number)
 99 DK

7-8

ITEM 12

Refer to 5a and 5b.
 (Living children)

1 1+ living children (Go to Item 13)
 2 All others (Skip to Item 14 on page 41)

9

ITEM 13

Refer to question 4 on page 39.
 (Household composition)

1 Any of SP's child(ren) in HH (Skip to 7)
 2 All others (Go to 6)

10

6a. How quickly can [any of your children/your son/your daughter] get here?
 If asked, "Here" means where the SP resides.

_____ { 1 Minutes
 2 Hours
 3 Days
 (Number)
 999 DK

11-13

b. How often do you see [any of your children/your son/your daughter]?

000 Less than once a year/never
 _____ { 1 Per day
 2 Per week
 3 Per month
 4 Per year
 (Times)
 999 DK

14-16

c. How often do you talk on the telephone with [any of your children/your son/your daughter]?

000 Less than once a year/never
 _____ { 1 Per day
 2 Per week
 3 Per month
 4 Per year
 (Times)
 999 DK

17-19

d. How often do you get mail from [any of your children/your son/your daughter]?

000 Less than once a year/never
 _____ { 1 Per day
 2 Per week
 3 Per month
 4 Per year
 (Times)
 999 DK

20-22

7. [Do your children/Does your son/Does your daughter] routinely give you money to help with your living expenses or pay your bills?

1 Yes
 2 No
 9 DK

23

Notes

Section I – FAMILY STRUCTURE, RELATIONSHIPS, AND LIVING ARRANGEMENTS – Continued

ITEM 14	Refer to question 4 on page 39. (Household composition) Mark (X) first appropriate box.	1 <input type="checkbox"/> SP is institutionalized 2 <input type="checkbox"/> SP lives alone 3 <input type="checkbox"/> SP lives w/spouse only 4 <input type="checkbox"/> Other (Go to 8) } (Skip to 11)	24
	8. (Other than your spouse) [is/are any of] the person(s) living with you 18 years of age or older?	1 <input type="checkbox"/> Yes (Go to 9) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Skip to 11)	25
	9. Do you live with [these people/this person] NOW because YOU need to share living expenses?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	26
	10. Do you live with [these people/this person] NOW because of a health or physical problem YOU have?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	27
	11. Including step and adopted brothers, how many LIVING brothers do you have?	00 <input type="checkbox"/> None _____ Brothers (Number) 99 <input type="checkbox"/> DK	28-29
	12. Including step and adopted sisters, how many LIVING sisters do you have?	00 <input type="checkbox"/> None _____ Sisters (Number) 99 <input type="checkbox"/> DK	30-31
	ASK OR VERIFY: 13a. Is your mother still living?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	32
	b. Is your father still living?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	33
ITEM 15	Refer to Item 14. (SP's living arrangement)	1 <input type="checkbox"/> Box 1, 2, or 3 marked (Go to 14) 2 <input type="checkbox"/> Box 4 marked (Skip to 15)	34
	The next few questions are about contact you have with family members (other than your spouse or children). 14a. How quickly can any member of your family (other than your spouse or children) get here? If asked, "Here" means where the SP resides.	000 <input type="checkbox"/> No other family (Skip to Section J on page 42) _____ { 1 <input type="checkbox"/> Minutes (Number) { 2 <input type="checkbox"/> Hours { 3 <input type="checkbox"/> Days 999 <input type="checkbox"/> DK	35-37
	b. How often do you see any member of your family (other than your spouse or children)?	000 <input type="checkbox"/> Less than once a year/Never _____ { 1 <input type="checkbox"/> Per day (Times) { 2 <input type="checkbox"/> Per week { 3 <input type="checkbox"/> Per month { 4 <input type="checkbox"/> Per year 999 <input type="checkbox"/> DK	38-40
	c. How often do you talk on the telephone with any member of your family (other than your spouse or children)?	000 <input type="checkbox"/> Less than once a year/Never _____ { 1 <input type="checkbox"/> Per day (Times) { 2 <input type="checkbox"/> Per week { 3 <input type="checkbox"/> Per month { 4 <input type="checkbox"/> Per year 999 <input type="checkbox"/> DK	41-43
	d. How often do you get mail from any member of your family (other than your spouse or children)?	000 <input type="checkbox"/> Less than once a year/Never _____ { 1 <input type="checkbox"/> Per day (Times) { 2 <input type="checkbox"/> Per week { 3 <input type="checkbox"/> Per month { 4 <input type="checkbox"/> Per year 999 <input type="checkbox"/> DK	44-46
	15. Do any members of your family (other than your spouse or children) routinely give you money to help with your living expenses or pay your bills?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	47

Section J - CONDITIONS AND IMPAIRMENTS

Now I'm going to ask some questions about vision and hearing. Please tell me if you have any of the following conditions, even if you have mentioned them before.

1. Do you NOW have —		Yes	No	DK	
a. Cataracts?	a.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	5
b. Glaucoma?	b.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	6
c. Blindness in both eyes?	c.	1 <input type="checkbox"/> (Skip to 3)	2 <input type="checkbox"/>	9 <input type="checkbox"/>	7
d. Blindness in one eye?	d.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	8
e. Any other trouble seeing with one or both eyes, EVEN when wearing glasses?	e.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	9
2a. Do you use eyeglasses? Include eyeglasses that just magnify.		1 <input type="checkbox"/> Yes (Go to 2b) 2 <input type="checkbox"/> No } (Skip to 2c) 9 <input type="checkbox"/> DK			10
b. Were these eyeglasses prescribed for you?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			11
c. Do you use contact lenses?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			12
3. Have you EVER had an operation for cataracts?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			13
ITEM J1	Refer to 1c above. (Blind in both eyes)	1 <input type="checkbox"/> "Yes" marked in 1c (Skip to 6) 2 <input type="checkbox"/> All others (Go to 4)			14
4. Do you have a lens implant?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			15
5. Do you use a magnifying glass to read or to do other close work?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			16
6. Do you NOW have —		Yes	No	DK	
a. Deafness in both ears?	a.	1 <input type="checkbox"/> (Skip to 7)	2 <input type="checkbox"/>	9 <input type="checkbox"/>	17
b. Deafness in one ear?	b.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	18
c. Any other trouble hearing with one or both ears ?	c.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	19

Notes

Section J - CONDITIONS AND IMPAIRMENTS - Continued

Now I'm going to ask about some other conditions. Again, please tell me if you ever had any of these conditions, even if you have mentioned them before.

Ask all of 7a (1)-(11) before going to 7b-d across.

Ask 7b-d as appropriate for each "Yes" in 7a.

7a. Have you EVER had —

b. In what year [did/was] (condition) first [occur/noticed]?

c. Did a doctor ever tell you that you had (condition)?

d. Do you still have (condition)?

(1) A broken hip?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	20	(1)	21-22		
(2) Osteoporosis?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	23	(2)	24-25	(2)	26
(3) Diabetes?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	27	(3)	28-29	(3)	30
(4) Arthritis?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	32	(4)	33-34	(4)	35
(5) Chronic bronchitis or emphysema?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	36	(5)	37-38	(5)	39
(6) Asthma?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	41	(6)	42-43	(6)	44
(7) Hypertension, sometimes called high blood pressure?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	46	(7)	47-48	(7)	49
(8) Heart disease, including coronary heart disease, angina, heart attack or myocardial infarction?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	51	(8)	52-53	(8)	54
(9) Any other heart disease?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	55	(9)	56-57	(9)	58
(10) A stroke or cerebrovascular accident?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	59	(10)	60-61	(10)	62
(11) Cancer of any kind?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	63	(11)	64-65	(11)	66

ITEM J2	Refer to 7a (11). (Cancer of any kind)	68
		1 <input type="checkbox"/> "Yes" marked in 7a (11) (Go to 8) 2 <input type="checkbox"/> All others (Skip to 9 on page 44)

8. What kind of cancer [is/was] it? (Anything else?)		
Mark (X) all that apply.	01 <input type="checkbox"/> Colon/rectal/bowel	69-70
	02 <input type="checkbox"/> Skin - melanoma	71-72
	03 <input type="checkbox"/> Skin - nonmelanoma	73-74
	04 <input type="checkbox"/> Skin - unknown type	75-76
	05 <input type="checkbox"/> Uterine/ovarian	77-78
	06 <input type="checkbox"/> Prostate	79-80
	07 <input type="checkbox"/> Stomach	81-82
	08 <input type="checkbox"/> Leukemia	83-84
	09 <input type="checkbox"/> Breast	85-86
	10 <input type="checkbox"/> Cervical	87-88
	11 <input type="checkbox"/> Lung	89-90
	12 <input type="checkbox"/> Other	91-92
	99 <input type="checkbox"/> DK	93-94

Section J - CONDITIONS AND IMPAIRMENTS - Continued

9a. Do you sometimes have trouble with dizziness?

- 1 Yes (Go to 9b)
 - 2 No
 - 9 DK
- } (Skip to 10)

95

b. Does dizziness prevent you in any way from doing things you otherwise could do?

- 1 Yes
- 2 No
- 9 DK

96

10. Do you have trouble biting or chewing any kinds of food, such as firm meat or apples?

If asked, this includes while wearing false teeth or dentures.

- 1 Yes
- 2 No
- 9 DK

97

Notes

Section L - COMMUNITY SERVICES

NOTE - Ask 2 immediately after a "Yes" in 1a-f.

READ TO RESPONDENT - The next questions are about community services.

1. [In the past 12 months/In the 12 months prior to coming to this (type of institution)], did you —

2. How often did you use it — frequently, sometimes, or rarely?

a. Use a senior center?

- 1 Yes (Go to 2a)
 2 No } (Go to 1b)
 9 DK

29

a.

- 1 Frequently
 2 Sometimes
 3 Rarely
 9 DK } (Go to 1b)

30

b. Use special transportation for the elderly?

- 1 Yes (Go to 2b)
 2 No } (Go to 1c)
 9 DK

31

b.

- 1 Frequently
 2 Sometimes
 3 Rarely
 9 DK } (Go to 1c)

32

c. Have meals delivered to your home by an agency or organization like Meals on Wheels?

- 1 Yes (Go to 2c)
 2 No } (Go to 1d)
 9 DK

33

c.

- 1 Frequently
 2 Sometimes
 3 Rarely
 9 DK } (Go to 1d)

34

d. Eat meals in a senior center or in some place with a special meal program for the elderly?

- 1 Yes (Go to 2d)
 2 No } (Go to 1e)
 9 DK

35

d.

- 1 Frequently
 2 Sometimes
 3 Rarely
 9 DK } (Go to 1e)

36

e. Use a homemaker service for the elderly that provides services like cleaning and cooking in the home?

- 1 Yes (Go to 2e)
 2 No } (Go to 1f)
 9 DK

37

e.

- 1 Frequently
 2 Sometimes
 3 Rarely
 9 DK } (Go to 1f)

38

f. Use information and referral services?

- 1 Yes (Go to 2f)
 2 No } (Go to
 9 DK } Section M
 on page 47)

39

f.

- 1 Frequently
 2 Sometimes
 3 Rarely
 9 DK } (Go to
 Section M
 on page 47)

40

Notes

Section M - UPDATE CONTACT PERSON INFORMATION

The National Center for Health Statistics may wish to contact you again to obtain additional health related information.

**ITEM
M1**

Refer to CP on label.

- 1 CP on label (Ask 1a)
- 2 No CP on label (Ask 1b)

5

1a. The last time a Census Bureau interviewer talked to you or your family, we were told that (CP on label) will always know how to get in touch with you if we want to contact you again. Is (CP on label) still the best person to contact if we are unable to reach you?

- 1 Yes (Verify CP's address and phone number. If incorrect, enter correct information in 2 below.)
- 2 No (Go to 1b)

6

b. The National Center for Health Statistics would like the name, address, and telephone number of a relative or friend who would know where you could be reached in case we need additional health information in the future but cannot reach you. Please give me the name of someone who is not currently living in the household.

(Record information in 2.)

2. Contact Person current information

Last name 7-26 First name 27-41 MI 42

Number and street 43-67

City 68-87 State 88-89 ZIP Code 90-98

Telephone

Area code 99-101 Number 102-108 None DK 109

- 1 None
- 7 Refused

Notes

Section N - INTERVIEWER OBSERVATIONS

ITEM N1

Mark (X) the one that best represents this interview.

- 1 Self response without assistance (Skip to 3)
- 2 Self response with assistance (Go to 1a)
- 3 Proxy (Skip to 1b)

5

ASK OR VERIFY:

1a. How is (assistant) related to you?

If more than one assistant, indicate the relationship of the one you consider to be the main assistant.

- 00 Parent
 - 01 Spouse
 - 02 Son/Daughter
 - 03 Son-in-law/Daughter-in-law
 - 04 Grandchild/Great grandchild
 - 05 Brother/Sister
 - 06 Brother-in-law/Sister-in-law
 - 07 Aunt/Uncle/Cousin
 - 08 Niece/Nephew
 - 09 Other relative
 - 10 Roommate/Friend/Neighbor
 - 11 Other non-relative
- (Skip to 1c)

6-7

b. How are you related to (sample person)?

If more than one proxy, direct this question to the one you consider to be the main proxy.

- 00 Parent
- 01 Spouse
- 02 Son/Daughter
- 03 Son-in-law/Daughter-in-law
- 04 Grandchild/Great grandchild
- 05 Brother/Sister
- 06 Brother-in-law/Sister-in-law
- 07 Aunt/Uncle/Cousin
- 08 Niece/Nephew
- 09 Other relative
- 10 Roommate/Friend/Neighbor
- 11 Other non-relative

8-9

ASK OR VERIFY:

c. Do(es) [you/assistant] live here?

- 1 Yes
- 2 No
- 9 DK

10

Mark each to indicate why a proxy/assistant was needed.

2a. Sample person hospitalized

- | | | |
|------|--------------------------|----------------------------|
| | Yes | No |
| a. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |

11

b. Sample person institutionalized

- | | | |
|------|--------------------------|----------------------------|
| b. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
|------|--------------------------|----------------------------|

12

c. Sample person's hearing problem

- | | | |
|------|--------------------------|----------------------------|
| c. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
|------|--------------------------|----------------------------|

13

d. Sample person's speech problem

- | | | |
|------|--------------------------|----------------------------|
| d. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
|------|--------------------------|----------------------------|

14

e. Sample person's language problem

- | | | |
|------|--------------------------|----------------------------|
| e. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
|------|--------------------------|----------------------------|

15

f. Sample person's poor memory, senility, or confusion

- | | | |
|------|--------------------------|----------------------------|
| f. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
|------|--------------------------|----------------------------|

16

g. Sample person's Alzheimer's disease

- | | | |
|------|--------------------------|----------------------------|
| g. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
|------|--------------------------|----------------------------|

17

h. Sample person's other mental condition

- | | | |
|------|--------------------------|----------------------------|
| h. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
|------|--------------------------|----------------------------|

18

i. Sample person's other physical illness and/or disability

- | | | |
|------|--------------------------|----------------------------|
| i. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
|------|--------------------------|----------------------------|

19

j. Other non-health related reason

- | | | |
|------|--------------------------|----------------------------|
| j. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> |
|------|--------------------------|----------------------------|

20

The "respondent" in the following items refers to the sample person if he/she answered questions with or without assistance, or to the proxy if the sample person was not interviewed.

3. Do you feel the —

- | | | | |
|--|-----|----|----|
| | Yes | No | DK |
|--|-----|----|----|

a. Respondent was intellectually capable of responding?

- | | | | |
|------|--------------------------|----------------------------|----------------------------|
| a. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> |
|------|--------------------------|----------------------------|----------------------------|

21

b. Respondent's answers were reasonably accurate?

- | | | | |
|------|--------------------------|----------------------------|----------------------------|
| b. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> |
|------|--------------------------|----------------------------|----------------------------|

22

c. Respondent understood the questions?

- | | | | |
|------|--------------------------|----------------------------|----------------------------|
| c. 1 | <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> |
|------|--------------------------|----------------------------|----------------------------|

23

Notes

Notes

Notes