OMB:
EXPIRATION DATE:

MATHEMATICA Policy Research

2011 National Evaluation of Title III-C Nutrition Services Local Service Provider (LSP) Survey

Web Requirements
DRAFT

INTRODUCTION

Thank you for helping us with the National Evaluation of the Title III-C Elderly Nutrition Services. This study will examine how effectively and efficiently the Elderly Nutrition Program helps to keep older Americans healthy and active in their homes and communities. Results of the study will be used to support program planning and guide program practices at various levels of the aging network.

The survey asks about your LSP's characteristics and objectives, staffing, use of technology, program decision processes, and measures used to coordinate with internal staff and other organizations. The questionnaire takes approximately XX minutes to complete.

- If you have any questions regarding the study or completing the Area Agency on Aging survey, please contact Rhoda Cohen at 1-800-232-8024 or email: rcohen@mathematica-mpr.com
- The information you provide will be used only for statistical purposes. In accordance with the Confidential Information Protection and Statistical Efficiency Act of 2002, your responses will not be disclosed in identifiable form without your consent.
- Participation is completely voluntary. We thank you for your cooperation and participation in this very important study.
- If you do not have exact information available to answer certain questions, your best estimate will be fine.

SECTION A. ORGANIZATIONAL STRUCTURE

REQUIRED
ALL

A1. Which of the following services does your organization provide to older adults or their caregivers through a grant or contract with the Area Agency on Aging?

SELECT ALL THAT APPLY

- ☐ Congregate nutrition services 1
- ☐ Home-delivered nutrition service 2
- ☐ Nutrition screening and assessment 3
- ☐ Nutrition education 4
- ☐ Nutrition counseling 5
- ☐ Social activities 6
- ☐ Health promotion and disease prevention activities 7
- ☐ Other non-nutrition services 8
- ☐ Don't know ..... d

SOFT CHECK: IF A1 DNE CONGREGATE NUTRITION SERVICES, SHOW VALIDATION **Your response indicates that your organization does not provide congregate nutrition services. Is this correct?**
SOFT CHECK: IF A1 DNE HOME-DELIVERED NUTRITION SERVICES, SHOW VALIDATION **Your response indicates that your organization does not provide home-delivered nutrition services. Is this correct?**
HARD CHECK: IF A1 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES "OTHER NON-NUTRITION SERVICES." ELSE SKIP TO A3.

A2. Which other non-nutrition services does your organization provide through a grant or contract with the Area Agency on Aging?

SELECT ALL THAT APPLY

- ☐ Housing 1
- ☐ Chore/housekeeping 2
- ☐ Grocery Assistance 3
- ☐ Personal care 4
- ☐ Home health 5
- ☐ Transportation 6
- ☐ Case management 7
- ☐ Other *(specify)* 8

- ☐ Don't know ..... d

HARD CHECK: IF A2 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

A3. Which of the following populations does your organization currently serve through all its programs and services?

SELECT ALL THAT APPLY

- ☐ Adults 60 years and older 1
- ☐ Adults with physical disabilities regardless of age 2
- ☐ Adults with mental retardation or developmental disability regardless of age 3
- ☐ Children with physical disabilities 4
- ☐ Children with mental retardation or developmental disability 5
- ☐ Family caregivers 6
- ☐ Don't know ..... d

HARD CHECK: IF A3 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

A4. Is your organization currently a standalone organization or is it part of another organization?

- ❍ Standalone organization 1
- ❍ Part of another organization 2
- ❍ Don't know ..... d

REQUIRED
ALL

A6. Which of the following best describes the current management structure of your organization?

- ❍ A not-for-profit agency (non-governmental) 1
- ❍ For Profit 2
- ❍ A division of city or county government 3
- ❍ Part of a council of governments or regional planning and development agency 4
- ❍ A Tribal Government entity 5
- ❍ Educational institution 6
- ❍ Other *(specify)* 7

  [ ]

- ❍ Don't know ..... d

REQUIRED
IF A6 DNE "A TRIBAL GOVERNMENT ENTITY"

A7. Is your service area for nutrition near an Older American Act Title VI program for Older Native Americans?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

A8. Is your organization a faith-based organization?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO A11.

A9. Please describe the areas included in your <u>congregate nutrition</u> service area:

SELECT ALL THAT APPLY

- ☐ Urban area 1
- ☐ Suburban area 2
- ☐ Rural area 3
- ☐ Frontier area 4
- ☐ Don't know ..... d

HARD CHECK: IF A9 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES

A10. Which of the following best describes the current boundaries of your <u>congregate nutrition</u> service area?

- ❍ Single county 1
- ❍ Multi-county 2
- ❍ Single city/Metro area 3
- ❍ Multiple city/Metro area 4
- ❍ Other *(Specify)* 5

  [ ]

- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES. ELSE SKIP TO B1.

A11. Please describe the areas included in your <u>home-delivered nutrition</u> service area:

SELECT ALL THAT APPLY

- ☐ Urban area 1
- ☐ Suburban area 2
- ☐ Rural area 3
- ☐ Don't know ..... d

HARD CHECK: IF A11 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES

A12. Which of the following best describes the current boundaries of your <u>home-delivered nutrition</u> service area?

- ❍ Single county 1
- ❍ Multi-county 2
- ❍ Single city/Metro area 3
- ❍ Multiple city/Metro area 4
- ❍ Other *(specify)* 5

  [ ]

- ❍ Don't know ..... d

SECTION B. AGING AND DISABILITY RESOURCE CENTER (ADRC)

REQUIRED
ALL

B1. Currently, is there an Aging and Disability Resource Center (ADRC) in your service area?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF B1 = YES. ELSE SKIP TO C1.

B2. Does your organization receive referrals for nutrition services from the ADRC?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF B1 = YES

B3. Does your organization refer nutrition clients to the ADRC for non-nutrition needs?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

SECTION C. STAFF AND VOLUNTEERS

REQUIRED
ALL

C1. What kinds of tasks are assigned to volunteers for your elderly nutrition services program?

SELECT ALL THAT APPLY

- ☐ Meal production (e.g., prepare or cook food) 1
- ☐ Congregate site meal delivery (e.g., serve meals) 2
- ☐ Congregate site work, non-production (e.g., hostess, table setting, clean-up, re-stock, cashier) 3
- ☐ Home-delivered meal delivery 4
- ☐ Nutrition education or counseling 5
- ☐ Nutrition program management or administration (fund-raising, accounting, human resources) 6
- ☐ Other *(specify)* 7

  [ ]

- ☐ Don't know ..... d

HARD CHECK: IF C1 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

C2. Who are your typical volunteers?

SELECT ALL THAT APPLY

- ☐ Older adults 1
- ☐ Client family members/friends 2
- ☐ Students 3
- ☐ Faith-based organization members 4
- ☐ Civic organization members 5
- ☐ Local business employees 6
- ☐ General public 7
- ☐ Other *(specify)* 7

  [ ]

- ☐ Don't know ..... d

HARD CHECK: IF C2 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO CHECK BEFORE C4

C3. Would your organization continue to provide congregate nutrition services if you had no volunteers?

- ❍ Yes, and at the current level of service provision 1
- ❍ Yes, but at a reduced level of service provision (e.g., close some sites, reduce the number of days of service, reduced number of people served) 2
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME DELIVERED NUTRITION SERVICES. ELSE SKIP TO D1

C4. Would your organization continue to provide home-delivered nutrition services without volunteers?

- ❍ Yes, and at the current level of service provision 1
- ❍ Yes, but at a reduced level of service provision (e.g., reduce service area, reduced frequency of delivery, reduce number of meals per person, reduce number of people served) 2
- ❍ No 0
- ❍ Don't know ..... d

SECTION D. TECHNOLOGY AND DATA

REQUIRED
ALL

D1. Which of the following electronic systems does your organization currently use?

SELECT ALL THAT APPLY

- ☐ Computer-assisted menu planning and analysis 1
- ☐ Software to track inventory or order food 2
- ☐ Delivery systems for home-delivered nutrition (e.g., route mapping software) 3
- ☐ Program participant tracking or referral systems..... 4
- ☐ Electronic client ID card..... 5
- ☐ Electronic system for recording service (the meal) was received 6
- ☐ Financial systems for billing..... 7
- ☐ Financial system for making payments for services..... 8
- ☐ Cost-centered accounting system 9
- ☐ HR/payroll system 10
- ☐ Geographic Information Systems (GIS) 11
- ☐ Other automated system 12
- ☐ No automated systems..... 0
- ☐ Don't know..... d

HARD CHECK: IF D1 = NO AUTOMATED SYSTEMS AND ANY OTHER ANSWER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **"No automated systems" cannot be selected along with other response options.**
HARD CHECK: IF D1 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

SECTION E. PROGRAM RESOURCES

REQUIRED
ALL

E1. **How many of each of the following are rented, owned, or donated for use in your elderly nutrition program?**

Resource	# RENTED	# OWNED	# DONATED/ FREE USE	NOT APPLICABLE	DON'T KNOW
a. Kitchen				n ❍	d ❍
b. Off-site storage (food/supplies)				n ❍	d ❍
c. Delivery vehicles				n ❍	d ❍
d. Vehicle garage/parking facility				n ❍	d ❍
e. Congregate site				n ❍	d ❍

PROGRAMMER: RANGE FOR E1a-e is (0-99)

HARD CHECK: IF E1a-e = NOT APPLICABLE AND NUMBER FIELD IS FILLED, SHOW VALIDATION MESSAGE, **"Not applicable" cannot be selected along with other response options.**

HARD CHECK: IF E1a-e = DON'T KNOW AND NUMBER FIELD IS FILLED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO E3.

E2. **Is your organization responsible for at least some utilities (e.g., electricity) at congregate nutrition sites?**

- ❍ Yes, all sites 1
- ❍ Yes, some sites 2
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

E3. Does your organization pay for at least some utilities (e.g., electricity) at your production sites?

- ❍ Yes, all sites 1
- ❍ Yes, some sites 2
- ❍ No 0
- ❍ Not applicable, we don't have a production site ..... n
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME DELIVERED NUTRITION SERVICES. ELSE SKIP TO E6

E4. How are home-delivered meals delivered to program participants' homes?

SELECT ALL THAT APPLY

- ☐ Drivers use their own vehicles 1
- ☐ Vehicles are provided by our organization 2
- ☐ Other *(specify)* 3

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF E4 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME DELIVERED NUTRITION SERVICES.

E5. Does your organization reimburse home-delivered nutrition program drivers for gas or mileage when using their own vehicles?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

E6. Does your organization provide stipends or other monetary rewards to volunteers (other than gas or mileage)?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

E7. Has your organization reduced or stopped reimbursement of program drivers for gas/mileage when using their own vehicle within the last 3 years?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

E8. Has your organization reduced or stopped providing stipends or other monetary rewards to volunteers within the last 3 years?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

SECTION F. ACCESS TO SERVICES

REQUIRED
ALL

F1. **Is your organization responsible for prioritizing clients (i.e., using characteristics to base decisions for serving some individuals before others when resources are limited) for the elderly nutrition service programs you provide?**

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF F1 = YES. ELSE SKIP TO F4

F2. **Does your organization have specific criteria that you use to prioritize clients in the elderly nutrition service programs you provide?**

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF F2 = YES AND A1 = CONGREGATE NUTRITION AND HOME-DELIVERED NUTRITION. ELSE SKIP TO F4

F3. Which of the following criteria do you currently use for prioritization?

CHARACTERISTIC	CONGREGATE NUTRITION PRIORITIZATION CRITERIA	HOME-DELIVERED NUTRITION PRIORITIZATION CRITERIA
a. ADL cut-off	1 ☐	2 ☐
b. IADL cut-off	1 ☐	2 ☐
c. Lack of informal/family support	1 ☐	2 ☐
d. Geographic isolation	1 ☐	2 ☐
e. Social isolation	1 ☐	2 ☐
f. Chronic health condition	1 ☐	2 ☐
g. Poor housing/lack kitchen access	1 ☐	2 ☐
h. Homebound	1 ☐	2 ☐
i. Racial/ethnic minority	1 ☐	2 ☐
j. Advanced age	1 ☐	2 ☐
k. Low Income	1 ☐	2 ☐
l. Limited English Proficiency	1 ☐	2 ☐
m. Dementia/Cognitive Impairment	1 ☐	2 ☐
n. Food insecure/hungry	1 ☐	2 ☐
o. Nutrition Risk Assessment	1 ☐	2 ☐
p. Adult day care participation	1 ☐	2 ☐
q. Long-term need for service	1 ☐	2 ☐
r. Other *(specify)*	1 ☐	2 ☐

HARD CHECK: IF NO ANSWER CATEGORY IS CHECKED, **At least one response is required.**

REQUIRED
IF F2 = YES AND A1 = CONGREGATE NUTRITION. ELSE SKIP TO F4

F3.1 Which of the following criteria do you currently use for prioritization?

CHARACTERISTIC	CONGREGATE NUTRITION PRIORITIZATION CRITERIA
a. ADL cut-off	1 ☐
b. IADL cut-off	1 ☐
c. Lack of informal/family support	1 ☐
d. Geographic isolation	1 ☐
e. Social isolation	1 ☐
f. Chronic health condition	1 ☐
g. Poor housing/lack kitchen access	1 ☐
h. Homebound	1 ☐
i. Racial/ethnic minority	1 ☐
j. Advanced age	1 ☐
k. Low Income	1 ☐
l. Limited English Proficiency	1 ☐
m. Dementia/Cognitive Impairment	1 ☐
n. Food insecure/hungry	1 ☐
o. Nutrition Risk Assessment	1 ☐
p. Adult day care participation	1 ☐
q. Long-term need for service	1 ☐
r. Other *(specify)*	1 ☐

HARD CHECK: IF NO ANSWER CATEGORY IS CHECKED, **At least one response is required.**

REQUIRED
IF F2 = YES AND A1 = HOME-DELIVERED NUTRITION. ELSE SKIP TO F4

F3.2 Which of the following criteria do you currently use for prioritization?

CHARACTERISTIC	HOME-DELIVERED NUTRITION PRIORITIZATION CRITERIA
a. ADL cut-off	2 ☐
b. IADL cut-off	2 ☐
c. Lack of informal/family support	2 ☐
d. Geographic isolation	2 ☐
e. Social isolation	2 ☐
f. Chronic health condition	2 ☐
g. Poor housing/lack kitchen access	2 ☐
h. Homebound	2 ☐
i. Racial/ethnic minority	2 ☐
j. Advanced age	2 ☐
k. Low Income	2 ☐
l. Limited English Proficiency	2 ☐
m. Dementia/Cognitive Impairment	2 ☐
n. Food insecure/hungry	2 ☐
o. Nutrition Risk Assessment	2 ☐
p. Adult day care participation	2 ☐
q. Long-term need for service	2 ☐
r. Other *(specify)*	2 ☐
☐	

HARD CHECK: IF NO ANSWER CATEGORY IS CHECKED, **At least one response is required.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES

F4. What method is used by participants to access congregate nutrition services?

SELECT ALL THAT APPLY

- ☐ Pre-approval mechanism 1
- ☐ Participants sign-up ahead/make a reservation 2
- ☐ First come, first served at site 3
- ☐ Other *(specify)* 4

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF F4 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO F6

F5. Does your organization provide transportation directly or arrange transportation services (such as free or low cost cabs, vans, or buses) for clients of the congregate nutrition program?

SELECT ALL THAT APPLY

- ☐ Organization directly provides transportation 1
- ☐ Organization arranges transportation services 2
- ☐ Transportation available through other entity 3
- ☐ Participant arranges for their own transportation 4
- ☐ Don't know ..... d

HARD CHECK: IF F5 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES. ELSE SKIP TO G1.

F6. Who authorizes home-delivered nutrition services for a new client?

SELECT ALL THAT APPLY

- ☐ Your organization authorizes clients to receive services using funding that includes Older Americans Act funds 1
- ☐ The Area Agency on Aging authorizes clients to receive service using funding that includes OAA funds 2
- ☐ Other authorizing system *(specify)* 3

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF F6 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

F7. Please identify the three (3) sources that provided the most referrals for the home-delivered nutrition program during your most recently completed fiscal year?

SELECT ALL THAT APPLY

- ☐ Family/Friends 1
- ☐ Hospital/health care facility/discharge planner 2
- ☐ Nursing homes 3
- ☐ Physician 4
- ☐ Case management system 5
- ☐ Aging and Disability Resource Center 6
- ☐ Information and Assistance system 7
- ☐ Medicaid waiver 8
- ☐ Other food or nutrition program 9
- ☐ Faith-based organizations 10
- ☐ Other *(specify)* 11

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF F7 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**
HARD CHECK: IF RESPONDENT CHECKS LT 3 SELECTIONS FROM LIST, SHOW VALIDATION MESSAGE, **You have selected fewer than three sources. Please select the three sources that provided the most referrals for the home-delivered nutrition program**.
HARD CHECK: IF RESPONDENT CHECKS GT 3 SELECTIONS FROM LIST, SHOW VALIDATION MESSAGE, **You have selected more than three sources. Please select the three sources that provided the most referrals for the home-delivered nutrition program.**

SECTION G. WAITING LISTS

REQUIRED
IF A1 = CONGREGATE NUTRITION AND HOME-DELIVERED NUTRITION

G1. Does your organization currently maintain waiting lists for the congregate nutrition or home-delivered nutrition programs?

MAINTAINS WAITING LIST FOR CONGREGATE NUTRITION PROGRAM			MAINTAINS WAITING LIST FOR HOME-DELIVERED NUTRITION PROGRAM		
YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
1 ❍	0 ❍	d ❍	1 ❍	0 ❍	d ❍

REQUIRED
IF A1 = CONGREGATE NUTRITION

G1.1 Does your organization currently maintain a waiting list for the congregate nutrition program?

MAINTAINS WAITING LIST FOR CONGREGATE NUTRITION PROGRAM		
YES	NO	DON'T KNOW
1 ❍	0 ❍	d ❍

REQUIRED
IF A1 = HOME-DELIVERED NUTRITION

G1.2 Does your organization currently maintain a waiting list for the home-delivered nutrition program?

MAINTAINS WAITING LIST FOR HOME-DELIVERED NUTRITION PROGRAM		
YES	NO	DON'T KNOW
1 ❍	0 ❍	d ❍

REQUIRED
IF G1 = YES FOR CONGREGATE NUTRITION AND G1 = YES FOR HOME-DELIVERED NUTRITION. ELSE SKIP TO H1.

G2. What is the current waiting list policy for congregate and home-delivered nutrition?

	CONGREGATE NUTRITION	HOME-DELIVERED NUTRITION
a. The waiting list contains everyone who requested service without screening for service eligibility or need, ordered by date of request	1 ❍	1 ❍
b. The waiting list contains everyone who is screened eligible for services on a first-come first-served basis	2 ❍	2 ❍
c. The waiting list contains everyone who is screened eligible and in priority order (by priority criteria)	3 ❍	3 ❍
d. Other *(specify)* ☐	4 ❍	4 ❍
e. There is no waiting list policy	5 ❍	5 ❍
f. Don't know	d ❍	d ❍

REQUIRED
IF G1.1 = YES FOR CONGREGATE NUTRITION. ELSE SKIP TO H1.

G2.1 What is the current waiting list policy for congregate nutrition?

	CONGREGATE NUTRITION
a. The waiting list contains everyone who requested service without screening for service eligibility or need, ordered by date of request	1 ❍
b. The waiting list contains everyone who is screened eligible for services on a first-come first-served basis	2 ❍
c. The waiting list contains everyone who is screened eligible and in priority order (by priority criteria)	3 ❍
d. Other *(specify)* ☐	4 ❍
e. There is no waiting list policy	5 ❍
f. Don't know	d ❍

REQUIRED
IF G1.2 = YES FOR HOME-DELIVERED NUTRITION. ELSE SKIP TO H1.

G2.2 What is the current waiting list policy for home-delivered nutrition?

	HOME-DELIVERED NUTRITION
a. The waiting list contains everyone who requested service without screening for service eligibility or need, ordered by date of request	1 ❍
b. The waiting list contains everyone who is screened eligible for services on a first-come first-served basis	2 ❍
c. The waiting list contains everyone who is screened eligible and in priority order (by priority criteria)	3 ❍
d. Other *(specify)* ☐	4 ❍
e. There is no waiting list policy	5 ❍
f. Don't know	d ❍

SECTION H. REFERRALS AND NEEDS ASSESSMENTS

REQUIRED
A1 = CONGREGATE NUTRITION AND HOME DELIVERED NUTRITION

H1. Does your organization currently have a formal process for assessing service needs for elderly nutrition program participants (e.g., transportation, SNAP, housing, etc.)?

Service Type	NUTRITION NEEDS			NON-NUTRITION NEEDS		
	YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
Congregate nutrition	1 ❍	0 ❍	d ❍	1 ❍	0 ❍	d ❍
Home-delivered nutrition	1 ❍	0 ❍	d ❍	1 ❍	0 ❍	d ❍

REQUIRED
A1 = CONGREGATE NUTRITION

H1.1 Does your organization currently have a formal process for assessing service needs for elderly nutrition program participants (e.g., transportation, SNAP, housing, etc.)?

Service Type	NUTRITION NEEDS			NON-NUTRITION NEEDS		
	YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
Congregate nutrition	1 ❍	0 ❍	d ❍	1 ❍	0 ❍	d ❍

REQUIRED
A1 = HOME-DELIVERED NUTRITION

H1.2 Does your organization currently have a formal process for assessing service needs for elderly nutrition program participants (e.g., transportation, SNAP, housing, etc.)?

Service Type	NUTRITION NEEDS			NON-NUTRITION NEEDS		
	YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
Home-delivered nutrition	1 ❍	0 ❍	d ❍	1 ❍	0 ❍	d ❍

REQUIRED
IF H1 = DON'T KNOW FOR NUTRITION NEEDS AND NON-NUTRITION NEEDS, SKIP TO H3.

H2. How often are elderly nutrition program participants re-assessed for service needs (both nutrition and non-nutrition services)?

	Congregate nutrition program participants	Home-delivered nutrition program participants
No policy (frequency determined by staff)	1 ❍	1 ❍
At least yearly (1 or more assessments per year)	2 ❍	2 ❍
Less than once per year	3 ❍	3 ❍
After acute care episode (hospital, ER visit)	4 ❍	4 ❍
Other *(specify)*		
Don't know	d ❍	d ❍

REQUIRED
IF H1.1 = DON'T KNOW FOR NUTRITION NEEDS AND NON-NUTRITION NEEDS, SKIP TO H3.

H2.1 How often are elderly nutrition program participants re-assessed for service needs (both nutrition and non-nutrition services)?

	Congregate nutrition program participants
No policy (frequency determined by staff)	1 ❍
At least yearly (1 or more assessments per year)	2 ❍
Less than once per year	3 ❍
After acute care episode (hospital, ER visit)	4 ❍
Other *(specify)*	
Don't know	d ❍

REQUIRED
IF H1.2 = DON'T KNOW FOR NUTRITION NEEDS AND NON-NUTRITION NEEDS, SKIP TO H3.

H2.2 How often are elderly nutrition program participants re-assessed for service needs (both nutrition and non-nutrition services)?

	Home-delivered nutrition program participants
No policy (frequency determined by staff)	1 ❍
At least yearly (1 or more assessments per year)	2 ❍
Less than once per year	3 ❍
After acute care episode (hospital, ER visit)	4 ❍
Other *(specify)*	
Don't know	d ❍

REQUIRED
IF A1 = CONGREGATE NUTRITION AND HOME-DELIVERED NUTRITION

H3. Currently, which of the following services does your organization actively assist elderly nutrition program participants to access? Active assistance involves more than providing reading materials and brochures.

SELECT ALL THAT APPLY

Service	Congregate nutrition program participant assistance	Home-delivered nutrition program participant assistance
a. Medicaid Waiver Programs	1 ☐	2 ☐
b. Medicaid (non-waiver)	1 ☐	2 ☐
c. Medicare Parts A or B	1 ☐	2 ☐
d. Medicare Part D	1 ☐	2 ☐
e. Housing Programs	1 ☐	2 ☐
f. Transportation Services	1 ☐	2 ☐
g. Low Income Home Energy Assistance Program	1 ☐	2 ☐
h. Supplemental Security Income	1 ☐	2 ☐
i. Other supportive services (chore, homemaker)	1 ☐	2 ☐
j. SNAP (Food Stamps)	1 ☐	2 ☐
k. Other food or nutrition services (food pantry)	1 ☐	2 ☐
l. Veterans Affairs services	1 ☐	2 ☐
m. Adult Protective Services	1 ☐	2 ☐
n. Evidence-based health promotion and disease prevention programs	1 ☐	2 ☐
o. Other *(specify)*	1 ☐	2 ☐
p. Do not provide this type of assistance	1 ☐	2 ☐

HARD CHECK: IF H3p = CONGREGATE AND ANY H3a-o = CONGREGATE, SHOW VALIDATION MESSAGE, **The response "do not provide this type of assistance" cannot be selected along with other response options.**
HARD CHECK: I IF H3p = HOME-DELIVERED AND ANY H3a-o = HOME-DELIVERED, SHOW VALIDATION MESSAGE, **The response "do not provide this type of assistance" cannot be selected along with other response options.**
HARD CHECK: AT LEAST ONE RESPONSE MUST BE SELECTED, **At least one response must be selected.**

REQUIRED
IF A1 = CONGREGATE NUTRITION.

H3.1 **Currently, which of the following services does your organization actively assist elderly nutrition program participants to access? Active assistance involves more than providing reading materials and brochures.**

Service	SELECT ALL THAT APPLY Congregate nutrition program participant assistance
a. Medicaid Waiver Programs	1 ☐
b. Medicaid (non-waiver)	1 ☐
c. Medicare Parts A or B	1 ☐
d. Medicare Part D	1 ☐
e. Housing Programs	1 ☐
f. Transportation Services	1 ☐
g. Low Income Home Energy Assistance Program	1 ☐
h. Supplemental Security Income	1 ☐
i. Other supportive services (chore, homemaker)	1 ☐
j. SNAP (Food Stamps)	1 ☐
k. Other food or nutrition services (food pantry)	1 ☐
l. Veterans Affairs services	1 ☐
m. Adult Protective Services	1 ☐
n. Evidence-based health promotion and disease prevention programs	1 ☐
o. Other *(specify)*	1 ☐
p. Do not provide this type of assistance	1 ☐

HARD CHECK: IF H3p = CONGREGATE AND ANY H3a-o = CONGREGATE, SHOW VALIDATION MESSAGE, **The response "do not provide this type of assistance" cannot be selected along with other response options.**
HARD CHECK: AT LEAST ONE RESPONSE MUST BE SELECTED, **At least one response must be selected.**

REQUIRED
IF A1 = HOME-DELIVERED NUTRITION.

H3. Currently, which of the following services does your organization actively assist elderly nutrition program participants to access? Active assistance involves more than providing reading materials and brochures.

Service	SELECT ALL THAT APPLY Home-delivered nutrition program participant assistance
a. Medicaid Waiver Programs	1 ☐
b. Medicaid (non-waiver)	1 ☐
c. Medicare Parts A or B	1 ☐
d. Medicare Part D	1 ☐
e. Housing Programs	1 ☐
f. Transportation Services	1 ☐
g. Low Income Home Energy Assistance Program	1 ☐
h. Supplemental Security Income	1 ☐
i. Other supportive services (chore, homemaker)	1 ☐
j. SNAP (Food Stamps)	1 ☐
k. Other food or nutrition services (food pantry)	1 ☐
l. Veterans Affairs services	1 ☐
m. Adult Protective Services	1 ☐
n. Evidence-based health promotion and disease prevention programs	1 ☐
o. Other *(specify)*	1 ☐
p. Do not provide this type of assistance	1 ☐

HARD CHECK: AT LEAST ONE RESPONSE MUST BE SELECTED, **At least one response must be selected.**
HARD CHECK: I IF H3p = HOME-DELIVERED AND ANY H3a-o = HOME-DELIVERED, SHOW VALIDATION MESSAGE, **The response "do not provide this type of assistance" cannot be selected along with other response options.**

REQUIRED
IF SUM OF SELECTIONS FROM H3, H3.1, or H3.2 IS GE 3. ELSE, SKIP TO I1.

H4. **Please identify the three (3) most common programs or services that your organization refers elderly nutrition program participants.**

MARK ONLY THREE

PROGRAMMER: DISPLAY ALL CHECKED SELECTIONS FROM H3, H3.1, or H3.2.

HARD CHECK: IF RESPONDENT CHECKS LT 3 OR GE 4 SELECTIONS FROM LIST, SHOW VALIDATION MESSAGE, **Please select the three most common programs or services.**

REQUIRED
IF ANY H3, H3.1, H3.2

H5. **Is follow-up done on active referrals?**

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

SECTION I. NUTRITION SERVICE OPERATION AND QUALITY ASSURANCE

REQUIRED
ALL

I1. Which of the following does your organization currently use to contribute to the <u>nutrient quality of meals</u>?

SELECT ALL THAT APPLY

- ☐ Computer-assisted menu analysis 1
- ☐ Meal patterns 2
- ☐ Use of dietician or state credentialed nutrition professional 3
- ☐ Area Agency on Aging guidance 4
- ☐ State Unit on Aging guidance 5
- ☐ Older Americans Act guidance 6
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: IF I1 = NONE OF THE ABOVE AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE **The response "none of the above" cannot be selected along with other response options.**
HARD CHECK: IF I1 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected along with other response options.**

REQUIRED
ALL

I2. Which of the following does your organization currently use to contribute to the <u>overall food service quality provided by your organization, caterers, or vendors</u>?

SELECT ALL THAT APPLY

- ☐ Food service license/safety inspections 1
- ☐ Training of staff 2
- ☐ Survey of program participants 3
- ☐ Program participant feedback mechanism (comment box/card, complaint mechanism, etc.) 4
- ☐ Regularly scheduled site visits either to production location and/or service location 5
- ☐ Visit to home of home-delivered nutrition client 6
- ☐ Program participant advisory/menu committee 7
- ☐ Food quality specifications 8
- ☐ Use of dietician or state credentialed nutrition professional 7
- ☐ Area Agency on Aging guidance 9
- ☐ State Unit on Aging guidance 10
- ☐ Older Americans Act guidance 11
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: IF I2 = NONE OF THE ABOVE AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE **The response "none of the above" cannot be selected along with other response options.**
HARD CHECK: IF I2 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected along with other response options.**

SECTION J. EMERGENCY PLANNING

REQUIRED
ALL

J1. Does your organization currently have an emergency plan that includes providing nutrition services?

SELECT ALL THAT APPLY

- ☐ Yes, for short-term emergencies 1
- ☐ Yes, for long-term emergencies 2
- ☐ No 0
- ☐ Don't know ..... d

REQUIRED
ALL

J2. Has your organization experienced a disaster (natural or manmade) in the past 3 years?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF J2 = YES. ELSE, SKIP TO K1.

J3. During the disaster did you organization initiate an emergency plan?

- ❍ Yes 1
- ❍ No 0
- ❍ Did not have an emergency plan at the time 3
- ❍ Don't know ..... d

REQUIRED
IF J3 = YES

J4. Please rate the effectiveness of the emergency plan.

- ❍ Very effective 1
- ❍ Effective 2
- ❍ Somewhat effective 3
- ❍ Not very effective 4
- ❍ Not effective 5
- ❍ Don't know ..... d

SECTION K. PARTNERSHIP DEVELOPMENT

REQUIRED
ALL

K1. Please mark all of your partners for the Elderly Nutrition Program during your most recently completed fiscal year.

SELECT ALL THAT APPLY

- ☐ Hospitals, nursing facilities, including discharge planning and emergency room care 1
- ☐ Home health agencies 2
- ☐ Transportation (public services – county/municipal) 3
- ☐ Medicare 4
- ☐ Medicaid (Non-waiver) 5
- ☐ Medicaid Waiver 6
- ☐ Veterans Affairs 7
- ☐ Social Security 8
- ☐ Public housing and related services, including senior housing 9
- ☐ Homeless shelters 10
- ☐ SNAP (Food Stamps)/SNAP Ed (Food Stamp Nutrition Education) 11
- ☐ Senior Farmers Market 12
- ☐ Other food and nutrition programs (e.g. Commodity Supplemental Nutrition Program, emergency food service programs including food banks and pantries) 13
- ☐ Title VI (Native American) program 14
- ☐ Other Older Americans Act programs 15
- ☐ Aging and Disability Resource Center 16
- ☐ Non OAA funded Meals on Wheels 17
- ☐ Community health centers 18
- ☐ Public health services 19
- ☐ City or county social services agency 20
- ☐ City or county regional planning office 21
- ☐ County/City/Local Public service providers such as EMS, police/fire departments 22
- ☐ Elder Abuse Prevention programs or Adult Protective Services (APS) 23
- ☐ Legal Services for older adults 24
- ☐ Energy assistance (LIHEAP) 25
- ☐ Churches, Synagogues, Mosques, Faith-based organizations 26
- ☐ College or university 27
- ☐ Volunteer Bureaus/organizations 28
- ☐ Civic Organization 29
- ☐ Local business *(specify the type)* 30

- ☐ Other *(specify)* 31

REQUIRED
IF GT 5 SELECTIONS FOR K1. ELSE, GO TO K3

K2. **Among your Elderly Nutrition Program partners during the last fiscal year, please mark the <u>five most important</u>.**

MARK ONLY FIVE

PROGRAMMER: DISPLAY ALL CHECKED SELECTIONS FROM K1. IF RESPONDENT CHECKED “Local business” or “Other”, ALSO DISPLAY TEXT IN “Specify” FIELD.

HARD CHECK: IF RESPONDENT CHECKS GT FIVE SELECTIONS FROM LIST, SHOW VALIDATION MESSAGE, “You have selected more than five partners. Please select your five most important partners.”

REQUIRED
ALL

K3. For each partnership listed, please indicate which activities you <u>jointly</u> engaged in for the Elderly Nutrition Program during your most recently completed fiscal year.

PROGRAMMER: IF MORE THAN 5 SELECTIONS FOR K1, FILL PARTNERSHIP NAME WITH CHECKED SELECTIONS FROM K2. ELSE, FILL PARTNERSHIP NAMES FROM K1 [MAY BE LESS THAN 5].

	[Partnership 1 Name]	[Partnership 2 Name]	[Partnership 3 Name]	[Partnership 4 Name]	[Partnership 5 Name]
a. Fundraising	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Shared resources	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Advocacy	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. Strategic planning	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
e. Public education	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
f. Referrals	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
g. Senior activities	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
h. Service delivery	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
i. Shared outreach	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
j. Targeting special populations	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
k. Training/technical assistance	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
l. Volunteer recruitment or retention	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
m. None of the above	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Don't know	d ☐	d ☐	d ☐	d ☐	d ☐

REQUIRED
IF PARTNERSHIPS LISTED FOR K3 NE "Title VI (Native American) program". ELSE, GO TO L1.

K4. What are the major areas in which your organization collaborated with Title VI programs during your most recently completed fiscal year?

SELECT ALL THAT APPLY

- ☐ Fundraising 1
- ☐ Shared resources 2
- ☐ Advocacy 3
- ☐ Strategic planning 4
- ☐ Public education 5
- ☐ Referrals 6
- ☐ Senior activities 7
- ☐ Service delivery 8
- ☐ Meal production 9
- ☐ Shared outreach 10
- ☐ Targeting special populations 11
- ☐ Training/technical assistance 12
- ☐ Volunteer recruitment or retention 13
- ☐ Other *(specify)* 14

- ☐ Don't collaborate with Title VI programs 15
- ☐ Don't know ..... d

HARD CHECK: IF K4 = DON'T COLLABORATE WITH TITLE VI PROGRAMS AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **The response "don't collaborate with Title VI programs" cannot be selected with other response options.**
HARD CHECK: IF K4 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected along with other response options.**

SECTION L. PRIVATE PAY/FEE-FOR-SERVICE AND MEDICAID WAIVER

The next series of questions are about private pay/fee-for-service and Medicaid waiver participation.

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO L6.

L1. Does your organization have a private pay/fee-for-service meal program in the congregate nutrition program?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF L1 = YES. ELSE SKIP TO L6.

L2. How is the private pay/fee-for-service program's meal price calculated in the congregate nutrition program?

- ❍ Cost-reimbursement 1
- ❍ Fair market value 2
- ❍ Other 3
- ❍ Don't know ..... d

REQUIRED
IF L1 = YES

L3. What is the average price of the private pay/fee-for-service lunch meal in the congregate nutrition program?

[ ] PRICE OF PRIVATE PAY MEAL (0-99.99)

- ☐ Don't know

SOFT CHECK: IF L3 GT 20.00, SHOW VALIDATION, **You indicated an average price over $20. Is this correct?**
HARD CHECK: IF L3 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF L1 = YES

L4. **Are OAA clients in the congregate nutrition program offered the same meal as private pay/fee-for-service customers?**

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF L1 = YES

L5. **Is the private pay/fee-for-service meal offered at the same site as the congregate meal?**

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES. ELSE SKIP TO L8.

L6. **Does your organization have a private pay/fee-for-service meal program in the home-delivered nutrition program?**

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF L6 = YES. ELSE SKIP TO L8.

L7. **How is the private pay/fee-for-service program's meal price calculated in the home-delivered nutrition program?**

- ❍ Cost-reimbursement 1
- ❍ Fair market value 2
- ❍ Other 3
- ❍ Don't know ..... d

REQUIRED
IF L6 = YES

L7a. What is the average price of the private pay/fee-for-service meal in the home-delivered nutrition program?

[ ] PRICE OF PRIVATE PAY MEAL (0-99.99)

☐ Don't know

SOFT CHECK: IF L7a GT 20.00, SHOW VALIDATION, **You indicated an average price over $20. Is this correct?**
HARD CHECK: IF L7a = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF L6 = YES

L7b. Are OAA clients in the home-delivered nutrition program offered the same meal as private pay/fee-for-service customers?

❍ Yes 1

❍ No 0

❍ Don't know ..... d

REQUIRED
ALL

L8. Is your organization a provider of Medicaid nutrition services to the elderly?

SELECT ALL THAT APPLY

☐ Yes, we are a provider of Medicaid waiver nutrition services to the elderly 1

☐ Yes, we are a provider of non-waiver Medicaid nutrition services to the elderly 2

☐ No, we do not provide Medicaid waiver or non-waiver nutrition services to the elderly 0

☐ Don't know ..... d

HARD CHECK: IF L8 = DON'T KNOW and any other answer category is selected, **"Don't know" cannot be selected along with other response options.**

SECTION M. NUTRITION EDUCATION AND NUTRITION COUNSELING

The next series of questions are about nutrition education and nutrition counseling services that your organization may provide.

REQUIRED

IF A1 INCLUDES CONGREGATE NUTRITION SERVICE

M1. **How many congregate nutrition sites operated by your organization currently provide <u>nutrition education (i.e. presented in a group setting)</u> to eligible program participants? The nutrition education may be offered by your organization or coordinated with another organization.**

☐ SITES (0-999)

☐ Don't know ..... d

HARD CHECK: IF M1 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED

IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICE

M2. **Currently, what is the availability of <u>nutrition education</u> for home-delivered nutrition program participants? The nutrition education may be offered by your organization or coordinated with another organization.**

❍ Available throughout your service area 1

❍ Available in a portion of your service area 2

❍ Not available in your service area 3

❍ Don't know ..... d

REQUIRED
IF M1 GE 1

M3. How often is nutrition education provided to program participants by your organization or coordinated with another organization?

	CONGREGATE NUTRITION PROGRAM PARTICIPANTS
a. Yearly (1 session per year)	1 ❍
b. Twice per year (2 sessions per year)	1 ❍
c. Quarterly (4 sessions per year)	1 ❍
d. Monthly (12 sessions per year)	1 ❍
e. More than monthly (12+ sessions per year)	1 ❍
f. Other *(specify)*	1 ❍
Don't know	d ❍

REQUIRED
IF M2 = 1 OR 2

M3.1 How often is nutrition education provided to program participants by your organization or coordinated with another organization?

	HOME-DELIVERED NUTRITION PROGRAM PARTICIPANTS
a. Yearly (1 session per year)	2 ❍
b. Twice per year (2 sessions per year)	2 ❍
c. Quarterly (4 sessions per year)	2 ❍
d. Monthly (12 sessions per year)	2 ❍
e. More than monthly (12+ sessions per year)	2 ❍
f. Other *(specify)*	2 ❍
Don't know	d ❍

REQUIRED
IF M1 GE 1 OR M2 = 1 OR 2

M4. Which of the following does your organization currently use to contribute to the quality of <u>nutrition education</u>?

SELECT ALL THAT APPLY

- ☐ Use credentialed nutrition professional to conduct education 1
- ☐ Conduct a survey of program participant need 2
- ☐ Use evidence-based education programs 3
- ☐ Use cooperative extension materials 4
- ☐ Use curricula from a reliable, science-based organization (academia, government, American Heart Association, American Diabetic Association) 5
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: IF M4 = NONE OF THE ABOVE AND ANY OTHER ANSWER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **"None of the above" cannot be selected along with other response options.**
HARD CHECK: IF M4 = DON'T KNOW and any other answer category is selected, **"Don't know" cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICE

M5. **How many of your congregate nutrition sites currently provide <u>nutrition counseling</u> (i.e. working one-on-one with an individual provide support for dietary issues) to eligible program participants? The nutrition counseling may be offered by your organization or coordinated with another organization.**

[ ] SITES (0-999)

☐ Don't know ..... d

HARD CHECK: IF M5 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICE

M6. **Currently, what is the availability of <u>nutrition counseling</u> for home-delivered nutrition program participants? The nutrition counseling may be offered by your organization or coordinated with another organization.**

❍ Available throughout your service area 1

❍ Available in a portion of your service area 2

❍ Not available in your service area 3

❍ Don't know ..... d

REQUIRED
IF M5 GT 0 OR M6 = AVAILABLE THROUGHOUT YOUR SERVICE AREA OR AVAILABLE IN A PORTION OF YOUR SERVICE AREA. ELSE, SKIP TO SECTION N.

M7. **How is the current need for <u>nutrition counseling</u> determined?**

SELECT ALL THAT APPLY

☐ Nutrition needs assessment 1

☐ Nutrition Screening Initiative (NSI) score 2

☐ Presence of nutrition related chronic disease 3

☐ Food insecurity assessment 4

☐ Other criteria 5

☐ Don't know ..... d

HARD CHECK: IF M7 = DK AND OTHER CATEGORY IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected along with other response options.**

REQUIRED
IF M5 GT 0 OR M6 = AVAILABLE THROUGHOUT YOUR SERVICE AREA OR AVAILABLE IN A PORTION OF YOUR SERVICE AREA.

M8. Which of the following does your organization currently use to contribute to the quality of nutrition counseling?

SELECT ALL THAT APPLY

- ☐ Use credentialed nutrition professional to conduct the counseling 1
- ☐ Use credentialed non-nutrition professionals (e.g., nurses, diabetes educators, etc.) 2
- ☐ Use protocols approved by a respected source such as the American Dietetic Association, Patient Education Association, or Association of Diabetic Educators 3
- ☐ None of the above 4
- ☐ Don't know ..... d

HARD CHECK: IF M8 = NONE OF THE ABOVE AND ANY OTHER ANSWER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **"None of the above" cannot be selected along with other response options.**
HARD CHECK: IF M8 = DON'T KNOW and any other answer category is selected, **"Don't know" cannot be selected along with other response options.**

REQUIRED
IF M5 GT 0 OR M6 = AVAILABLE THROUGHOUT YOUR SERVICE AREA OR AVAILABLE IN A PORTION OF YOUR SERVICE AREA.

M9. How frequently is the need for nutrition counseling assessed with elderly nutrition program participants?

SELECT ALL THAT APPLY

- ☐ At program enrollment/entry only 1
- ☐ On a regular basis (e.g., annually) *(specify)* 2

  [ ]
- ☐ When staff notice a change in the participant 3
- ☐ Program participant/caregiver/family request 4
- ☐ Healthcare professional request 5
- ☐ Other *(specify)* 6

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF M9 = DON'T KNOW and any other answer category is selected, **"Don't know" cannot be selected along with other response options.**

REQUIRED
IF M5 GT 0 OR M6 = AVAILABLE THROUGHOUT YOUR SERVICE AREA OR AVAILABLE IN A PORTION OF YOUR SERVICE AREA.

M10. Does your organization have a formal mechanism for following-up with program participants who have had nutrition counseling?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

N. TITLE III-C ELDERLY NUTRITION PROGRAM CONGREGATE NUTRITION CHARACTERISTICS AND OPERATIONS

The next series of questions are about the characteristics and operations of the congregate nutrition program operated by your organization.

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO O1.

N1. For how many years has your organization offered congregate nutrition services?

☐ YEARS ***(0-99)***

☐ Don't know ..... d

HARD CHECK: IF N1 GT 99 SHOW VALIDATION MESSAGE, **The number of years must be between 0 and 99.**
HARD CHECK: IF N1 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N2. How many different congregate nutrition sites does your organization currently operate?

☐ NUMBER OF CONGREGATE NUTRITION SITES ***(0-999)***

☐ Don't know ..... d

SOFT CHECK: IF N2 = 0, SHOW VALIDATION MESSAGE, **You have indicated that your organization currently operates 0 congregate nutrition sites. Is this correct?**
SOFT CHECK: **I**F GT 100, SHOW VALIDATION MESSAGE, **You have indicated that your organization operates more than 100 congregate nutrition sites. Is this correct?**
HARD CHECK: IF N2 GT 999 SHOW VALIDATION MESSAGE, **The number of sites cannot be greater than 999.**
HARD CHECK: IF N2 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N3. How many different congregate nutrition sites offer meals…

	NUMBER OF CONGREGATE NUTRITION SITES	DON'T KNOW
a. more than 5 days per week	☐ *(0-999)*	d ❍
b. only 5 days per week	☐ *(0-999)*	d ❍
c. only 4 days per week	☐ *(0-999)*	d ❍
d. only 3 days per week	☐ *(0-999)*	d ❍
e. only 2 days per week	☐ *(0-999)*	d ❍
f. only 1 day per week	☐ *(0-999)*	d ❍

HARD CHECK: IF SUM OF N3a-e GT NUMBER OF CONGREGATE NUTRITION SITES FROM N2, SHOW VALIDATION MESSAGE, **The total cannot be more than the number of sites your organization operates.**
HARD CHECK: IF N3a-e = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N4. How many different congregate nutrition sites offer…

	NUMBER OF CONGREGATE NUTRITION SITES	DON'T KNOW
a. breakfast	☐ *(0-999)*	d ❍
b. lunch	☐ *(0-999)*	d ❍
c. dinner	☐ *(0-999)*	d ❍

HARD CHECK: IF N4a-c GT NUMBER OF CONGREGATE NUTRITION SITES FROM N2, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of sites your organization operates.**
HARD CHECK: IF N4a-c = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N5. How many different congregate nutrition sites offer meals on weekends?

☐ NUMBER OF CONGREGATE NUTRITION SITES *(0-999)*

☐ Don't know ..... d

HARD CHECK: IF N5 GT NUMBER OF CONGREGATE NUTRITION SITES FROM N2, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of sites your organization operates.**
HARD CHECK: IF N5 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N6. **How many different congregate nutrition sites meet the Americans with Disabilities Act standards for accessible design?**

	NUMBER OF CONGREGATE NUTRITION SITES ***(0-999)***

☐ Don't know ..... d

HARD CHECK: IF N6 GT NUMBER OF CONGREGATE NUTRITION SITES FROM N2, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of sites your organization operates.**
HARD CHECK: IF N6 GT 999 SHOW VALIDATION MESSAGE, **The number of congregate nutrition sites cannot be greater than 999.**
HARD CHECK: IF N6 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N7. **How many total individuals <u>can</u> your organization serve at one lunch meal in the congregate nutrition program? Please include all congregate nutrition sites and calculate the maximum number of lunches that can be served in one sitting if all sites are open and operating.**

	MAXIMUM NUMBER OF INDIVIDUALS ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF N7 GT 1000 SHOW VALIDATION MESSAGE, **You entered a number greater than 1,000. Is this correct?**
HARD CHECK: IF N7 GT 9999 SHOW VALIDATION MESSAGE, **The number of individuals who can be served cannot be greater than 9,999.**
HARD CHECK: IF N7 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N7a. **How many individuals <u>can</u> your largest congregate nutrition site serve at one lunch meal?**

☐ MAXIMUM NUMBER OF INDIVIDUALS ***(0-9999)***

☐ Don't know ..... d

HARD CHECK: IF N7a GT NUMBER OF INDIVIDUALS FROM N7, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of individuals your organization can serve.**
HARD CHECK: IF n7a GT 999 SHOW VALIDATION MESSAGE, **The number of individuals who can be served cannot be greater than 999.**
HARD CHECK: IF N7a = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N7b. **How many individuals <u>can</u> your smallest congregate nutrition site serve at one lunch meal?**

☐ MAXIMUM NUMBER OF INDIVIDUALS ***(0-9999)***

☐ Don't know ..... d

HARD CHECK: IF N7b GT NUMBER OF INDIVIDUALS FROM N7, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of individuals your organization can serve.**
HARD CHECK: IF N7b GT 999 SHOW VALIDATION MESSAGE, **The number of individuals who can be served cannot be greater than 999.**
HARD CHECK: IF N7b = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N8. How many <u>total lunches</u> did your organization serve last week?

☐ NUMBER OF LUNCHES ***(0-999999)***

☐ Don't know ..... d

HARD CHECK: IF N8 GT NUMBER OF INDIVIDUALS FROM N7, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of individuals your organization can serve.**
HARD CHECK: IF N8 GT 999,999 SHOW VALIDATION MESSAGE, **The number of individuals who can be served cannot be greater than 999,999.**
HARD CHECK: IF N8 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N9. How many of your agency's elderly congregate nutrition sites have closed, opened, reduced or expanded in the last 3 years?

	NUMBER OF SITES	DON'T KNOW
a. number of sites that have closed.....	☐ *(0-999)*	d ❍
b. number of sites that have reduced service (fewer days open, fewer meals served)	☐ *(0-999)*	d ❍
c. number of sites that have opened	☐ *(0-999)*	d ❍
d. number of sites that have expanded service (more days open, more meals served).....	☐ *(0-999)*	d ❍

SOFT CHECK: IF N9b GT 100 SHOW VALIDATION MESSAGE, **You entered a number greater than 100. Is this correct?**
SOFT CHECK: IF N9d GT 100 SHOW VALIDATION MESSAGE, **You entered a number greater than 100. Is this correct?**
HARD CHECK: IF N9b GT 999 SHOW VALIDATION MESSAGE, **The number of sites cannot be greater than 999.**
HARD CHECK: IF N9d GT 999 SHOW VALIDATION MESSAGE, **The number of sites cannot be greater than 999.**
HARD CHECK: IF N9a GT 99 SHOW VALIDATION MESSAGE, **The number of sites cannot be greater than 99.**
HARD CHECK: IF N9c GT 99 SHOW VALIDATION MESSAGE, **The number of sites cannot be greater than 99.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N10. Which of the following methods are used for meal production in your congregate nutrition sites?

SERVICE TYPE	USED IN ANY CONGREGATE NUTRITION SITES?		
	YES	NO	DON'T KNOW
a. Central kitchen	1 ❍	0 ❍	d ❍
b. On-site production	1 ❍	0 ❍	d ❍
c. Catering/vendor contract	1 ❍	0 ❍	d ❍
d. Restaurant vouchers	1 ❍	0 ❍	d ❍

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N11. Which of the following best describes the menu provided by your congregate nutrition program?

- ❍ Set menu that does not offer the participant any choice of food items 1
- ❍ Choice of different complete meal options (ex. Meal A or Meal B) 2
- ❍ A choice of different food items within the meal (ex. Choice of entrée, choice of vegetables, fruit, dessert, salad bar) 3
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N12. Are any sites that offer congregate nutrition services operated for specific populations, religious, cultural or ethnic groups (e.g., Somali, Chinese, Buddhist, or Orthodox Jewish communities)?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N13. Which of the following special or therapeutic diets does your organization offer in the congregate nutriton program?

SELECT ALL THAT APPLY

- ☐ Diabetic 1
- ☐ Low sodium/salt 2
- ☐ Modified texture 3
- ☐ Vegetarian 4
- ☐ Kosher 5
- ☐ Halal 6
- ☐ Do not offer special or therapeutic diets 7
- ☐ Other *(specify)* 8

- ☐ Don't know ..... d

HARD CHECK: IF N13 = Do not offer special or therapeutic diets AND ANY OTHER ANSWER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **"Do not offer special or therapeutic diets" cannot be selected along with other response options.**
HARD CHECK: IF N13 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N14. What is the recommended contribution for congregate nutrition program participants for a single meal?

RECOMMENDED CONTRIBUTION ***(0-9.99)***

- ☐ No dollar amount is recommended 0
- ☐ Don't know ..... d

HARD CHECK: IF N14 GT 9.99, SHOW VALIDATION, **The recommended contribution cannot be greater than $9.99.**
HARD CHECK: IF N14 = NO DOLLAR AMOUNT IS RECOMMENDED and any other answer category is selected, **"No dollar amount is recommended" cannot be selected along with other response options.**
HARD CHECK: IF N14 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF G1 = YES FOR CONGREGATE NUTRITION PROGRAM

N15. How many people are currently on the waiting list for the congregate nutrition program?

[ ] PEOPLE ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF LT 1, SHOW VALIDATION MESSAGE, **You have indicated that there are currently 0 people on the waiting list. Is this correct?**
SOFT CHECK: IF GT 1000, SHOW VALIDATION MESSAGE, **You have indicated that there are currently more than 1000 people on the waiting list. Is this correct?**
HARD CHECK: IF GT 9999, SHOW VALIDATION MESSAGE, **The number of people on the waiting list cannot be greater than 9999.**
HARD CHECK: IF N15 = DK AND NUMBER IS ENTERED SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
IF N15 GE 1. ELSE SKIP TO SECTION O.

N16. What is the longest time a person has been on the current congregate nutrition program waiting list in your service area?

[ ] DAYS/WEEKS/MONTHS/YEARS [DROP DOWN BOX]

☐ Don't know ..... d

SOFT CHECK: IF GT 5 YEARS, SHOW VALIDATION MESSAGE, **You have indicated that the longest time a person has been on the current waiting list is more than 5 years. Is this correct?**
HARD CHECK: IF LT 1 DAY OR GT 10 YEARS, SHOW VALIDATION MESSAGE, **The length of time on the waiting list must be between 1 day and 10 years.**
HARD CHECK: IF NUMBER FIELD IS FILLED BUT DROP DOWN IS NOT SELECTED, SHOW VALIDATION MESSAGE, **Please select days, weeks, months or years from the drop down menu.**
HARD CHECK: IF N16 = DK AND NUMBER IS ENTERED SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
IF G1 = YES FOR CONGREGATE NUTRITION PROGRAM

N17. On average, how often is the waiting list for the congregate nutrition program checked for duplicates and those no longer eligible or in need and then updated?

- ❍ Weekly 1
- ❍ Monthly 2
- ❍ Quarterly 3
- ❍ Semi-annually 4
- ❍ Yearly 5
- ❍ Never 0
- ❍ Other (SPECIFY) 6

- ❍ Don't know ..... d

SECTION O. TITLE III-C ELDERLY NUTRITION PROGRAM HOME-DELIVERED NUTRITION CHARACTERISTICS AND OPERATIONS

The next series of questions are about the characteristics and operations of the home-delivered nutrition program operated by your organization.

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES. ELSE SKIP TO SECTION P.

O1. For how many years has your organization offered home-delivered nutrition services?

☐ YEARS ***(0-99)***

☐ Don't know ..... d

HARD CHECK: IF O1 GT 99 SHOW VALIDATION MESSAGE, **The number of years must be between 0 and 99.**
HARD CHECK: IF O1 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O2. Which meals does your organization provide in home-delivered nutrition services?

SELECT ALL THAT APPLY

☐ Breakfast 1

☐ Lunch 2

☐ Dinner 3

☐ Don't know ..... d

HARD CHECK: IF O2 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O3. How many clients can your organization provide meals to through home-delivered nutrition services for a single meal?

☐ MAXIMUM NUMBER OF CLIENTS ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF O3 GT 1,000 SHOW VALIDATION MESSAGE, **You entered a number greater than 1,000. Is this correct?**
HARD CHECK: IF O3 GT 9999 SHOW VALIDATION MESSAGE, **The number of individuals who can be served cannot be greater than 9,999.**
HARD CHECK: IF O3 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be** selected **if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O3a. On an average day when your organization makes deliveries, how many clients receive meals through home-delivered nutrition services for a single meal?

☐ NUMBER OF CLIENTS SERVED ON AN AVERAGE DAY ***(0-9999)***

☐ Don't know ..... d

HARD CHECK: IF O3a GT NUMBER OF INDIVIDUALS FROM O3, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of individuals your organization can serve.**
HARD CHECK: IF O3a = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O4. How many days per week are meal deliveries made to clients' homes?

☐ NUMBER OF DAYS PER WEEK ***(0-7)***

☐ Don't know ..... d

HARD CHECK: IF O4 GT 7, SHOW VALIDATION MESSAGE, **The number of days per week cannot be greater than seven.**
HARD CHECK: IF O4 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O4a. How many meals are usually provided to a client at each visit?

[ ] NUMBER OF MEALS PROVIDED AT ONE VISIT ***(1-99)***

☐ Don't know ..... d

HARD CHECK: IF O4a LT 1 OR GT 99, SHOW VALIDATION MESSAGE, **Please enter a number between 1 and 99.**
HARD CHECK: IF O4a = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O4b. Are meal deliveries made to clients' homes on the weekends?

❍ Yes 1
❍ No 0
❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O5. How many of the following types of meals were delivered in your most recently completed week in the home-delivered nutrition program?

	NUMBER OF MEALS	DON'T KNOW
a. Hot meals	☐ *(0-999)*	d ❍
b. Frozen meals	☐ *(0-999)*	d ❍
c. Cold meals	☐ *(0-999)*	d ❍
d. Shelf stable meals	☐ *(0-999)*	d ❍
e. Combination	☐ *(0-999)*	d ❍
f. Other *(specify)* ☐	☐ *(0-999)*	d ❍

HARD CHECK: IF O5a-f = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O6. What is the total mileage on the longest route for which your organization provides home-delivered nutrition services?

☐ MILES *(0-9.99)*

☐ Don't know ..... d

HARD CHECK: IF O6 GT 999, SHOW VALIDATION MESSAGE, **The total mileage must be less than 1000.**

HARD CHECK: IF O6 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O6a. What is the total mileage on the shortest route for which your organization provides home-delivered nutrition services?

☐ MILES ***(0-9.99)***

☐ Don't know ..... d

HARD CHECK: IF O6a GT 999, SHOW VALIDATION MESSAGE, **The total mileage must be less than 1000.**
HARD CHECK: IF O6a = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O7. Have you increased or started using frozen meals in your home-delivered nutrition program <u>in the last 3 years</u>?

❍ Yes 1
❍ No 0
❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O8. Which of the following changes has your agency's home-delivered nutrition program experienced <u>in the last 3 years</u>?

SELECT ALL THAT APPLY

☐ Service area has been reduced 1
☐ Frequency of meal delivery has been reduced 2
☐ Number of meals delivered per customer has been reduced 3
☐ Service area has been expanded 4
☐ Frequency of meal delivery has been increased 5
☐ Number of meals served per customer has been increased 6
☐ None of the above 0
☐ Don't know ..... d

HARD CHECK: IF O8 = NONE OF THE ABOVE AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **"None of the above" cannot be selected along with other response options.**
HARD CHECK: IF O8 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O9. Which of the following methods are used for meal production in your home-delivered nutrition program?

Service Type	USED FOR MEAL PRODUCTION IN HOME-DELIVERED NUTRITION PROGRAM?		
	YES	NO	DON'T KNOW
a. Central kitchen	1 ❍	0 ❍	d ❍
b. On-site production (e.g., CM site)	1 ❍	0 ❍	d ❍
c. Catering/vendor contract including restaurants	1 ❍	0 ❍	d ❍

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O10. Which of the following best describes the menu provided by your home-delivered nutrition program?

- ❍ Set menu that does not offer the participant any choice of food items 1
- ❍ Choice of different complete meal options (ex. Meal A or Meal B) 2
- ❍ A choice of different food items within the meal (ex. Choice of entrée, choice of vegetables, fruit, dessert) 3
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O11. Which of the following special or therapeutic diets does your organization offer in the home-delivered nutriton program?

SELECT ALL THAT APPLY

- ☐ Diabetic 1
- ☐ Low sodium/salt 2
- ☐ Modified texture 3
- ☐ Vegetarian 4
- ☐ Kosher 5
- ☐ Halal 6
- ☐ Other *(specify)* 7

- ☐ Do not offer special or therapeutic diets 0
- ☐ Don't know ..... d

HARD CHECK: IF O11 = DO NOT OFFER SPECIAL OR THERAPEUTIC DIETS and any other answer category is selected, **"Do not offer special or therapeutic diets" cannot be selected along with other response options.**
HARD CHECK: IF O11 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O12. What is the recommended contribution for home-delivered nutrition program participants?

[ ] RECOMMENDED CONTRIBUTION ***(0-9.99)***

☐ No dollar amount is recommended.....0

☐ Don't know.....d

HARD CHECK: IF O12 GT 9.99, SHOW VALIDATION, **The recommended contribution cannot be greater than $9.99.**
HARD CHECK: IF O12 = NO DOLLAR AMOUNT IS RECOMMENDED and any other answer category is selected, **"No dollar amount is recommended" cannot be selected along with other response options.**
HARD CHECK: IF O12 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF G1 = YES FOR HOME-DELIVERED NUTRITION PROGRAM

O13. How many people are currently on the waiting list for the home-delivered nutrition program in your service area?

[ ] PEOPLE ***(0-999)***

☐ Don't know.....d

SOFT CHECK: IF LT 1, SHOW VALIDATION MESSAGE, **You have indicated that there are currently 0 people on the waiting list. Is this correct?**
SOFT CHECK: IF GT 1000, SHOW VALIDATION MESSAGE, **You have indicated that there are currently more than 1000 people on the waiting list. Is this correct?**
HARD CHECK: IF GT 9999, SHOW VALIDATION MESSAGE, **The number of people on the waiting list cannot be greater than 9,999.**
HARD CHECK: IF O13 = DK AND NUMBER IS ENTERED SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
IF O13 GE 1. ELSE SKIP TO SECTION P.

O14. What is the longest time a person has been on the current home-delivered nutrition program waiting list in your service area?

☐ DAYS/WEEKS/MONTHS/YEARS [DROP DOWN BOX]

☐ Don't know ..... d

SOFT CHECK: IF GT 5 YEARS, SHOW VALIDATION MESSAGE, **You have indicated that the longest time a person has been on the current waiting list is more than 5 years. Is this correct?**
HARD CHECK: IF LT 1 DAY OR GT 10 YEARS, SHOW VALIDATION MESSAGE, **The length of time on the waiting list must be between 1 day and 10 years.**
HARD CHECK: IF NUMBER FIELD IS FILLED BUT DROP DOWN IS NOT SELECTED, SHOW VALIDATION MESSAGE, **Please select days, weeks, months or years from the drop down menu.**
HARD CHECK: IF O14 = DK AND NUMBER IS ENTERED SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
IF G1 = YES FOR HOME-DELIVERED NUTRITION PROGRAM

O15. On average, how often is the waiting list for the home-delivered nutrition program checked for duplicates and those no longer eligible or in need and then updated?

❍ Weekly 1

❍ Monthly 2

❍ Quarterly 3

❍ Semiannually 4

❍ Yearly 5

❍ Never 0

❍ Other *(specify)* 6

❍ Don't know ..... d

SECTION P. FOOD SAFETY

REQUIRED
ALL

P1. Does your organization or caterer currently have a food service license for its production facilities?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

P2. Are the food service personnel for the Elderly Nutrition Program in your service area currently required to have food safety and sanitation training?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

P3. To which of the following entities is your organization currently required to report food borne illness incidents in the Elderly Nutrition Program?

SELECT ALL THAT APPLY

- ☐ AAA 1
- ☐ State Unit on Aging 2
- ☐ State or Local Department of Health 3
- ☐ Other 4
- ☐ No requirement to report food borne illness 0
- ☐ Don't know ..... d

HARD CHECK: IF P3 = No requirement to report food borne illness AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE **The response "No requirement to report food borne illness" cannot be selected along with other response options.**
HARD CHECK: IF P3 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO P6.

P4. **In the past 3 years, how many different times was the food served in the congregate nutrition program associated with an outbreak of food borne illness?**

☐ TIMES ***(0-99)***

☐ Don't know ..... d

SOFT CHECK: IF GT 50, SHOW VALIDATION MESSAGE **You have indicated that food served in the congregate nutrition program was associated with an outbreak of food borne illness more than 50 times in the last 3 years. Is this correct?**
HARD CHECK: IF GT 99, SHOW VALIDATION MESSAGE **The number of times food served in the congregate nutrition program was associated with an outbreak of food borne illness in the past 3 years cannot be greater than 99.**
HARD CHECK: IF P4 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF P4 GT 0

P5. **In total, how many program participants got sick in the past 3 years?**

☐ PROGRAM PARTICIPANTS ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF GT 1000, SHOW VALIDATION MESSAGE **You have indicated that more than 1000 program participants got sick in the past 3 years. Is this correct?**
HARD CHECK: IF GT 9999, SHOW VALIDATION MESSAGE **The number of program participants who got sick in the past 3 years cannot be greater than 9,999.**
HARD CHECK: IF P4 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES. ELSE SKIP TO Q1.

P6. **In the past 3 years, how many different times was food served in the home-delivered nutrition program associated with an outbreak of food borne illness?**

[ ] TIMES ***(0-99)***

☐ Don't know ..... d

SOFT CHECK: IF GT 50, SHOW VALIDATION MESSAGE **You have indicated that food served in the home-delivered nutrition program was associated with an outbreak of food borne illness more than 50 times in the last 3 years. Is this correct?**
HARD CHECK: IF GT 99, SHOW VALIDATION MESSAGE **The number of times food served in the home-delivered nutrition program was associated with an outbreak of food borne illness in the past 3 years cannot be greater than 99.**
HARD CHECK: IF P6 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

REQUIRED
IF P6 GT 0

P7. **In total, how many program participants got sick in the past 3 years?**

[ ] PROGRAM PARTICIPANTS ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF GT 1000, SHOW VALIDATION MESSAGE **You have indicated that more than 1000 program participants got sick in the past 3 years. Is this correct?**
HARD CHECK: IF GT 9999, SHOW VALIDATION MESSAGE **The number of program participants who got sick in the past 3 years cannot be greater than 9,999.**
HARD CHECK: IF P7 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **"Don't know" cannot be selected if a number is entered.**

SECTION Q. CONTACT INFORMATION

Q1. Please provide contact information for the person who completed this questionnaire.

REQUIRED
ALL

Contact First Name	
Contact Last Name	
Title or Role in local service provider organization	
Email Address	
Telephone Number	

HARD CHECK: IF TELEPHONE IS LT OR GT 10 DIGITS, SHOW VALIDATION **Please enter a valid telephone number**
HARD CHECK: IF EMAIL ADDRESS DOES NOT CONTAIN "@" and "." SHOW VALIDATION MESSAGE, **Please enter a valid email address.**

THANK YOU FOR COMPLETING THIS SURVEY. WE VALUE YOUR PARTICIPATION.