

Section G – 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>SHOW MEDICARE CARD.</p> | | 5 |
| <p>1a. In (month), were you covered by Medicare?</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>Read categories if necessary.</p> <p>Mark (X) only one.</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> | 6 |
| <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> | | 7 |
| <p>2a. In (month), were you covered by MEDICAID or (state name)?</p> | <p>1 <input type="checkbox"/> Yes (Go to 3) 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>Read categories if necessary.</p> <p>Mark (X) only one.</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> | 8 |
| <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>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> | 9 |
| <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>1 <input type="checkbox"/> Yes (Go to 4b) 2 <input type="checkbox"/> No } (Skip to 5) 9 <input type="checkbox"/> DK }</p> | 10 |
| <p>b. Was this CHAMPUS, or CHAMP-VA?</p> <p>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.</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> | 11 |
| <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>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> | 12 |
| <p>5. In (month), were you covered by the Indian Health Service?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> | 13 |
| <p>6a. (Not counting the government health programs we just mentioned), in (month), were you covered by a private health insurance plan?</p> <p>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.</p> | <p>1 <input type="checkbox"/> Yes (Go to 6b) 2 <input type="checkbox"/> No } (Skip to Section H on page 35) 9 <input type="checkbox"/> DK }</p> | 14 |
| <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>Mark (X) only one.</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> | 15 |

RT 56
3-4

Section H - 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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK | 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable 9 <input type="checkbox"/> DK | 00 <input type="checkbox"/> Less than 1 year 99 <input type="checkbox"/> DK _____ Number of years |
| b. Walking up 10 steps without resting? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK | 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable 9 <input type="checkbox"/> DK | 00 <input type="checkbox"/> Less than 1 year 99 <input type="checkbox"/> DK _____ Number of years |
| c. Standing or being on your feet for about 2 hours? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK | 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable 9 <input type="checkbox"/> DK | 00 <input type="checkbox"/> Less than 1 year 99 <input type="checkbox"/> DK _____ Number of years |
| d. Sitting for about 2 hours? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK | 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable 9 <input type="checkbox"/> DK | 00 <input type="checkbox"/> Less than 1 year 99 <input type="checkbox"/> DK _____ Number of years |
| e. Stooping, crouching, or kneeling? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK | 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable 9 <input type="checkbox"/> DK | 00 <input type="checkbox"/> Less than 1 year 99 <input type="checkbox"/> DK _____ Number of years |
| f. Reaching up over your head? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK | 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable 9 <input type="checkbox"/> DK | 00 <input type="checkbox"/> Less than 1 year 99 <input type="checkbox"/> DK _____ Number of years |
| g. Reaching out (as if to shake someone's hand)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK | 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable 9 <input type="checkbox"/> DK | 00 <input type="checkbox"/> Less than 1 year 99 <input type="checkbox"/> DK _____ Number of years |
| h. Using your fingers to grasp or handle? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK | 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable 9 <input type="checkbox"/> DK | 00 <input type="checkbox"/> Less than 1 year 99 <input type="checkbox"/> DK _____ Number of years |
| i. Lifting or carrying something as heavy as 25 pounds, (such as two full bags of groceries)? 1 <input type="checkbox"/> Yes (Go to j) 2 <input type="checkbox"/> No (Skip to 2) 9 <input type="checkbox"/> NA/DK (Go to j) | 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable 9 <input type="checkbox"/> DK | 00 <input type="checkbox"/> Less than 1 year 99 <input type="checkbox"/> DK _____ Number of years |
| j. Lifting or carrying something as heavy as 10 pounds? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK | 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable 9 <input type="checkbox"/> DK | 00 <input type="checkbox"/> Less than 1 year 99 <input type="checkbox"/> DK _____ Number of years |

Notes

Section H – 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) RT 57 3-4 | (B) RT 58 3-4 | (C) RT 59 3-4 |
|--|-----|---|---|---|
| | | Bathing or showering? | Dressing? | Eating? |
| <p>4. Because of a health or physical problem, do you have ANY difficulty —</p> <p>Ask if "Doesn't do": Is this because of a HEALTH or PHYSICAL problem? If "Yes", mark box 1; if "No" mark box 3.</p> | 4. | <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> | 4. | <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> |
| | | 5 | 5 | 5 |
| ITEM H1 | | <p>Refer to question 4.</p> <p>1 <input type="checkbox"/> "Yes" marked (Go to 5)</p> <p>2 <input type="checkbox"/> All other (Go to H1 for next activity)</p> | <p>Refer to question 4.</p> <p>1 <input type="checkbox"/> "Yes" marked (Go to 5)</p> <p>2 <input type="checkbox"/> All other (Go to H1 for next activity)</p> | <p>Refer to question 4.</p> <p>1 <input type="checkbox"/> "Yes" marked (Go to 5)</p> <p>2 <input type="checkbox"/> All other (Go to H1 for next activity)</p> |
| | H1 | 6 | 6 | 6 |
| <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> | 5. | <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 (H1 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 6)</p> | 5. | <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 (H1 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 6)</p> |
| | | 7 | 7 | 7 |
| <p>6. When you DO NOT HAVE HELP OR USE SPECIAL EQUIPMENT, is (activity) by yourself —</p> <p>(1) Very tiring?</p> <p>(2) Does (activity) take a long time?</p> <p>(3) Is it very painful?</p> | 6. | <p>0 <input type="checkbox"/> Never do without help or special equipment (H1 for next activity)</p> | 6. | <p>0 <input type="checkbox"/> Never do without help or special equipment (H1 for next activity)</p> |
| | (1) | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> | (1) | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> |
| | (2) | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> | (2) | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> |
| | (3) | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>(Go to H1 for next activity)</p> | (3) | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>(Go to H1 for next activity)</p> |
| | 8 | 8 | 8 | 8 |
| | 9 | 9 | 9 | 9 |
| | 10 | 10 | 10 | 10 |
| | 11 | 11 | 11 | 11 |
| ITEM H2 | | <p>Refer to question 4.</p> <p>1 <input type="checkbox"/> Box 3 marked (H2 for next activity)</p> <p>2 <input type="checkbox"/> All other (Go to 7)</p> | <p>Refer to question 4.</p> <p>1 <input type="checkbox"/> Box 3 marked (H2 for next activity)</p> <p>2 <input type="checkbox"/> All other (Go to 7)</p> | <p>Refer to question 4.</p> <p>1 <input type="checkbox"/> Box 3 marked (H2 for next activity)</p> <p>2 <input type="checkbox"/> All other (Go to 7)</p> |
| | H2 | 12 | 12 | 12 |
| <p>7a. Do you use any special equipment or aids in (activity)?</p> | 7a. | <p>1 <input type="checkbox"/> Yes (Go to 7b)</p> <p>2 <input type="checkbox"/> No (H2 for next activity)</p> | 7a. | <p>1 <input type="checkbox"/> Yes (Go to 7b)</p> <p>2 <input type="checkbox"/> No (H2 for next activity)</p> |
| | | 13 | 13 | 13 |
| <p>b. What special equipment or aids do you use?</p> <p>Anything else?</p> <p>Mark (X) all that apply.</p> | b. | <p>1 <input type="checkbox"/> Stool, seat or chair</p> <p>2 <input type="checkbox"/> Handbar or rail</p> <p>3 <input type="checkbox"/> Other</p> <p>9 <input type="checkbox"/> DK</p> | b. | <p>1 <input type="checkbox"/> Special clothes</p> <p>2 <input type="checkbox"/> Special fasteners</p> <p>3 <input type="checkbox"/> Cord, string, zipper pull</p> <p>4 <input type="checkbox"/> Orthopedic shoes</p> <p>5 <input type="checkbox"/> Other</p> <p>9 <input type="checkbox"/> DK</p> |
| | | 14 | 14 | 14 |
| | | 15 | 15 | 15 |
| | | 16 | 16 | 16 |
| | | 17 | 17 | 17 |
| <p>c. When you USE SPECIAL EQUIPMENT AND DO NOT HAVE HELP, is (activity) —</p> <p>(1) Very tiring?</p> <p>(2) Does (activity) take a long time?</p> <p>(3) Is it very painful?</p> | c. | <p>0 <input type="checkbox"/> Never do without help (Go to H2 for next activity)</p> | c. | <p>0 <input type="checkbox"/> Never do without help (Go to H2 for next activity)</p> |
| | (1) | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> | (1) | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> |
| | (2) | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> | (2) | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> |
| | (3) | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>(Go to H2 for next activity)</p> | (3) | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>(Go to H2 for next activity)</p> |
| | 18 | 18 | 18 | 18 |
| | 19 | 19 | 19 | 19 |
| | 20 | 20 | 20 | 20 |
| | 21 | 21 | 21 | 21 |
| | 22 | 22 | 22 | 22 |
| | 23 | 23 | 23 | 23 |

Section H - ASSISTANCE WITH KEY ACTIVITIES - Continued

| (D) RT 60 3-4 | | (E) RT 61 3-4 | | (F) RT 62 3-4 | | (G) RT 63 3-4 | |
|--|--|--|--|--|--|--|--|
| Getting in and out of bed or chairs? | | Walking? | | Getting outside? | | Using the toilet, including getting to the toilet? | |
| 4. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/> DK | 4. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/> DK | 4. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/> DK | 4. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/> DK |
| H1 | | H1 | | H1 | | H1 | |
| Refer to question 4. <input type="checkbox"/> "Yes" marked (Go to 5) <input type="checkbox"/> All other (Go to H1 for next activity) | | Refer to question 4. <input type="checkbox"/> "Yes" marked (Go to 5) <input type="checkbox"/> All other (Go to H1 for next activity) | | Refer to question 4. <input type="checkbox"/> "Yes" marked (Go to 5) <input type="checkbox"/> All other (Go to H1 for next activity) | | Refer to question 4. <input type="checkbox"/> "Yes" marked (Go to 5) <input type="checkbox"/> All other (Go to H1 for next activity (A)) | |
| 5. | <input type="checkbox"/> Some } (Go to 6) <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (H1 for next activity) <input type="checkbox"/> DK (Go to 6) | 5. | <input type="checkbox"/> Some } (Go to 6) <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (H1 for next activity) <input type="checkbox"/> DK (Go to 6) | 5. | <input type="checkbox"/> Some } (Go to 6) <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (H1 for next activity) <input type="checkbox"/> DK (Go to 6) | 5. | <input type="checkbox"/> Some } (Go to 6) <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (H2 for activity (A)) <input type="checkbox"/> DK (Go to 6) |
| 6. | <input type="checkbox"/> Never do without help or special equipment (H1 for next activity) (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (Go to H1 for next activity) | 6. | <input type="checkbox"/> Never do without help or special equipment (H1 for next activity) (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (Go to H1 for next activity) | 6. | <input type="checkbox"/> Never do without help or special equipment (H1 for next activity) (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (Go to H1 for next activity) | 6. | <input type="checkbox"/> Never do without help or special equipment (H2 for activity (A)) (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (Go to H2 for activity (A)) |
| H2 | | H2 | | H2 | | H2 | |
| Refer to question 4. <input type="checkbox"/> Box 3 marked (H2 for next activity) <input type="checkbox"/> All other (Go to 7) | | Refer to question 4. <input type="checkbox"/> Box 3 marked (H2 for next activity) <input type="checkbox"/> All other (Go to 7) | | Refer to question 4. <input type="checkbox"/> Box 3 marked (H2 for next activity) <input type="checkbox"/> All other (Go to 7) | | Refer to question 4. <input type="checkbox"/> Box 3 marked (Skip to H3 on page 38) <input type="checkbox"/> All other (Go to 7) | |
| 7a. | <input type="checkbox"/> Yes (Go to 7b) <input type="checkbox"/> No (H2 for next activity) | 7a. | <input type="checkbox"/> Yes (Go to 7b) <input type="checkbox"/> No (H2 for next activity) | 7a. | <input type="checkbox"/> Yes (Go to 7b) <input type="checkbox"/> No (H2 for next activity) | 7a. | <input type="checkbox"/> Yes (Go to 7b) <input type="checkbox"/> No (Skip to H3 on page 38) |
| b. | <input type="checkbox"/> Cane or walking stick <input type="checkbox"/> Walker <input type="checkbox"/> Extra/special cushions <input type="checkbox"/> Special "raising seat" chair/lift chair <input type="checkbox"/> Hospital bed <input type="checkbox"/> Trapeze/sling <input type="checkbox"/> Ramp <input type="checkbox"/> Other <input type="checkbox"/> DK | b. | <input type="checkbox"/> Cane or walking stick <input type="checkbox"/> Walker <input type="checkbox"/> Crutch or crutches <input type="checkbox"/> Wheelchair <input type="checkbox"/> Artificial leg <input type="checkbox"/> Brace <input type="checkbox"/> Guide dog <input type="checkbox"/> Oxygen/special breathing equipment <input type="checkbox"/> Other <input type="checkbox"/> DK | b. | <input type="checkbox"/> Cane or walking stick <input type="checkbox"/> Walker <input type="checkbox"/> Crutch or crutches <input type="checkbox"/> Wheelchair <input type="checkbox"/> Artificial leg <input type="checkbox"/> Brace <input type="checkbox"/> Guide dog <input type="checkbox"/> Oxygen/special breathing equipment <input type="checkbox"/> Other <input type="checkbox"/> DK | b. | <input type="checkbox"/> Cane or walking stick <input type="checkbox"/> Walker <input type="checkbox"/> Crutch or crutches <input type="checkbox"/> Wheelchair <input type="checkbox"/> Artificial leg <input type="checkbox"/> Brace <input type="checkbox"/> Guide dog <input type="checkbox"/> Bed pan <input type="checkbox"/> Raised toilet seat <input type="checkbox"/> Special toilet/portable toilet <input type="checkbox"/> Hand holds/rails near toilet <input type="checkbox"/> Other <input type="checkbox"/> DK |
| c. | <input type="checkbox"/> Never do without help (Go to H2 for next activity) (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (Go to H2 for next activity) | c. | <input type="checkbox"/> Never do without help (Go to H2 for next activity) (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (Go to H2 for next activity) | c. | <input type="checkbox"/> Never do without help (Go to H2 for next activity) (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (Go to H2 for next activity) | c. | <input type="checkbox"/> Never do without help (Go to H3 on page 38) (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK (Go to H3 on page 38) |

| Section H - ASSISTANCE WITH KEY ACTIVITIES - Continued | | | | | | | | | | | | |
|---|--|---|--|--------------|--|---|------------|------------|--|---|--|--|
| | (A) Bathing or showering | | | (B) Dressing | | | (C) Eating | | | | | |
| | RT 57 | | | RT 58 | | | RT 59 | | | | | |
| ITEM H3 | H3 | Refer to question 4 on page 36. | | | H3 | Refer to question 4 on page 36. | | | H3 | Refer to question 4 on page 36. | | |
| | | 1 <input type="checkbox"/> Box 3 marked (Go to H3 for next activity) 2 <input type="checkbox"/> All other (Go to 8) | | | | 1 <input type="checkbox"/> Box 3 marked (Go to H3 for next activity) 2 <input type="checkbox"/> All other (Go to 8) | | | | 1 <input type="checkbox"/> Box 3 marked (Go to H3 for next activity) 2 <input type="checkbox"/> All other (Go to 8) | | |
| 8a. Do you receive help from another person in (activity)? | 8a. | 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK } | | | 8a. | 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK } | | | 8a. | 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? | b. | 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK } | | | b. | 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK } | | | b. | 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) — (1) Very tiring? (2) Does (activity) take a long time? (3) Is it very painful? | c. | 0 <input type="checkbox"/> Never does activity (Go to 8e) | | | c. | 0 <input type="checkbox"/> Never does activity (Go to 8e) | | | c. | 0 <input type="checkbox"/> Never does activity (Go to 8e) | | |
| | (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 | | | (2) | 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 | | | (3) | 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 | | |
| d. How often do you have hands-on help with (activity)? Would you say always, sometimes, or rarely? | d. | 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK | | | d. | 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK | | | d. | 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. | 1 <input type="checkbox"/> Yes } (Go to H3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | | | e. | 1 <input type="checkbox"/> Yes } (Go to H3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | | | e. | 1 <input type="checkbox"/> Yes } (Go to H3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | | |
| ITEM H4 | H4 | Refer to H3 and 8b above. | | | H4 | Refer to H3 and 8b above. | | | H4 | Refer to H3 and 8b above. | | |
| | | 1 <input type="checkbox"/> Box 1 marked in H3 (Go to H4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to H4 for next activity) 3 <input type="checkbox"/> All other (Go to 9) | | | | 1 <input type="checkbox"/> Box 1 marked in H3 (Go to H4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to H4 for next activity) 3 <input type="checkbox"/> All other (Go to 9) | | | | 1 <input type="checkbox"/> Box 1 marked in H3 (Go to H4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to H4 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)? | 9a. | 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK } | | | 9a. | 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK } | | | 9a. | 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 — (1) Supervisory help, such as making sure the activity is performed correctly when you are (activity)? (2) Standby help, such as observing to see if any help is needed when you are (activity)? | b. | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK | | | b. | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK | | | b. | 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 | | | (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 | | | (2) | 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 | | | |
| 10. How often do you have supervision or standby help when you are (activity)? Would you say always, sometimes, or rarely? | 10. | 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK | | | 10. | 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK | | | 10. | 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)? | 11. | 1 <input type="checkbox"/> Yes } (Go to H4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | | | 11. | 1 <input type="checkbox"/> Yes } (Go to H4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | | | 11. | 1 <input type="checkbox"/> Yes } (Go to H4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | | |

| Section H – ASSISTANCE WITH KEY ACTIVITIES – Continued | | | |
|--|--|--|---|
| (D) Getting in and out of bed or chairs | (E) Walking | (F) Getting outside | (G) Using the toilet, including getting to the toilet |
| RT 60 | RT 61 | RT 62 | RT 63 |
| H3 Refer to question 4 on page 37. 1 <input type="checkbox"/> Box 3 marked (Go to H3 for next activity) 2 <input type="checkbox"/> All other (Go to 8) | H3 Refer to question 4 on page 37. 1 <input type="checkbox"/> Box 3 marked (Go to H3 for next activity) 2 <input type="checkbox"/> All other (Go to 8) | H3 Refer to question 4 on page 37. 1 <input type="checkbox"/> Box 3 marked (Go to H3 for next activity) 2 <input type="checkbox"/> All other (Go to 8) | H3 Refer to question 4 on page 37. 1 <input type="checkbox"/> Box 3 marked (Skip to H4 for activity (A)) 2 <input type="checkbox"/> All other (Go to 8) |
| 8a. 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK } | 8a. 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK } | 8a. 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK } | 8a. 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK } |
| b. 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK } | b. 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK } | b. 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK } | b. 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK } |
| c. 0 <input type="checkbox"/> Never does activity (Go to 8e) | c. 0 <input type="checkbox"/> Never does activity (Go to 8e) | c. 0 <input type="checkbox"/> Never does activity (Go to 8e) | c. 0 <input type="checkbox"/> Never does activity (Go to 8e) |
| (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 | (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 | (2) 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 | (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 | (3) 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 | (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK |
| d. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK | d. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK | d. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK | d. 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 H3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | e. 1 <input type="checkbox"/> Yes } (Go to H3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | e. 1 <input type="checkbox"/> Yes } (Go to H3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | e. 1 <input type="checkbox"/> Yes } (Go to H4 for activity (A)) 2 <input type="checkbox"/> No } 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 |
|---|---|---|---|
| H4 Refer to H3 and 8b above. 1 <input type="checkbox"/> Box 1 marked in H3 (Go to H4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to H4 for next activity) 3 <input type="checkbox"/> All other (Go to 9) | H4 Refer to H3 and 8b above. 1 <input type="checkbox"/> Box 1 marked in H3 (Go to H4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to H4 for next activity) 3 <input type="checkbox"/> All other (Go to 9) | H4 Refer to H3 and 8b above. 1 <input type="checkbox"/> Box 1 marked in H3 (Go to H4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to H4 for next activity) 3 <input type="checkbox"/> All other (Go to 9) | H4 Refer to H3 and 8b above. 1 <input type="checkbox"/> Box 1 marked in H3 (Skip to H5 on page 40) 2 <input type="checkbox"/> "Yes" in 8b (Skip to H5 on page 40) 3 <input type="checkbox"/> All other (Go to 9) |
| 9a. 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK } | 9a. 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK } | 9a. 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK } | 9a. 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK } |
| b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK | b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK | b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK | b. 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 | (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 | (2) 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 | (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK |
| 10. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK | 10. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK | 10. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK | 10. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK |
| 11. 1 <input type="checkbox"/> Yes } (Go to H4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | 11. 1 <input type="checkbox"/> Yes } (Go to H4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | 11. 1 <input type="checkbox"/> Yes } (Go to H4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | 11. 1 <input type="checkbox"/> Yes } (Go to H5 on page 40) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } |

Section H - ASSISTANCE WITH KEY ACTIVITIES - Continued

| | (A) RT 57 Bathing or showering | (B) RT 58 Dressing | (C) RT 59 Eating |
|---|--|---|--|
| ITEM H5 | <p><i>Refer to 8a, 8e, 9a and 11 on page 38.</i> 37</p> <p>1 <input type="checkbox"/> Any "Yes" (Go to 12)</p> <p>2 <input type="checkbox"/> All other (Go to H5 for activity (B))</p> | <p><i>Refer to 8a, 8e, 9a and 11 on page 38.</i> 39</p> <p>1 <input type="checkbox"/> Any "Yes" (Go to 12)</p> <p>2 <input type="checkbox"/> All other (Go to H5 for activity (C))</p> | <p><i>Refer to 8a, 8e, 9a and 11 on page 38.</i> 38</p> <p>1 <input type="checkbox"/> Any "Yes" (Go to 12)</p> <p>2 <input type="checkbox"/> All other (Go to H5 for activity (D))</p> |
| | <p>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)</p> <p>1 <input type="checkbox"/> Everyday, 38</p> <p>2 <input type="checkbox"/> 2-3 times per week,</p> <p>3 <input type="checkbox"/> Once a week, or</p> <p>4 <input type="checkbox"/> Less than once a week?</p> <p>9 <input type="checkbox"/> DK</p> | <p>12a. Do you get dressed for the day — (Read categories)</p> <p>1 <input type="checkbox"/> Everyday, (Skip to 13) 40</p> <p>2 <input type="checkbox"/> 2-3 times per week,</p> <p>3 <input type="checkbox"/> Once a week, or } (Go to 12b)</p> <p>4 <input type="checkbox"/> Do you stay in night clothes?</p> <p>9 <input type="checkbox"/> DK</p> | <p>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?</p> <p>1 <input type="checkbox"/> Yes 39</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> |
| | <p>b. How often do you have a partial bath? Would you say — (Read categories)</p> <p>1 <input type="checkbox"/> Everyday, 39</p> <p>2 <input type="checkbox"/> 2-3 times per week,</p> <p>3 <input type="checkbox"/> Once a week, or</p> <p>4 <input type="checkbox"/> Less than once a week?</p> <p>9 <input type="checkbox"/> DK</p> | <p>b. How often do you change your night clothes? Would you say — (Read categories)</p> <p>1 <input type="checkbox"/> Everyday, 41</p> <p>2 <input type="checkbox"/> 2-3 times per week,</p> <p>3 <input type="checkbox"/> Once a week, or</p> <p>4 <input type="checkbox"/> Less than once a week?</p> <p>9 <input type="checkbox"/> DK</p> | <p>b. During the past month, have you —</p> <p>(1) Lost any weight because you were on a diet?</p> <p>1 <input type="checkbox"/> Yes 40</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> |
| | <p>13a. During the past month, did you experience discomfort because you were not able to bathe as often as you would have liked?</p> <p><i>If necessary: That can be either physical or emotional discomfort.</i></p> <p>1 <input type="checkbox"/> Yes 40</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> | <p>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?</p> <p>1 <input type="checkbox"/> Yes } (Go to H5 for activity (C)) 42</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> | <p>(2) Lost weight even though you were not on a diet?</p> <p>1 <input type="checkbox"/> Yes 41</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> |
| <p>b. During the past month, did you experience a burn or scald caused by bathing with water that was too hot?</p> <p>1 <input type="checkbox"/> Yes } (Go to H5 for activity (B)) 41</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> | | <p>(3) Been dehydrated, that is not had enough liquid in your diet?</p> <p>1 <input type="checkbox"/> Yes } (Go to H5 for activity (D)) 42</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> <p><i>If necessary: If you were dehydrated, you might have been thirsty or lost body fluids.</i></p> | |

Notes

Section H - ASSISTANCE WITH KEY ACTIVITIES - Continued

| (D) RT 60 | | (E) RT 61 | | (G) RT 63 | |
|--|--|---|---|--|--|
| Getting in and out of bed or chairs | | Walking | | Using the toilet, including getting to the toilet | |
| <p>H5</p> <p>Refer to 8a, 8e, 9a and 11 on page 39. 42</p> <p>1 <input type="checkbox"/> Any "Yes" (Go to 12)</p> <p>2 <input type="checkbox"/> All other (Go to H5 for activity (E))</p> | <p>H5</p> <p>Refer to 8a, 8e, 9a and 11 on page 39. 53</p> <p>1 <input type="checkbox"/> Any "Yes" (Go to 12)</p> <p>2 <input type="checkbox"/> All other (Go to H5 for activity (G))</p> | <p>H5</p> <p>Refer to 8a, 8e, 9a and 11 on page 39. 59</p> <p>1 <input type="checkbox"/> Any "Yes" (Go to 12)</p> <p>2 <input type="checkbox"/> All other (Skip to H6 on page 42)</p> | | | |
| <p>12a.</p> <p>Because of a health or physical problem, do you usually stay in bed all or most of the time?</p> <p>1 <input type="checkbox"/> Yes (Go to H5 for activity (E)) 43</p> <p>2 <input type="checkbox"/> No } (Go to 12b)</p> <p>9 <input type="checkbox"/> DK }</p> | <p>12a.</p> <p>How often do you move around your [house/apartment/room]? Would you say — (Read categories)</p> <p>1 <input type="checkbox"/> Whenever you want, 54</p> <p>2 <input type="checkbox"/> Often enough to stretch and have a change of scenery now and then,</p> <p>3 <input type="checkbox"/> Often enough to take care of toileting needs but not much more than that, or</p> <p>4 <input type="checkbox"/> Not often enough even to use the bathroom?</p> <p>9 <input type="checkbox"/> DK</p> <p>(Go to H5 for activity (G))</p> | <p>12a.</p> <p>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?</p> <p><i>If necessary: That can be either physical or emotional discomfort.</i></p> <p>1 <input type="checkbox"/> Yes 60</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> | | | |
| <p>b.</p> <p>Because of a health or physical problem, do you usually stay in a chair all or most of the time?</p> <p>1 <input type="checkbox"/> Yes 44</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> | | | <p>b.</p> <p>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?</p> <p>1 <input type="checkbox"/> Yes (Go to 12c) 61</p> <p>2 <input type="checkbox"/> No } (Skip to 12d)</p> <p>9 <input type="checkbox"/> DK }</p> | | |
| <p>c.</p> <p>How often do you get out of bed? Would you say — (Read categories)</p> <p>1 <input type="checkbox"/> Everyday, 45</p> <p>2 <input type="checkbox"/> 2-3 times per week,</p> <p>3 <input type="checkbox"/> Once a week, or</p> <p>4 <input type="checkbox"/> Less than once a week?</p> <p>9 <input type="checkbox"/> DK</p> <p>(Go to H5 for activity (E))</p> | | | <p>c.</p> <p>During the past month, did you experience skin problems such as a rash or irritation because of this?</p> <p>1 <input type="checkbox"/> Yes 62</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> | | |
| | | | | <p>d.</p> <p>During the past month, did you use a commode or bed pan because no help was available?</p> <p>1 <input type="checkbox"/> Yes 63</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> <p>(Go to H6 on page 42)</p> | |

Notes

Section H – ASSISTANCE WITH KEY ACTIVITIES – Continued

| | | |
|--|---|--|
| ITEM H6 | <p>Refer to question 4 for activities A–G on pages 36 and 37. Indicate the activities marked "Yes".</p> <p>Insert these marked activities when asking 14.</p> | <p><input type="checkbox"/> A. Bathing or showering</p> <p><input type="checkbox"/> B. Dressing</p> <p><input type="checkbox"/> C. Eating</p> <p><input type="checkbox"/> D. Getting in and out of bed or chairs</p> <p><input type="checkbox"/> E. Walking</p> <p><input type="checkbox"/> F. Getting outside</p> <p><input type="checkbox"/> G. Using the toilet, including getting to the toilet</p> <p><input type="checkbox"/> No activities marked (Skip to 16)</p> |
| <p>Insert activities marked in H6.</p> <p>14a. What (other) condition causes the trouble in (activities)?</p> <p>Record conditions and ask 14b.</p> <p>Ask if operation:</p> <p>For what condition did you have the operation?</p> <p>Record up to 5 conditions.</p> | | <p>00 <input type="checkbox"/> No condition (Skip to 16) 5-6</p> <p>01 <input type="checkbox"/> Old age (Go to 14c) 7-8</p> <p>(a) _____ 9-10</p> <p>(b) _____ 11-12</p> <p>(c) _____ 13-14</p> <p>(d) _____ 15-16</p> <p>(e) _____ 17-18</p> |
| <p>b. Besides (condition), is there any other condition which causes this trouble in (activities)?</p> | | <p>1 <input type="checkbox"/> Yes (Reask 14a and 14b) 19</p> <p>2 <input type="checkbox"/> No } (Skip to 15)</p> <p>9 <input type="checkbox"/> DK }</p> |
| <p>c. Is this trouble in (activities) caused by any specific condition?</p> | | <p>1 <input type="checkbox"/> Yes (Reask 14a and 14b) 20</p> <p>2 <input type="checkbox"/> No } (Go to 15)</p> <p>9 <input type="checkbox"/> DK }</p> |
| <p>15. [Was this/Were any of these] condition(s) a result of a motor vehicle accident?</p> | | <p>1 <input type="checkbox"/> Yes 21</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> |
| <p>16. During the past 12 months, did you receive training to increase your independence in daily living skills such as bathing, eating, or toileting?</p> | | <p>1 <input type="checkbox"/> Yes 22</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> |
| <p>17a. Do you have difficulty controlling your bowels?</p> | | <p>1 <input type="checkbox"/> Yes (Go to 17b) 23</p> <p>2 <input type="checkbox"/> No } (Skip to 17c)</p> <p>9 <input type="checkbox"/> DK }</p> |
| <p>b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week?</p> <p>Mark (X) only one.</p> | | <p>1 <input type="checkbox"/> Daily 24</p> <p>2 <input type="checkbox"/> Several times a week</p> <p>3 <input type="checkbox"/> Once a week</p> <p>4 <input type="checkbox"/> Less than once a week</p> <p>9 <input type="checkbox"/> DK</p> |
| <p>c. Do you have a colostomy or a device to help control bowel movements?</p> | | <p>1 <input type="checkbox"/> Yes (Go to 17d) 25</p> <p>2 <input type="checkbox"/> No } (Skip to 18a on page 43)</p> <p>9 <input type="checkbox"/> DK }</p> |
| <p>d. Do you need help from another person in taking care of this device?</p> | | <p>1 <input type="checkbox"/> Yes 26</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> |

Notes

Section H - ASSISTANCE WITH KEY ACTIVITIES - Continued

| | | |
|---|--|----|
| 18a. Do you have difficulty controlling urination? | 1 <input type="checkbox"/> Yes (<i>Go to 18b</i>) 2 <input type="checkbox"/> No } (<i>Skip to 18c</i>) 9 <input type="checkbox"/> DK } | 27 |
| b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week? <i>Mark (X) only one.</i> | 1 <input type="checkbox"/> Daily 2 <input type="checkbox"/> Several times a week 3 <input type="checkbox"/> Once a week 4 <input type="checkbox"/> Less than once a week 9 <input type="checkbox"/> DK | 28 |
| c. Do you have a urinary catheter or a device to help control urination? | 1 <input type="checkbox"/> Yes (<i>Go to 18d</i>) 2 <input type="checkbox"/> No } (<i>Skip to Item H8</i>) 9 <input type="checkbox"/> DK } | 29 |
| d. Do you need help from another person in taking care of this device? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK | 30 |

| | | | |
|----------------|---------------|---|----|
| ITEM H8 | Status of SP. | 1 <input type="checkbox"/> Institutionalized (<i>Skip to 31 on page 50</i>) 2 <input type="checkbox"/> All others (<i>Go to 19 on page 44</i>) | 31 |
|----------------|---------------|---|----|

Notes

Section H – ASSISTANCE WITH KEY ACTIVITIES – Continued

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

| | | | |
|--|---|---|---|
| <p>Ask questions 19(H)–(J) before continuing to Item H9.</p> <p>19. Because of a health or physical problem, do you have ANY difficulty —</p> <p>Ask if "Doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p> <p>If "Yes", mark box 1; if "No" mark box 3.</p> | <p>(H) RT 65 3-4</p> <p>Preparing your own meals?</p> | <p>(I) RT 66 3-4</p> <p>Shopping for groceries and personal items, such as toilet items or medicines?</p> | <p>(J) RT 67 3-4</p> <p>Managing your money, such as keeping track of expenses or paying bills.</p> |
| | <p>19. 1 <input type="checkbox"/> Yes 5</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/> Z</p> <p>Does someone else regularly do this for you?</p> <p>4 <input type="checkbox"/> Yes 6</p> <p>5 <input type="checkbox"/> No</p> | <p>1 <input type="checkbox"/> Yes 5</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/> Z</p> <p>Does someone else regularly do this for you?</p> <p>4 <input type="checkbox"/> Yes 6</p> <p>5 <input type="checkbox"/> No</p> | <p>1 <input type="checkbox"/> Yes 5</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/> Z</p> <p>Does someone else regularly do this for you?</p> <p>4 <input type="checkbox"/> Yes 6</p> <p>5 <input type="checkbox"/> No</p> |

| | | | |
|--|--|--|--|
| <p>ITEM H9</p> | <p>(H)</p> <p>Preparing your own meals</p> | <p>(I)</p> <p>Shopping for groceries and personal items</p> | <p>(J)</p> <p>Managing your money</p> |
| | <p>H9 Refer to 19. 7</p> <p>1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 20)</p> <p>2 <input type="checkbox"/> All other (Go to H9 for next activity)</p> | <p>I9 Refer to 19. 7</p> <p>1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 20)</p> <p>2 <input type="checkbox"/> All other (Go to H9 for next activity)</p> | <p>J9 Refer to 19. 7</p> <p>1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 20)</p> <p>2 <input type="checkbox"/> All other (Go to H9 for next activity)</p> |
| <p>20. By yourself, how much difficulty do you have (activity), — some, a lot, or are you unable to do it?</p> | <p>20. 1 <input type="checkbox"/> Some } (Go to 21) 8</p> <p>2 <input type="checkbox"/> A lot }</p> <p>3 <input type="checkbox"/> Unable (Go to H9 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 21)</p> | <p>20. 1 <input type="checkbox"/> Some } (Go to 21) 8</p> <p>2 <input type="checkbox"/> A lot }</p> <p>3 <input type="checkbox"/> Unable (Go to H9 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 21)</p> | <p>20. 1 <input type="checkbox"/> Some } (Go to 21) 8</p> <p>2 <input type="checkbox"/> A lot }</p> <p>3 <input type="checkbox"/> Unable (Go to H9 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 21)</p> |
| <p>21. 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>21a. 0 <input type="checkbox"/> Never do without help (Go to H9 for next activity)</p> <p>Yes No DK</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 10</p> <p>b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 11</p> <p>c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 12</p> <p>(Go to H9 for next activity)</p> | <p>21a. 0 <input type="checkbox"/> Never do without help (Go to H9 for next activity)</p> <p>Yes No DK</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 10</p> <p>b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 11</p> <p>c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 12</p> <p>(Go to H9 for next activity)</p> | <p>21a. 0 <input type="checkbox"/> Never do without help (Go to H9 for next activity)</p> <p>Yes No DK</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 10</p> <p>b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 11</p> <p>c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 12</p> <p>(Go to H9 for next activity)</p> |

Notes

Section H - ASSISTANCE WITH KEY ACTIVITIES - Continued

| (K) RT 68 3-4 Using the telephone? | | (L) RT 69 3-4 Doing heavy housework, like scrubbing floors, or washing windows? | | (M) RT 70 3-4 Doing light housework, like doing dishes, straightening up, or light cleaning? | | (N) RT 71 3-4 Getting to places outside of walking distance? | | (O) RT 72 3-4 Managing your medication? | |
|---------------------------------------|---|---|---|---|---|---|--|--|--|
| 19. | <input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/> Does someone else regularly do this for you? <input type="checkbox"/> Yes 6 <input type="checkbox"/> No | <input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/> Does someone else regularly do this for you? <input type="checkbox"/> Yes 6 <input type="checkbox"/> No | <input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/> Does someone else regularly do this for you? <input type="checkbox"/> Yes 6 <input type="checkbox"/> No | <input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/> Does someone else regularly do this for you? <input type="checkbox"/> Yes 6 <input type="checkbox"/> No | <input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/> Does someone else regularly do this for you? <input type="checkbox"/> Yes 6 <input type="checkbox"/> No | | | | |

| (K) RT 68 3-4 Using the telephone | | (L) RT 69 3-4 Doing heavy housework | | (M) RT 70 3-4 Doing light housework | | (N) RT 71 3-4 Getting to places outside of walking distance | | (O) RT 72 3-4 Managing your medication | |
|--------------------------------------|---|---|---|---|---|--|--|---|--|
| H9 | Refer to 19. 7 <input type="checkbox"/> Box 1 "Yes" marked (Go to 20) <input type="checkbox"/> All other (Go to H9 for next activity) | Refer to 19. 7 <input type="checkbox"/> Box 1 "Yes" marked (Go to 20) <input type="checkbox"/> All other (Go to H9 for next activity) | Refer to 19. 7 <input type="checkbox"/> Box 1 "Yes" marked (Go to 20) <input type="checkbox"/> All other (Go to H9 for next activity) | Refer to 19. 7 <input type="checkbox"/> Box 1 "Yes" marked (Go to 20) <input type="checkbox"/> All other (Go to H9 for next activity) | Refer to 19. 7 <input type="checkbox"/> Box 1 "Yes" marked (Go to 20) <input type="checkbox"/> All other (Skip to H10 on page 46) | | | | |
| 20. | <input type="checkbox"/> Some } (Go to 21) 8 <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (Go to H9 for next activity) <input type="checkbox"/> DK (Go to 21) | <input type="checkbox"/> Some } (Go to 21) 8 <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (Go to H9 for next activity) <input type="checkbox"/> DK (Go to 21) | <input type="checkbox"/> Some } (Go to 21) 8 <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (Go to H9 for next activity) <input type="checkbox"/> DK (Go to 21) | <input type="checkbox"/> Some } (Go to 21) 8 <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (Go to H9 for next activity) <input type="checkbox"/> DK (Go to 21) | <input type="checkbox"/> Some } (Go to 21) 8 <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (Skip to H10 on page 46) <input type="checkbox"/> DK (Go to 21) | | | | |
| 21a. | <input type="checkbox"/> Never do without help (Go to H9 for next activity) 9 Yes No DK <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 10 | <input type="checkbox"/> Never do without help (Go to H9 for next activity) 9 Yes No DK <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 10 | <input type="checkbox"/> Never do without help (Go to H9 for next activity) 9 Yes No DK <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 10 | <input type="checkbox"/> Never do without help (Go to H9 for next activity) 9 Yes No DK <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 10 | <input type="checkbox"/> Never do without help (Skip to H10 on page 46) 9 Yes No DK <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 10 | | | | |
| b. | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 11 | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 11 | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 11 | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 11 | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 11 | | | | |
| c. | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 12 (Go to H9 for next activity) | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 12 (Go to H9 for next activity) | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 12 (Go to H9 for next activity) | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 12 (Go to H9 for next activity) | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 12 (Go to H10 on page 46) | | | | |

Notes

Section H – ASSISTANCE WITH KEY ACTIVITIES – Continued

| | | | | (H) | RT 65 | (I) | RT 66 | (J) | RT 67 |
|---|--|--|--|--|-------|--|-------|--|-------|
| | | | | Preparing your own meals | | Shopping for groceries and personal items | | Managing your money | |
| ITEM H10 | | | | H10 | 13 | H10 | 13 | H10 | 13 |
| Refer to 19 on page 44. | | | | 1 <input type="checkbox"/> Box 3 marked (Go to H10 for next activity) | | 1 <input type="checkbox"/> Box 3 marked (Go to H10 for next activity) | | 1 <input type="checkbox"/> Box 3 marked (Go to H10 for next activity) | |
| | | | | 2 <input type="checkbox"/> All others (Go to 22) | | 2 <input type="checkbox"/> All others (Go to 22) | | 2 <input type="checkbox"/> All others (Go to 22) | |
| 22a. Do you receive help from another person in (activity)? | | | | 22a. | 14 | 22a. | 14 | 22a. | 14 |
| | | | | 1 <input type="checkbox"/> Yes (Go to 22b) | | 1 <input type="checkbox"/> Yes (Go to 22b) | | 1 <input type="checkbox"/> Yes (Go to 22b) | |
| | | | | 2 <input type="checkbox"/> No } (Skip to 22e) | | 2 <input type="checkbox"/> No } (Skip to 22e) | | 2 <input type="checkbox"/> No } (Skip to 22e) | |
| | | | | 9 <input type="checkbox"/> DK } (Skip to 22e) | | 9 <input type="checkbox"/> DK } (Skip to 22e) | | 9 <input type="checkbox"/> DK } (Skip to 22e) | |
| b. Is this hands-on help? | | | | b. | 15 | b. | 15 | b. | 15 |
| | | | | 1 <input type="checkbox"/> Yes (Go to 22c) | | 1 <input type="checkbox"/> Yes (Go to 22c) | | 1 <input type="checkbox"/> Yes (Go to 22c) | |
| | | | | 2 <input type="checkbox"/> No } (Skip to 22e) | | 2 <input type="checkbox"/> No } (Skip to 22e) | | 2 <input type="checkbox"/> No } (Skip to 22e) | |
| | | | | 9 <input type="checkbox"/> DK } (Skip to 22e) | | 9 <input type="checkbox"/> DK } (Skip to 22e) | | 9 <input type="checkbox"/> DK } (Skip to 22e) | |
| c. When you HAVE HANDS-ON HELP FROM ANOTHER PERSON, is (activity): | | | | c. | 16 | c. | 16 | c. | 16 |
| 0 <input type="checkbox"/> Never does activity (Go to 22e) | | | | | | 0 <input type="checkbox"/> Never does activity (Go to 22e) | | 0 <input type="checkbox"/> Never does activity (Go to 22e) | |
| Yes No DK | | | | | | Yes No DK | | Yes No DK | |
| (1) Very tiring? | | | | (1) | 17 | (1) | 17 | (1) | 17 |
| 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | | | | | | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | |
| (2) Does (activity) take a long time? | | | | (2) | 18 | (2) | 18 | (2) | 18 |
| 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | | | | | | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | |
| (3) Is it very painful? | | | | (3) | 19 | (3) | 19 | (3) | 19 |
| 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | | | | | | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | | 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. | 20 | d. | 20 | d. | 20 |
| 1 <input type="checkbox"/> Always | | | | | | 1 <input type="checkbox"/> Always | | 1 <input type="checkbox"/> Always | |
| 2 <input type="checkbox"/> Sometimes | | | | | | 2 <input type="checkbox"/> Sometimes | | 2 <input type="checkbox"/> Sometimes | |
| 3 <input type="checkbox"/> Rarely | | | | | | 3 <input type="checkbox"/> Rarely | | 3 <input type="checkbox"/> Rarely | |
| 9 <input type="checkbox"/> DK | | | | | | 9 <input type="checkbox"/> DK | | 9 <input type="checkbox"/> DK | |
| e. Do you need (more) hands-on help with (activity)? | | | | e. | 21 | e. | 21 | e. | 21 |
| 1 <input type="checkbox"/> Yes } (Go to H10 for next activity) | | | | | | 1 <input type="checkbox"/> Yes } (Go to H10 for next activity) | | 1 <input type="checkbox"/> Yes } (Go to H10 for next activity) | |
| 2 <input type="checkbox"/> No } (Go to H10 for next activity) | | | | | | 2 <input type="checkbox"/> No } (Go to H10 for next activity) | | 2 <input type="checkbox"/> No } (Go to H10 for next activity) | |
| 9 <input type="checkbox"/> DK } (Go to H10 for next activity) | | | | | | 9 <input type="checkbox"/> DK } (Go to H10 for next activity) | | 9 <input type="checkbox"/> DK } (Go to H10 for next activity) | |
| | | | | (H) | RT 65 | (I) | RT 66 | (J) | RT 67 |
| | | | | Preparing your own meals | | Shopping for groceries and personal items | | Managing your money | |
| ITEM H11 | | | | H11 | 22 | H11 | 22 | H11 | 22 |
| Refer to H10 and 22b. | | | | 1 <input type="checkbox"/> Box 1 marked in H10 (Go to H11 for next activity) | | 1 <input type="checkbox"/> Box 1 marked in H10 (Go to H11 for next activity) | | 1 <input type="checkbox"/> Box 1 marked in H10 (Go to H11 for next activity) | |
| | | | | 2 <input type="checkbox"/> "Yes" marked in 22b (Go to H11 for next activity) | | 2 <input type="checkbox"/> "Yes" marked in 22b (Go to H11 for next activity) | | 2 <input type="checkbox"/> "Yes" marked in 22b (Go to H11 for next activity) | |
| | | | | 3 <input type="checkbox"/> Other (Go to 23) | | 3 <input type="checkbox"/> Other (Go to 23) | | 3 <input type="checkbox"/> Other (Go to 23) | |
| 23a. Do you have someone who supervises you or stays nearby when you are (activity)? | | | | 23a. | 23 | 23a. | 23 | 23a. | 23 |
| | | | | 1 <input type="checkbox"/> Yes (Go to 23b) | | 1 <input type="checkbox"/> Yes (Go to 23b) | | 1 <input type="checkbox"/> Yes (Go to 23b) | |
| | | | | 2 <input type="checkbox"/> No } (Skip to 25) | | 2 <input type="checkbox"/> No } (Skip to 25) | | 2 <input type="checkbox"/> No } (Skip to 25) | |
| | | | | 9 <input type="checkbox"/> DK } (Skip to 25) | | 9 <input type="checkbox"/> DK } (Skip to 25) | | 9 <input type="checkbox"/> DK } (Skip to 25) | |
| b. Does this person provide — | | | | b. | 24 | b. | 24 | b. | 24 |
| Supervisory help, such as making sure the activity is performed correctly when you are (activity)? | | | | | | | | | |
| 1 <input type="checkbox"/> Yes | | | | | | 1 <input type="checkbox"/> Yes | | 1 <input type="checkbox"/> Yes | |
| 2 <input type="checkbox"/> No | | | | | | 2 <input type="checkbox"/> No | | 2 <input type="checkbox"/> No | |
| 9 <input type="checkbox"/> DK | | | | | | 9 <input type="checkbox"/> DK | | 9 <input type="checkbox"/> DK | |
| c. Stand-by help, such as observing to see if any help is needed when you are (activity)? | | | | c. | 25 | c. | 25 | c. | 25 |
| 1 <input type="checkbox"/> Yes | | | | | | 1 <input type="checkbox"/> Yes | | 1 <input type="checkbox"/> Yes | |
| 2 <input type="checkbox"/> No | | | | | | 2 <input type="checkbox"/> No | | 2 <input type="checkbox"/> No | |
| 9 <input type="checkbox"/> DK | | | | | | 9 <input type="checkbox"/> DK | | 9 <input type="checkbox"/> DK | |
| 24. How often do you have supervision or standby help when you are (activity)? Would you say always, sometimes, or rarely? | | | | 24. | 26 | 24. | 26 | 24. | 26 |
| 1 <input type="checkbox"/> Always | | | | | | 1 <input type="checkbox"/> Always | | 1 <input type="checkbox"/> Always | |
| 2 <input type="checkbox"/> Sometimes | | | | | | 2 <input type="checkbox"/> Sometimes | | 2 <input type="checkbox"/> Sometimes | |
| 3 <input type="checkbox"/> Rarely | | | | | | 3 <input type="checkbox"/> Rarely | | 3 <input type="checkbox"/> Rarely | |
| 9 <input type="checkbox"/> DK | | | | | | 9 <input type="checkbox"/> DK | | 9 <input type="checkbox"/> DK | |
| 25. Do you need (more) supervision or standby help with (activity)? | | | | 25. | 27 | 25. | 27 | 25. | 27 |
| 1 <input type="checkbox"/> Yes } (Go to H11 for next activity) | | | | | | 1 <input type="checkbox"/> Yes } (Go to H11 for next activity) | | 1 <input type="checkbox"/> Yes } (Go to H11 for next activity) | |
| 2 <input type="checkbox"/> No } (Go to H11 for next activity) | | | | | | 2 <input type="checkbox"/> No } (Go to H11 for next activity) | | 2 <input type="checkbox"/> No } (Go to H11 for next activity) | |
| 9 <input type="checkbox"/> DK } (Go to H11 for next activity) | | | | | | 9 <input type="checkbox"/> DK } (Go to H11 for next activity) | | 9 <input type="checkbox"/> DK } (Go to H11 for next activity) | |
| Notes | | | | | | | | | |

Section H – ASSISTANCE WITH KEY ACTIVITIES – Continued

| (K) RT 68 | | (L) RT 69 | | (M) RT 70 | | (N) RT 71 | | (O) RT 72 | |
|---|--|---|--|---|--|---|--|---|--|
| Using the telephone | | Doing heavy housework | | Doing light housework | | Getting to places outside of walking distance | | Managing your medication | |
| H10 Refer to 19 on page 45. 13 1 <input type="checkbox"/> Box 3 marked (Go to H10 for next activity) 2 <input type="checkbox"/> All others (Go to 22) | | Refer to 19 on page 45. 13 1 <input type="checkbox"/> Box 3 marked (Go to H10 for next activity) 2 <input type="checkbox"/> All others (Go to 22) | | Refer to 19 on page 45. 13 1 <input type="checkbox"/> Box 3 marked (Go to H10 for next activity) 2 <input type="checkbox"/> All others (Go to 22) | | Refer to 19 on page 45. 13 1 <input type="checkbox"/> Box 3 marked (Go to H10 for next activity) 2 <input type="checkbox"/> All others (Go to 22) | | Refer to 19 on page 45. 13 1 <input type="checkbox"/> Box 3 marked (Skip to H11 for activity (H)) 2 <input type="checkbox"/> All others (Go to 22) | |
| 22a. 1 <input type="checkbox"/> Yes (Go to 22b) 2 <input type="checkbox"/> No } (Skip to 22e) 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes (Go to 22b) 2 <input type="checkbox"/> No } (Skip to 22e) 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes (Go to 22b) 2 <input type="checkbox"/> No } (Skip to 22e) 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes (Go to 22b) 2 <input type="checkbox"/> No } (Skip to 22e) 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes (Go to 22b) 2 <input type="checkbox"/> No } (Skip to 22e) 9 <input type="checkbox"/> DK | |
| b. 1 <input type="checkbox"/> Yes (Go to 22c) 2 <input type="checkbox"/> No } (Skip to 22e) 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes (Go to 22c) 2 <input type="checkbox"/> No } (Skip to 22e) 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes (Go to 22c) 2 <input type="checkbox"/> No } (Skip to 22e) 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes (Go to 22c) 2 <input type="checkbox"/> No } (Skip to 22e) 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes (Go to 22c) 2 <input type="checkbox"/> No } (Skip to 22e) 9 <input type="checkbox"/> DK | |
| c. 0 <input type="checkbox"/> Never does activity (Go to 22e) Yes No DK (1) 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 (3) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 19 | | 0 <input type="checkbox"/> Never does activity (Go to 22e) Yes No DK 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"/> 18 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 19 | | 0 <input type="checkbox"/> Never does activity (Go to 22e) Yes No DK 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"/> 18 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 19 | | 0 <input type="checkbox"/> Never does activity (Go to 22e) Yes No DK 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"/> 18 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 19 | | 0 <input type="checkbox"/> Never does activity (Go to 22e) Yes No DK 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"/> 18 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 H10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes } (Go to H10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes } (Go to H10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes } (Go to H10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes } (Skip to H11 for activity (H)) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK | |

| (K) RT 68 | | (L) RT 69 | | (M) RT 70 | | (N) RT 71 | | (O) RT 72 | |
|--|--|--|--|--|--|--|--|--|--|
| Using the telephone | | Doing heavy housework | | Doing light housework | | Getting to places outside of walking distance | | Managing your medication | |
| H11 Refer to H10 and 22b: 22 1 <input type="checkbox"/> Box 1 marked in H10 (Go to H11 for next activity) 2 <input type="checkbox"/> "Yes" marked in 22b (Go to H11 for next activity) 3 <input type="checkbox"/> Other (Go to 23) | | Refer to H10 and 22b: 22 1 <input type="checkbox"/> Box 1 marked in H10 (Go to H11 for next activity) 2 <input type="checkbox"/> "Yes" marked in 22b (Go to H11 for next activity) 3 <input type="checkbox"/> Other (Go to 23) | | Refer to H10 and 22b: 22 1 <input type="checkbox"/> Box 1 marked in H10 (Go to H11 for next activity) 2 <input type="checkbox"/> "Yes" marked in 22b (Go to H11 for next activity) 3 <input type="checkbox"/> Other (Go to 23) | | Refer to H10 and 22b: 22 1 <input type="checkbox"/> Box 1 marked in H10 (Go to H11 for next activity) 2 <input type="checkbox"/> "Yes" marked in 22b (Go to H11 for next activity) 3 <input type="checkbox"/> Other (Go to 23) | | Refer to H10 and 22b: 22 1 <input type="checkbox"/> Box 1 marked in H10 (Skip to H12 on page 48) 2 <input type="checkbox"/> "Yes" marked in 22b (Skip to H12 on page 48) 3 <input type="checkbox"/> Other (Go to 23) | |
| 23a. 1 <input type="checkbox"/> Yes (Go to 23b) 2 <input type="checkbox"/> No } (Skip to 25) 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes (Go to 23b) 2 <input type="checkbox"/> No } (Skip to 25) 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes (Go to 23b) 2 <input type="checkbox"/> No } (Skip to 25) 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes (Go to 23b) 2 <input type="checkbox"/> No } (Skip to 25) 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes (Go to 23b) 2 <input type="checkbox"/> No } (Skip to 25) 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 | |
| 24. 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 | |
| 25. 1 <input type="checkbox"/> Yes } (Go to H11 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes } (Go to H11 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes } (Go to H11 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes } (Go to H11 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK | | 1 <input type="checkbox"/> Yes } (Skip to H12 on page 48) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK | |

Notes

| Section H – ASSISTANCE WITH KEY ACTIVITIES – Continued | | | | |
|---|---|-------|--|-------|
| | (H) | RT 65 | (I) | RT 66 |
| | Preparing your own meals | | Shopping for groceries and personal items | |
| ITEM H12 | H12 <i>Refer to 22a, 22e, 23a, and 25 on page 46.</i> 1 <input type="checkbox"/> Any "Yes" (Go to 26) 2 <input type="checkbox"/> All other (Go to H12 for activity (I)) | 28 | H12 <i>Refer to 22a, 22e, 23a, and 25 on page 46.</i> 1 <input type="checkbox"/> Any "Yes" (Go to 26) 2 <input type="checkbox"/> All other (Go to H12 for activity (L)) | 28 |
| | 26a. 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 | 26a. During the past month, were you unable to follow a special diet because you needed help shopping? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK | 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 | 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 } (Go to H12 for activity (L)) | 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 } (Go to H12 for activity (I)) | 31 | | |

| | (H) | RT 65 | (I) | RT 66 | (J) | RT 67 |
|---|---|-------|---|-------|--|-------|
| | Prepare your own meals | | Shop for groceries and personal items | | Manage your money | |
| ITEM H13 | H13 <i>Refer to 19 on page 44.</i> 1 <input type="checkbox"/> Box 3 marked (Go to H13 for next activity) 2 <input type="checkbox"/> All other (Go to 27) | 32 | H13 <i>Refer to 19 on page 44.</i> 1 <input type="checkbox"/> Box 3 marked (Go to H13 for next activity) 2 <input type="checkbox"/> All other (Go to 27) | 31 | H13 <i>Refer to 19 on page 44.</i> 1 <input type="checkbox"/> Box 3 marked (Go to H13 for activity (L)) 2 <input type="checkbox"/> All other (Go to 27) | 28 |
| 27. In your household, how often do YOU (activity)? Would you say always, sometimes, rarely, or never? | 27. 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 H13 for next activity) | 33 | 27. 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 H13 for next activity) | 32 | 27. 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 H13 for activity (L)) | 29 |

Notes

Section H – ASSISTANCE WITH KEY ACTIVITIES – Continued

| | | (L) RT 69 | (M) RT 70 | (N) RT 71 |
|------------|---|------------------------------|--|--|
| | | Doing heavy housework | Doing light housework | Getting to places outside of walking distance |
| H12 | Refer to 22a, 22e, 23a, and 25 on page 47. 1 <input type="checkbox"/> Any "Yes" (Go to 26) 2 <input type="checkbox"/> All other (Go to H12 for activity (M)) | 28 | Refer to 22a, 22e, 23a, and 25 on page 47. 1 <input type="checkbox"/> Any "Yes" (Go to 26) 2 <input type="checkbox"/> All other (Go to H12 for activity (N)) | 28 1 <input type="checkbox"/> Any "Yes" (Go to 26) 2 <input type="checkbox"/> All other (Skip to H13 for activity (H)) |
| 26. | 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 } (Go to H12 for next activity (M)) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | 29 | 26. 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 } (Go to H12 for next activity (N)) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | 26a. 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 } |
| | | | | b. During the past month, were you unable to go places you wanted to go 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 } |
| | | | | 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 } (Go to H13 for activity (H)) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } |

| | | (L) RT 69 | (M) RT 70 |
|------------|---|---------------------------|--|
| | | Do heavy housework | Do light housework |
| H13 | Refer to 19 on page 45. 1 <input type="checkbox"/> Box 3 marked (Go to H13 for activity (M)) 2 <input type="checkbox"/> All other (Go to 27) | 30 | Refer to 19 on page 45. 1 <input type="checkbox"/> Box 3 marked (Skip to H14 on page 50) 2 <input type="checkbox"/> All other (Go to 27) |
| 27. | 1 <input type="checkbox"/> Always } (Go to H13 for next activity) 2 <input type="checkbox"/> Sometimes } 3 <input type="checkbox"/> Rarely } 4 <input type="checkbox"/> Never } 9 <input type="checkbox"/> DK } | 31 | 1 <input type="checkbox"/> Always } (Go to H14 on page 50) 2 <input type="checkbox"/> Sometimes } 3 <input type="checkbox"/> Rarely } 4 <input type="checkbox"/> Never } 9 <input type="checkbox"/> DK } |

Notes

Section H - ASSISTANCE WITH KEY ACTIVITIES - Continued

| | | |
|---|--|---|
| ITEM H14 | <p>Refer to question 19 for activities H-O on pages 44 and 45. Indicate the activities marked "Yes".</p> <p>Insert these marked activities when asking 28.</p> | <p><input type="checkbox"/> H. Preparing your own meals</p> <p><input type="checkbox"/> I. Shopping for groceries and personal items</p> <p><input type="checkbox"/> J. Managing your money</p> <p><input type="checkbox"/> K. Using the telephone</p> <p><input type="checkbox"/> L. Doing heavy housework</p> <p><input type="checkbox"/> M. Doing light housework</p> <p><input type="checkbox"/> N. Getting to places outside of walking distance</p> <p><input type="checkbox"/> O. Managing your medication</p> <p><input type="checkbox"/> No activities marked (Skip to 30)</p> |
| <p>Insert activities marked in H14.</p> <p>28a. What (other) condition causes the trouble in (activities)?</p> <p>Record conditions and ask 28b.</p> <p>Ask if operation:</p> <p>For what condition did you have the operation?</p> <p>Record up to 5 conditions.</p> | | <p>00 <input type="checkbox"/> No condition (Skip to 30) 5-6</p> <p>01 <input type="checkbox"/> Old age (Skip to 28c) 7-8</p> <p>(a) _____ 9-10</p> <p>(b) _____ 11-12</p> <p>(c) _____ 13-14</p> <p>(d) _____ 15-16</p> <p>(e) _____ 17-18</p> |
| <p>b. Besides (condition), is there any other condition which causes this trouble in (activities)?</p> | | <p>1 <input type="checkbox"/> Yes (Reask 28a and b)</p> <p>2 <input type="checkbox"/> No } (Skip to 29)</p> <p>9 <input type="checkbox"/> DK }</p> <p style="text-align:right">19</p> |
| <p>c. Is this trouble in (activities) caused by any specific condition?</p> | | <p>1 <input type="checkbox"/> Yes (Reask 28a and b)</p> <p>2 <input type="checkbox"/> No } (Go to 29)</p> <p>9 <input type="checkbox"/> DK }</p> <p style="text-align:right">20</p> |
| <p>29. [Was this/Were any of these] condition(s) a result of a motor vehicle accident?</p> | | <p>1 <input type="checkbox"/> Yes 21</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> |
| <p>30. During the past 12 months, did you receive training to increase your independence in life skills such as managing money, preparing meals, or doing housework?</p> | | <p>1 <input type="checkbox"/> Yes 22</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> |
| <p>31a. During the past 12 months, that is, since (today's date) a year ago, have you fallen?</p> | | <p>1 <input type="checkbox"/> Yes (Go to 31b) 23</p> <p>2 <input type="checkbox"/> No } (Skip to Item H16 on page 51)</p> <p>9 <input type="checkbox"/> DK }</p> |
| <p>b. Have you fallen more than once in the past 12 months?</p> | | <p>1 <input type="checkbox"/> Yes 24</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> |
| <p>c. Were you injured as a result of the fall(s)?</p> | | <p>1 <input type="checkbox"/> Yes (Go to 31d) 25</p> <p>2 <input type="checkbox"/> No } (Skip to 31e)</p> <p>9 <input type="checkbox"/> DK }</p> |
| <p>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?</p> <p>Mark (X) all that apply.</p> | | <p>1 <input type="checkbox"/> Fracture 26</p> <p>2 <input type="checkbox"/> Bruise, cut, or scrape 27</p> <p>3 <input type="checkbox"/> Lost consciousness 28</p> <p>4 <input type="checkbox"/> Other 29</p> <p>9 <input type="checkbox"/> DK 30</p> |
| <p>e. [Did you fall/Were any of your falls] because you did not have help getting around or because your helper could not prevent you from falling?</p> | | <p>1 <input type="checkbox"/> Yes 31</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> |
| <p>f. [Did you fall/Were any of these falls] because you felt dizzy?</p> | | <p>1 <input type="checkbox"/> Yes 32</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> |

Notes

| Section H - ASSISTANCE WITH KEY ACTIVITIES - Continued | | |
|---|---|---|
| ITEM H16 | Status of SP. | <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">33</div> 1 <input type="checkbox"/> Institutionalized (<i>Skip to 55 on page 56</i>) 2 <input type="checkbox"/> All others (<i>Go to 32</i>) |
| 32a. During the past three months, did you experience bedsores or pressure sores? | | <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">34</div> 1 <input type="checkbox"/> Yes (<i>Go to 32</i>) 2 <input type="checkbox"/> No } (<i>Skip to 33</i>) 9 <input type="checkbox"/> DK } |
| b. Were any of these NEW bedsores or pressure sores? | | <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">35</div> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK |
| 33a. During the past three months, did you experience contractures, that is, joints that won't straighten out? | | <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">36</div> 1 <input type="checkbox"/> Yes (<i>Go to 33b</i>) 2 <input type="checkbox"/> No } (<i>Skip to Item H17</i>) 9 <input type="checkbox"/> DK } |
| b. Were any of these NEW contractures? | | <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">37</div> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK |
| ITEM H17 | Refer to question 8a on pages 38 and 39, columns A, D, and G. (<i>Receives help</i>) Mark (X) all that apply. | <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">38</div> 1 <input type="checkbox"/> "Yes" in 8a for A. Bathing 2 <input type="checkbox"/> "Yes" in 8a for D. Getting in/out of bed/chairs } (<i>Go to 34</i>) 3 <input type="checkbox"/> "Yes" in 8a for G. Using the toilet 4 <input type="checkbox"/> All others (<i>Skip to 35</i>) <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">39</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">40</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">41</div> |
| 34. 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? | | <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">42</div> 1 <input type="checkbox"/> Yes, strong enough 2 <input type="checkbox"/> No, physically difficult 9 <input type="checkbox"/> DK |
| If proxy respondent, ask; otherwise, skip to H18. 35. Does (sample person) need supervision to ensure [his/her] personal safety or the safety of others? | | <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">43</div> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK |
| ITEM H18 | Refer to questions 8a and 9a on pages 38 and 39 and questions 22a and 23a on pages 46 and 47. (<i>Receives help and/or supervision</i>) Mark (X) all that apply. | <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">38</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">39</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">40</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">41</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">42</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">43</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">44</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">45</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">46</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">47</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">48</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">49</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">50</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">51</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">52</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">53</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">54</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">55</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">56</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">57</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">58</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">59</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">60</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">61</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">62</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">63</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">64</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">65</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">66</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">67</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">68</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">69</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">70</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">71</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">72</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">73</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">74</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">75</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">76</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">77</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">78</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">79</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">80</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">81</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">82</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">83</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">84</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">85</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">86</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">87</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">88</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">89</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">90</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">91</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">92</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">93</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">94</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">95</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">96</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">97</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">98</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">99</div> <div style="text-align: right; border-bottom: 1px solid black; margin-bottom: 5px;">100</div> |
| Notes | | |

| Section H – ASSISTANCE WITH KEY ACTIVITIES – Continued | | RT 74 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|---|-------|--|------------------------------------|---|------------------|--------------------------------------|------------------------------------|--|------------------------------------|--|-------|--|-------|--|-------|---|-------|--|-------|---|-------|---|-------|---|-------|---|-------|--------------------------------|-------|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--------------------------------|--|--|--|
| | | 3-4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>36. Who usually helps you with (activities marked in H18)? Anyone else? Enter the name or description of each helper in separate columns.</p> | 36. | <p>(01) _____ First helper</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Ask 37–41 for each helper in 36. ASK OR VERIFY:</p> <p>37. Which activities does (Helper) help you with? Mark (X) all that apply.</p> | 37. | <table 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</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 | 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 | 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>38a. Which of these best describes (Helper)? Mark (X) only one.</p> | 38a. | <table style="width:100%; border-collapse: collapse;"> <tr><td>01 <input type="checkbox"/> Spouse</td><td rowspan="2" style="font-size: 2em; vertical-align: middle;">}</td><td rowspan="2">In household</td><td rowspan="2" style="width: 50px;"></td></tr> <tr><td>02 <input type="checkbox"/> Child</td></tr> <tr><td>03 <input type="checkbox"/> Parent</td><td rowspan="3" style="font-size: 2em; vertical-align: middle;">}</td><td rowspan="3">Not in household</td><td rowspan="3"></td></tr> <tr><td>04 <input type="checkbox"/> Spouse</td></tr> <tr><td>05 <input type="checkbox"/> Child</td></tr> <tr><td>06 <input type="checkbox"/> Parent</td></tr> <tr><td>07 <input type="checkbox"/> Other HH relative</td><td colspan="3"></td></tr> <tr><td>08 <input type="checkbox"/> Non-HH relative</td><td colspan="3"></td></tr> <tr><td>09 <input type="checkbox"/> HH non-relative</td><td colspan="3"></td></tr> <tr><td>10 <input type="checkbox"/> Friend/Neighbor</td><td colspan="3"></td></tr> <tr><td>11 <input type="checkbox"/> Unpaid volunteer from organization/business</td><td colspan="3"></td></tr> <tr><td>12 <input type="checkbox"/> Paid employee of organization/business</td><td colspan="3"></td></tr> <tr><td>13 <input type="checkbox"/> Paid employee of yours</td><td colspan="3"></td></tr> <tr><td>14 <input type="checkbox"/> Other</td><td colspan="3"></td></tr> <tr><td>99 <input type="checkbox"/> DK</td><td colspan="3"></td></tr> </table> | 01 <input type="checkbox"/> Spouse | } | In household | | 02 <input type="checkbox"/> Child | 03 <input type="checkbox"/> Parent | } | Not in household | | 04 <input type="checkbox"/> Spouse | 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 02 <input type="checkbox"/> Child | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 03 <input type="checkbox"/> Parent | } | Not in household | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 04 <input type="checkbox"/> Spouse | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 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 38a, skip to 40; otherwise ask:</p> <p>39a. Is (Helper) paid? HAND CARD A1. Read answers if telephone interview.</p> | 39a. | <table style="width:100%; border-collapse: collapse;"> <tr><td>1 <input type="checkbox"/> Yes (Go to 39b)</td><td style="text-align: right;">42</td></tr> <tr><td>2 <input type="checkbox"/> No (Skip to 40)</td><td></td></tr> </table> | 1 <input type="checkbox"/> Yes (Go to 39b) | 42 | 2 <input type="checkbox"/> No (Skip to 40) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 <input type="checkbox"/> Yes (Go to 39b) | 42 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> No (Skip to 40) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>b. Who pays for this help? (Anyone else?) Mark (X) all that apply.</p> | b. | <table style="width:100%; border-collapse: collapse;"> <tr><td>01 <input type="checkbox"/> Self or 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> | 01 <input type="checkbox"/> Self or 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 | | | | | | | | | | | | | | | | | | | | |
| 01 <input type="checkbox"/> Self or 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>40. DURING THE PAST 2 WEEKS, how many days did (Helper) help you?</p> | 40. | <table 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> <tr><td>_____ Days (Number)</td><td></td></tr> <tr><td>99 <input type="checkbox"/> DK</td><td></td></tr> </table> | 00 <input type="checkbox"/> None in past 2 weeks | 71-72 | _____ Days (Number) | | 99 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 00 <input type="checkbox"/> None in past 2 weeks | 71-72 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ Days (Number) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 99 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>41. On the days you receive help from (Helper), about how many hours per day does [he/she] usually help you?</p> | 41. | <table 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">(Go to 37 for next helper, or H19)</td><td style="text-align: right;">73-74</td></tr> <tr><td>99 <input type="checkbox"/> DK</td></tr> </table> | _____ Hours/day (Number) | } | (Go to 37 for next helper, or H19) | 73-74 | 99 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ Hours/day (Number) | } | (Go to 37 for next helper, or H19) | 73-74 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 99 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>ITEM H19</p> | <p>Refer to 36 above. (Number of helpers)</p> | <p>H19</p> <table style="width:100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Only one helper (Skip to 43 on page 54)</td></tr> <tr><td><input type="checkbox"/> More than one helper (Go to 42 on page 54)</td></tr> </table> | <input type="checkbox"/> Only one helper (Skip to 43 on page 54) | <input type="checkbox"/> More than one helper (Go to 42 on page 54) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Only one helper (Skip to 43 on page 54) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> More than one helper (Go to 42 on page 54) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| Section H – ASSISTANCE WITH KEY ACTIVITIES – Continued | | | | | | RT 75 |
|--|---|----------------------------|----------------------------|----------------------------|----------------------------|-------|
| | | | | | | 3-4 |
| 42. 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 : _____ | | | | | 5-6 |
| 43a. During the past 12 months, has someone other than (main helper) stayed with you or assisted you so that (main helper) could go out for a while, take a break, or go on vacation? | 1 <input type="checkbox"/> Yes (Go to 43b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Skip to 44) | | | | | 7 |
| b. How many days in the past 12 months? | _____ (Days) 999 <input type="checkbox"/> DK | | | | | 8-10 |
| Ask 44 about only helper in 36 or main helper in 42. | | | | | | |
| 44. 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"/> | 11 |
| 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"/> | 12 |
| 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"/> | 13 |
| d. (Helper's) ability to do what you need [him/her] to do? (Would you say — (Read categories)?) If helper is present or related to SP, skip to 45; otherwise, ask: | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 9 <input type="checkbox"/> | 14 |
| How satisfied are you with — | | | | | | 15 |
| 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"/> | 16 |
| 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"/> | 17 |
| 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"/> | 18 |
| 45. Are you EVER home alone for more than two hours at a time? | 1 <input type="checkbox"/> Yes (Skip to 47) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Go to 46) | | | | | 18 |
| 46. Would it be a problem for you to be alone at home for more than two hours at a time because you would need help or feel afraid? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Skip to 48) | | | | | 19 |
| 47. If it could be arranged, would it be better if you did not have to stay alone for as long as two hours? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK | | | | | 20 |
| 48a. Including the other persons living here, is there a friend, relative, or neighbor who would take care of you for a few DAYS, if necessary? | 1 <input type="checkbox"/> Yes (Go to 48b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Skip to Item H20 on page 55) | | | | | 21 |
| b. Who is this person? Probe for description if necessary. Mark (X) only one. | 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 | | | | | 22 |
| 49a. Again, including the 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 49b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Skip to Item H20 on page 55) | | | | | 23 |
| b. Who is this person? Probe for description if necessary. Mark (X) only one. | 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 | | | | | 24 |

| Section H – ASSISTANCE WITH KEY ACTIVITIES – Continued | | |
|--|---|--|
| ITEM H20 | Refer to questions 8e and 11 for activities A–G on pages 38 and 39. (Need [more] help or supervision) | 1 <input type="checkbox"/> Any "Yes" in questions 8e or 11 (Skip to 50) 2 <input type="checkbox"/> All other (Go to Item H21) |
| ITEM H21 | Refer to questions 22e for activities H–O on pages 46 and 47. (Need [more] help) | 1 <input type="checkbox"/> Any "Yes" in question 22e (Skip to 50) 2 <input type="checkbox"/> All other (Go to Item H22) |
| ITEM H22 | Refer to question 25 for activities H–O on pages 46 and 47. (Need [more] supervision) | 1 <input type="checkbox"/> Any "Yes" in question 25 (Go to 50) 2 <input type="checkbox"/> All other (Skip to 53) |
| 50a. You mentioned earlier that you need help or more help with certain activities. Have you or someone else ever tried to hire help or get someone from a program or agency to help you? | | 1 <input type="checkbox"/> Yes (Skip to 51) 2 <input type="checkbox"/> No (Go to 50b) 3 <input type="checkbox"/> DK (Skip to 52) |
| b. Why not? | | |
| Anything else? | | |
| Read categories if necessary. | | |
| Mark (X) all that apply. | | |
| | 01 <input type="checkbox"/> Did not want stranger for helper 02 <input type="checkbox"/> Too expensive/can't afford 03 <input type="checkbox"/> Not sick enough to get help from agency 04 <input type="checkbox"/> Income too high to get help from agency 05 <input type="checkbox"/> Type of help needed probably not available 06 <input type="checkbox"/> Quality help not available 07 <input type="checkbox"/> Did not know where to look for help 08 <input type="checkbox"/> Too sick to look for help 09 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK | 29-30 31-32 33-34 35-36 37-38 39-40 41-42 43-44 45-46 47-48 |
| | | (Skip to 52) |
| 51. What problems have you had in trying to find help? | | |
| Anything else? | | |
| Read categories if necessary. | | |
| Mark (X) all that apply. | | |
| | 0 <input type="checkbox"/> No problems 1 <input type="checkbox"/> Too expensive 2 <input type="checkbox"/> Can't locate right type of help 3 <input type="checkbox"/> Can't locate adequately trained helper 4 <input type="checkbox"/> Can't locate helper who is available when needed 5 <input type="checkbox"/> Not sick enough to get help from agency 6 <input type="checkbox"/> Income is too high to get help from agency 7 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK | 49 50 51 52 53 54 55 56 57 |
| 52. Has any agency or organization tried to find someone to help you? | | |
| | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK | 58 |
| 53. Have you ever hired someone or received help from a public agency or a non-profit agency? | | |
| | 1 <input type="checkbox"/> Yes (Go to 54a) 2 <input type="checkbox"/> No } (Skip to 55) 3 <input type="checkbox"/> DK } | 59 |
| 54a. Did you stop getting help from the person or agency even though you still needed it? | | |
| | 1 <input type="checkbox"/> Yes (Skip to 54b) 2 <input type="checkbox"/> No } (Skip to 55) 3 <input type="checkbox"/> DK } | 60 |
| b. Why did you stop getting help? | | |
| Any other reason? | | |
| Read categories if necessary. | | |
| Mark (X) all that apply. | | |
| | 1 <input type="checkbox"/> Too expensive 2 <input type="checkbox"/> Inadequate training 3 <input type="checkbox"/> Unavailable when needed 4 <input type="checkbox"/> No longer sick enough to qualify for public agency or non-profit agency help 5 <input type="checkbox"/> Income too high to get help from public or non-profit agency 6 <input type="checkbox"/> Unreliable 7 <input type="checkbox"/> Language problems 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK | 61 62 63 64 65 66 67 68 69 |
| Notes | | |

Section H - ASSISTANCE WITH KEY ACTIVITIES - Continued

| | | |
|--|---|--|
| <p>55a. [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?</p> | <p>1 <input type="checkbox"/> Yes (Go to 55b) 2 <input type="checkbox"/> No 3 <input type="checkbox"/> DK } (Skip to 56)</p> | <p>70</p> |
| <p>b. What kind of problems did you have? Anything else? Read categories if necessary. Mark (X) all that apply.</p> | <p>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</p> | <p>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 97-98</p> |

| | | |
|--|---|------------|
| <p>56. Because of YOUR health, did anyone in your family EVER —</p> | <p>Yes No DK</p> | |
| <p>a. Quit a job or retire early?</p> | <p>a. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p> | <p>99</p> |
| <p>b. Change jobs?</p> | <p>b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p> | <p>100</p> |
| <p>c. Change or reduce work hours?</p> | <p>c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p> | <p>101</p> |
| <p>d. Not take a job in order to care for you?</p> | <p>d. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/></p> | <p>102</p> |

Notes

| Section I – OTHER SERVICES | | RT 76 |
|--|---------------|--|
| | | 3-4 |
| ITEM 11 | Status of SP. | 1 <input type="checkbox"/> Institutionalized <i>(Skip to Section K on page 78)</i> 2 <input type="checkbox"/> All others <i>(Go to 1)</i> |
| The next questions are about medical care received at home. | | 5 |
| 1. DURING THE PAST 3 MONTHS, did you get any medical treatments at home such as injections, therapy, blood or urine testing, or catheter care? | | 6 |
| 1 <input type="checkbox"/> Yes <i>(Go to 2)</i> 2 <input type="checkbox"/> No } <i>(Skip to 7)</i> 9 <input type="checkbox"/> DK } | | |
| 2. Do you need more help or a different kind of help with your medical treatments at home? | | 7 |
| 1 <input type="checkbox"/> Yes <i>(Go to 3)</i> 2 <input type="checkbox"/> No } <i>(Skip to 4)</i> 9 <input type="checkbox"/> DK } | | |
| 3. Have you experienced any problems because you did not have enough help or the right kind of help with home medical treatments? | | 8 |
| 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK | | |
| 4. Do family members or friends help you with medical treatments at home? | | 9 |
| 1 <input type="checkbox"/> Yes <i>(Go to 5)</i> 2 <input type="checkbox"/> No } <i>(Skip to 7)</i> 9 <input type="checkbox"/> DK } | | |
| 5. Have these friends or family members been trained by a health care professional to administer these medical treatments? | | 10 |
| 1 <input type="checkbox"/> Yes, all have been trained 2 <input type="checkbox"/> Yes, some have been trained 3 <input type="checkbox"/> No, none have been trained 9 <input type="checkbox"/> DK | | |
| 6a. Do you receive any home medical treatments from friends or relatives that you feel should be administered by a health professional? | | 11 |
| 1 <input type="checkbox"/> Yes <i>(Go to 6b)</i> 2 <input type="checkbox"/> No } <i>(Skip to 7)</i> 9 <input type="checkbox"/> DK } | | |
| b. Why aren't you getting this help from a health professional? | | |
| Any other reason? | | |
| <i>Mark (X) all that apply.</i> | | |
| 1 <input type="checkbox"/> Don't know where to go for help 2 <input type="checkbox"/> Looked for help, help not available 3 <input type="checkbox"/> No insurance coverage 4 <input type="checkbox"/> Cannot afford, even with insurance coverage 5 <input type="checkbox"/> Don't want the treatment 6 <input type="checkbox"/> Getting new helper/in between helpers 7 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK | | 12 13 14 15 16 17 18 19 |
| 7. Are there any home medical treatments that have been prescribed for you but you are not getting? | | 20 |
| 1 <input type="checkbox"/> Yes <i>(Go to 8)</i> 2 <input type="checkbox"/> No } <i>(Skip to 9)</i> 9 <input type="checkbox"/> DK } | | |
| 8. Why aren't you getting this treatment? | | |
| Any other reason? | | |
| <i>Mark (X) all that apply.</i> | | |
| 1 <input type="checkbox"/> Don't know where to go for help 2 <input type="checkbox"/> Looked for help, help not available 3 <input type="checkbox"/> No insurance coverage 4 <input type="checkbox"/> Cannot afford, even with insurance coverage 5 <input type="checkbox"/> Don't want the treatment 6 <input type="checkbox"/> Getting new helper/in between helpers 7 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK | | 21 22 23 24 25 26 27 28 |
| Now I would like to ask about prescription medicines. | | 29 |
| 9. 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. | | |
| 0 <input type="checkbox"/> None <i>(Skip to 17 on page 58)</i> 1 <input type="checkbox"/> One or two } <i>(Go to 10)</i> 2 <input type="checkbox"/> Three-five } 3 <input type="checkbox"/> Six-nine } 4 <input type="checkbox"/> Ten or more } 9 <input type="checkbox"/> DK } | | |
| <i>Mark (X) only one.</i> | | |
| The next questions are about these prescription medicines. | | 30 |
| 10. Would you say that you use medicine(s) as prescribed by the doctor — <i>(Read all categories)</i> | | |
| <i>Mark (X) only one.</i> | | |
| 1 <input type="checkbox"/> All of the time, <i>(Skip to 14 on page 58)</i> 2 <input type="checkbox"/> Most of the time, 3 <input type="checkbox"/> Some of the time, 4 <input type="checkbox"/> Rarely, or, 5 <input type="checkbox"/> Never? } <i>(Skip to 11 on page 58)</i> 9 <input type="checkbox"/> DK } | | |

| Section I – OTHER SERVICES – Continued | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|-------|--|-------|--|-------------------------------|---|-------|---|----------------------------|---|-------|--|----------------------------|--|-------|--|----------------------------|---|-------|-----------------------------------|----------------------------|--------------------------------|-------|-------------------------------|----------------------------|----------------------------|----|-------------------------------|----------------------------|----------------------------|----|-------------------------------|----------------------------|----------------------------|----|
| <p>11. Are there any prescription medicines that you are supposed to use, but —</p> <p>a. did not get when first prescribed because of the cost?</p> <p>b. did not get the entire prescription filled because of the cost?</p> <p>c. did not refill when you ran out because of the cost?</p> <p>d. use less often than prescribed in order to stretch them out because of the cost?</p> <p>e. sometimes forget to use?</p> <p>f. don't use as prescribed because of the side effects?</p> <p>g. cannot pick up from the drug store or get delivered?</p> <p>h. don't use because you think you don't need it?</p> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> <td style="text-align: center;">DK</td> <td></td> </tr> <tr> <td style="text-align: center;">a. 1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td style="text-align: center;">9 <input type="checkbox"/></td> <td style="text-align: right; border: 1px solid black;">31</td> </tr> <tr> <td style="text-align: center;">b. 1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td style="text-align: center;">9 <input type="checkbox"/></td> <td style="text-align: right; border: 1px solid black;">32</td> </tr> <tr> <td style="text-align: center;">c. 1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td style="text-align: center;">9 <input type="checkbox"/></td> <td style="text-align: right; border: 1px solid black;">33</td> </tr> <tr> <td style="text-align: center;">d. 1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td style="text-align: center;">9 <input type="checkbox"/></td> <td style="text-align: right; border: 1px solid black;">34</td> </tr> <tr> <td style="text-align: center;">e. 1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td style="text-align: center;">9 <input type="checkbox"/></td> <td style="text-align: right; border: 1px solid black;">35</td> </tr> <tr> <td style="text-align: center;">f. 1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td style="text-align: center;">9 <input type="checkbox"/></td> <td style="text-align: right; border: 1px solid black;">36</td> </tr> <tr> <td style="text-align: center;">g. 1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td style="text-align: center;">9 <input type="checkbox"/></td> <td style="text-align: right; border: 1px solid black;">37</td> </tr> <tr> <td style="text-align: center;">h. 1 <input type="checkbox"/></td> <td style="text-align: center;">2 <input type="checkbox"/></td> <td style="text-align: center;">9 <input type="checkbox"/></td> <td style="text-align: right; border: 1px solid black;">38</td> </tr> </table> | Yes | No | DK | | a. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 31 | b. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 32 | c. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 33 | d. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 34 | e. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 35 | f. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 36 | g. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 37 | h. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 38 |
| Yes | No | DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 31 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 32 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 33 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 34 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 35 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 36 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 37 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 38 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>12. Have you experienced any problems because you forgot to use your medicine or didn't use your medicine as prescribed?</p> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">1 <input type="checkbox"/> Yes (Go to 13)</td> <td rowspan="3" style="font-size: 2em; vertical-align: middle;">}</td> <td rowspan="3" style="vertical-align: middle;">(Skip to 14)</td> <td style="border: 1px solid black; width: 50px;"></td> </tr> <tr> <td>2 <input type="checkbox"/> No</td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> </tr> </table> | 1 <input type="checkbox"/> Yes (Go to 13) | } | (Skip to 14) | | 2 <input type="checkbox"/> No | 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 <input type="checkbox"/> Yes (Go to 13) | } | (Skip to 14) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>13. What problems did you experience?</p> <p>Anything else?</p> <p><i>Mark (X) all that apply.</i></p> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">01 <input type="checkbox"/> Pain/Discomfort</td> <td style="text-align: right; border: 1px solid black;">40-41</td> </tr> <tr> <td>02 <input type="checkbox"/> Dizziness/Fainting</td> <td style="text-align: right; border: 1px solid black;">42-43</td> </tr> <tr> <td>03 <input type="checkbox"/> Disorientation</td> <td style="text-align: right; border: 1px solid black;">44-45</td> </tr> <tr> <td>04 <input type="checkbox"/> Overdose/Withdrawal</td> <td style="text-align: right; border: 1px solid black;">46-47</td> </tr> <tr> <td>05 <input type="checkbox"/> Change in blood pressure, breathing, or other vital signs</td> <td style="text-align: right; border: 1px solid black;">48-49</td> </tr> <tr> <td>06 <input type="checkbox"/> Condition for which medicine prescribed got worse</td> <td style="text-align: right; border: 1px solid black;">50-51</td> </tr> <tr> <td>07 <input type="checkbox"/> Other condition(s) got worse</td> <td style="text-align: right; border: 1px solid black;">52-53</td> </tr> <tr> <td>08 <input type="checkbox"/> Had to be admitted to hospital</td> <td style="text-align: right; border: 1px solid black;">54-55</td> </tr> <tr> <td>09 <input type="checkbox"/> Had to go to doctor/emergency room</td> <td style="text-align: right; border: 1px solid black;">56-57</td> </tr> <tr> <td>10 <input type="checkbox"/> Drug reaction</td> <td style="text-align: right; border: 1px solid black;">58-59</td> </tr> <tr> <td>11 <input type="checkbox"/> Other</td> <td style="text-align: right; border: 1px solid black;">60-61</td> </tr> <tr> <td>99 <input type="checkbox"/> DK</td> <td style="text-align: right; border: 1px solid black;">62-63</td> </tr> </table> | 01 <input type="checkbox"/> Pain/Discomfort | 40-41 | 02 <input type="checkbox"/> Dizziness/Fainting | 42-43 | 03 <input type="checkbox"/> Disorientation | 44-45 | 04 <input type="checkbox"/> Overdose/Withdrawal | 46-47 | 05 <input type="checkbox"/> Change in blood pressure, breathing, or other vital signs | 48-49 | 06 <input type="checkbox"/> Condition for which medicine prescribed got worse | 50-51 | 07 <input type="checkbox"/> Other condition(s) got worse | 52-53 | 08 <input type="checkbox"/> Had to be admitted to hospital | 54-55 | 09 <input type="checkbox"/> Had to go to doctor/emergency room | 56-57 | 10 <input type="checkbox"/> Drug reaction | 58-59 | 11 <input type="checkbox"/> Other | 60-61 | 99 <input type="checkbox"/> DK | 62-63 | | | | | | | | | | | | |
| 01 <input type="checkbox"/> Pain/Discomfort | 40-41 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 02 <input type="checkbox"/> Dizziness/Fainting | 42-43 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 03 <input type="checkbox"/> Disorientation | 44-45 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 04 <input type="checkbox"/> Overdose/Withdrawal | 46-47 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 05 <input type="checkbox"/> Change in blood pressure, breathing, or other vital signs | 48-49 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 06 <input type="checkbox"/> Condition for which medicine prescribed got worse | 50-51 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 07 <input type="checkbox"/> Other condition(s) got worse | 52-53 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 08 <input type="checkbox"/> Had to be admitted to hospital | 54-55 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 09 <input type="checkbox"/> Had to go to doctor/emergency room | 56-57 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 <input type="checkbox"/> Drug reaction | 58-59 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11 <input type="checkbox"/> Other | 60-61 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 99 <input type="checkbox"/> DK | 62-63 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>14. 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?</p> <p><i>Mark (X) only one.</i></p> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">1 <input type="checkbox"/> Receive help</td> <td rowspan="3" style="font-size: 2em; vertical-align: middle;">}</td> <td rowspan="3" style="vertical-align: middle;">(Skip to 17)</td> <td style="border: 1px solid black; width: 50px;"></td> </tr> <tr> <td>2 <input type="checkbox"/> All by self</td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> </tr> </table> | 1 <input type="checkbox"/> Receive help | } | (Skip to 17) | | 2 <input type="checkbox"/> All by self | 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 <input type="checkbox"/> Receive help | } | (Skip to 17) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> All by self | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>15. Not counting financial help, do you NEED (more) help with your medicine?</p> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">1 <input type="checkbox"/> Yes (Go to 16)</td> <td rowspan="3" style="font-size: 2em; vertical-align: middle;">}</td> <td rowspan="3" style="vertical-align: middle;">(Skip to 17)</td> <td style="border: 1px solid black; width: 50px;"></td> </tr> <tr> <td>2 <input type="checkbox"/> No</td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> </tr> </table> | 1 <input type="checkbox"/> Yes (Go to 16) | } | (Skip to 17) | | 2 <input type="checkbox"/> No | 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 <input type="checkbox"/> Yes (Go to 16) | } | (Skip to 17) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>16. What do you NEED (more) help with?</p> <p>Anything else?</p> <p><i>Mark (X) all that apply.</i></p> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">1 <input type="checkbox"/> Ordering/Shopping for/Getting medicines from pharmacy</td> <td style="text-align: right; border: 1px solid black;">66</td> </tr> <tr> <td>2 <input type="checkbox"/> Reminder/Monitoring/Measuring/Setting up/Taking medicines</td> <td style="text-align: right; border: 1px solid black;">67</td> </tr> <tr> <td>3 <input type="checkbox"/> Other</td> <td style="text-align: right; border: 1px solid black;">68</td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> <td style="text-align: right; border: 1px solid black;">69</td> </tr> </table> | 1 <input type="checkbox"/> Ordering/Shopping for/Getting medicines from pharmacy | 66 | 2 <input type="checkbox"/> Reminder/Monitoring/Measuring/Setting up/Taking medicines | 67 | 3 <input type="checkbox"/> Other | 68 | 9 <input type="checkbox"/> DK | 69 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 <input type="checkbox"/> Ordering/Shopping for/Getting medicines from pharmacy | 66 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> Reminder/Monitoring/Measuring/Setting up/Taking medicines | 67 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 <input type="checkbox"/> Other | 68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 <input type="checkbox"/> DK | 69 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>These next questions are about your sources of medical care.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>17. Do you have a general practitioner, internist, or family doctor whom you see regularly?</p> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">1 <input type="checkbox"/> Yes (Go to 18)</td> <td rowspan="3" style="font-size: 2em; vertical-align: middle;">}</td> <td rowspan="3" style="vertical-align: middle;">(Skip to 26 on page 59)</td> <td style="border: 1px solid black; width: 50px;"></td> </tr> <tr> <td>2 <input type="checkbox"/> No</td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> </tr> </table> | 1 <input type="checkbox"/> Yes (Go to 18) | } | (Skip to 26 on page 59) | | 2 <input type="checkbox"/> No | 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 <input type="checkbox"/> Yes (Go to 18) | } | (Skip to 26 on page 59) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>18. Which do you see most often — a general practitioner, an internist, or family doctor?</p> <p><i>Mark (X) only one.</i></p> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">1 <input type="checkbox"/> General practitioner</td> <td style="text-align: right; border: 1px solid black;">71</td> </tr> <tr> <td>2 <input type="checkbox"/> Internist</td> <td></td> </tr> <tr> <td>3 <input type="checkbox"/> Family doctor</td> <td></td> </tr> <tr> <td>4 <input type="checkbox"/> DK specialty/title</td> <td></td> </tr> <tr> <td>9 <input type="checkbox"/> DK which seen most often</td> <td></td> </tr> </table> | 1 <input type="checkbox"/> General practitioner | 71 | 2 <input type="checkbox"/> Internist | | 3 <input type="checkbox"/> Family doctor | | 4 <input type="checkbox"/> DK specialty/title | | 9 <input type="checkbox"/> DK which seen most often | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 <input type="checkbox"/> General practitioner | 71 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> Internist | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 <input type="checkbox"/> Family doctor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 <input type="checkbox"/> DK specialty/title | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 <input type="checkbox"/> DK which seen most often | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>19. Have you seen this [(provider in 18)/doctor] in the past 12 months?</p> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">1 <input type="checkbox"/> Yes (Go to 20)</td> <td rowspan="3" style="font-size: 2em; vertical-align: middle;">}</td> <td rowspan="3" style="vertical-align: middle;">(Skip to 25 on page 59)</td> <td style="border: 1px solid black; width: 50px;"></td> </tr> <tr> <td>2 <input type="checkbox"/> No</td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> </tr> </table> | 1 <input type="checkbox"/> Yes (Go to 20) | } | (Skip to 25 on page 59) | | 2 <input type="checkbox"/> No | 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 <input type="checkbox"/> Yes (Go to 20) | } | (Skip to 25 on page 59) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>20. In the past 3 months, how many times have you seen this [(provider in 18)/doctor]?</p> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">00 <input type="checkbox"/> None (Skip to 22 on page 59)</td> <td rowspan="4" style="font-size: 3em; vertical-align: middle;">}</td> <td rowspan="4" style="vertical-align: middle;">(Go to 21 on page 59)</td> <td style="border: 1px solid black; width: 50px;"></td> </tr> <tr> <td>_____ Times</td> </tr> <tr> <td>(Number)</td> </tr> <tr> <td>99 <input type="checkbox"/> DK</td> </tr> </table> | 00 <input type="checkbox"/> None (Skip to 22 on page 59) | } | (Go to 21 on page 59) | | _____ Times | (Number) | 99 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 00 <input type="checkbox"/> None (Skip to 22 on page 59) | } | (Go to 21 on page 59) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ Times | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Number) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 99 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| Section I – OTHER SERVICES – Continued | | RT 77 |
|--|---|--|
| | | 3-4 |
| 21. Did this [(provider in 18)/doctor] ask to see you for more [than the (number in 20) visit(s)/visits]? | <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 9 DK | 5 |
| 22. In the past 3 months, did this [(provider in 18)/doctor] refer you to another doctor, therapist, or medical professional, or send you for tests or x-rays? | <input type="checkbox"/> 1 Yes (Go to 23) <input type="checkbox"/> 2 No } (Skip to Item I2) <input type="checkbox"/> 9 DK } | 6 |
| 23. Did you or will you go for all, some, or none of the visits or tests recommended by this [(provider in 18)/doctor]? <i>Mark (X) only one.</i> | <input type="checkbox"/> 1 All (Go to Item I2) <input type="checkbox"/> 2 Some } (Skip to 24) <input type="checkbox"/> 3 None } <input type="checkbox"/> 9 DK (Go to Item I2) | 7 |
| ITEM I2 | Refer to question 21. (Additional visits recommended) | 8 |
| HAND CARD A6. Read categories if telephone interview. | | |
| 24. Why did you not go for (all) your recommended visits or tests? (Anything else?) <i>Mark (X) all that apply.</i> | <input type="checkbox"/> 01 Waiting for upcoming appointment <input type="checkbox"/> 02 Did not like doctor or doctor's advice <input type="checkbox"/> 03 Went to another doctor instead <input type="checkbox"/> 04 Problems at place — long wait, no bathroom, not accessible <input type="checkbox"/> 05 Clinic/Office in unsafe neighborhood <input type="checkbox"/> 06 No insurance <input type="checkbox"/> 07 Insurance did not cover <input type="checkbox"/> 08 Can't afford it <input type="checkbox"/> 09 Transportation problem <input type="checkbox"/> 10 Could not get convenient appointment <input type="checkbox"/> 11 Thought problem would go away, or problem went away <input type="checkbox"/> 12 Used home remedy <input type="checkbox"/> 13 Health got worse <input type="checkbox"/> 14 Health of other family member interfered <input type="checkbox"/> 15 Other reason <input type="checkbox"/> 99 DK | 9-10 11-12 13-14 15-16 17-18 19-20 21-22 23-24 25-26 27-28 29-30 31-32 33-34 35-36 37-38 39-40 |
| 25. How would you rate this [(provider in 18)/doctor] in terms of overall quality of care and services? Would you say excellent, good, fair, or poor? <i>Mark (X) only one.</i> | <input type="checkbox"/> 1 Excellent <input type="checkbox"/> 2 Good <input type="checkbox"/> 3 Fair <input type="checkbox"/> 4 Poor <input type="checkbox"/> 9 DK | 41 |
| RT 78 | | |
| Now, I'd like to ask about the (other) types of doctors you see most often. | | 3-4 |
| 26a. What types of specialists do you see regularly? Any others? <i>Read categories if necessary.</i> <i>Mark (X) all that apply.</i> Ask only if more than one specialist in 26a. If only one, transcribe the number of the box in 26b without asking. | 26a. Regularly <input type="checkbox"/> 00 None (Skip to 35 on page 61) <input type="checkbox"/> 01 Allergist/Immunologist (Allergy doctor) <input type="checkbox"/> 02 Cardiologist (Heart doctor) <input type="checkbox"/> 03 Dermatologist (Skin doctor) <input type="checkbox"/> 04 Endocrinologist (Gland/Hormone doctor) <input type="checkbox"/> 05 Gastroenterologist (Stomach doctor) <input type="checkbox"/> 06 Hematologist (Blood doctor) <input type="checkbox"/> 07 Nephrologist (Kidney doctor) <input type="checkbox"/> 08 Neurologist/Neuropathologist (Nervous system doctor) <input type="checkbox"/> 09 Neurosurgeon (Nervous system surgeon) <input type="checkbox"/> 10 Obstetrician/Gynecologist (OB/GYN) <input type="checkbox"/> 11 Oncologist (Cancer doctor) <input type="checkbox"/> 12 Ophthalmologist (Eye doctor) <input type="checkbox"/> 13 Orthopedist/Orthopedic surgeon (Bone and Muscle doctor) <input type="checkbox"/> 14 Otolaryngologist/Otorhinolaryngologist (Ear, nose, throat doctor) <input type="checkbox"/> 15 Physical medicine/Rehabilitation specialist (Physical therapy) <input type="checkbox"/> 16 Podiatrist (Foot doctor) <input type="checkbox"/> 17 Psychiatrist (Mental health doctor) <input type="checkbox"/> 18 Pulmonary/Lung specialist (Respiratory doctor) <input type="checkbox"/> 19 Radiologist (X-Ray/Nuclear medicine doctor) <input type="checkbox"/> 20 Rheumatologist (Joint doctor) <input type="checkbox"/> 21 Urologist (Urinary tract doctor) <input type="checkbox"/> 22 Other <input type="checkbox"/> 99 Specialist – DK type | 53-54 Specialist 5-6 7-8 9-10 11-12 13-14 15-16 17-18 19-20 21-22 23-24 25-26 27-28 29-30 31-32 33-34 35-36 41-42 43-44 45-46 47-48 49-50 51-52 |
| b. Which of these specialists have you seen most often? <i>Mark (X) only one.</i> | | 53-54 |

| Section I - OTHER SERVICES - Continued | | RT 79 |
|---|---|--|
| | | 3-4 |
| 27. Have you seen this [(specialist in 26b)/doctor] in the past 12 months? | <input type="checkbox"/> Yes (Go to 28) <input type="checkbox"/> No } (Skip to 29) <input type="checkbox"/> DK } | 5 |
| 28. In the past 3 months, how many times have you seen this [(specialist in 26b)/doctor]? Do not count times while an overnight patient in a hospital. | 00 <input type="checkbox"/> None (Skip to 30) 01 <input type="checkbox"/> Only while overnight patient } _____ Times } (Go to 29) (Number) 99 <input type="checkbox"/> DK | 6-7 |
| 29. Did this [(specialist in 26b)/doctor] ask to see you for more [than the (number in 28) visit(s)/visits]? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | 8 |
| 30. In the past 3 months, did this [(specialist in 26b)/doctor] refer you to another doctor, therapist, or medical professional, or send you for tests or x-rays? | <input type="checkbox"/> Yes (Go to 31) <input type="checkbox"/> No } (Skip to Item 13) <input type="checkbox"/> DK } | 9 |
| 31. Did you or will you go for all, some, or none of the visits or tests recommended by this [(specialist in 26b)/doctor]? Mark (X) only one. | <input type="checkbox"/> All (Go to Item 13) <input type="checkbox"/> Some } (Skip to 32) <input type="checkbox"/> None } <input type="checkbox"/> DK (Go to Item 13) | 10 |
| ITEM 13 Refer to question 29. (Additional visits recommended) | <input type="checkbox"/> "Yes" in 29 (Go to 32) <input type="checkbox"/> All others (Skip to 33) | 11 |
| <i>HAND CARD A6. Read categories if telephone interview.</i> | | |
| 32. Why did you not go for (all) your recommended visits or tests? (Anything else?) Mark (X) all that apply. | 01 <input type="checkbox"/> Waiting for upcoming appointment 02 <input type="checkbox"/> Did not like doctor or doctor's advice 03 <input type="checkbox"/> Went to another doctor instead 04 <input type="checkbox"/> Problems at place — long wait, no bathroom, not accessible 05 <input type="checkbox"/> Clinic/Office in unsafe neighborhood 06 <input type="checkbox"/> No insurance 07 <input type="checkbox"/> Insurance did not cover 08 <input type="checkbox"/> Can't afford it 09 <input type="checkbox"/> Transportation problem 10 <input type="checkbox"/> Could not get convenient appointment 11 <input type="checkbox"/> Thought problem would go away, or problem went away 12 <input type="checkbox"/> Used home remedy 13 <input type="checkbox"/> Health got worse 14 <input type="checkbox"/> Health of other family member interfered 15 <input type="checkbox"/> Other reason 99 <input type="checkbox"/> DK | 12-13 14-15 16-17 18-19 20-21 22-23 24-25 26-27 28-29 30-31 32-33 34-35 36-37 38-39 40-41 42-43 |
| 33. How would you rate this [(specialist in 26b)/doctor] in terms of overall quality of care and services? Would you say excellent, good, fair, or poor? Mark (X) only one. | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> DK | 44 |
| <i>Refer to questions 19 and 27, then ASK or VERIFY:</i> | | |
| 34. During the past 12 months, which doctor have you seen the most often — the (provider in 18) or the (specialist in 26b)? | <input type="checkbox"/> Neither seen in past 12 months (Skip to 37 on page 62) <input type="checkbox"/> GP/Internist/Family doctor } (Go to 35 on page 61) <input type="checkbox"/> Specialist } <input type="checkbox"/> DK } | 45 |
| Notes | | |

Section I – OTHER SERVICES – Continued

| 35. Now, I'm going to read you a list of items which concern visits to the doctor you see most often. For each item, tell me if you would rate it as excellent, good, fair, or poor. | Excellent | Good | Fair | Poor | NA | DK | | |
|---|--|-------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----|
| | a. The thoroughness of the examination. Would you say excellent, good, fair, or poor? | a. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 9 <input type="checkbox"/> | 46 |
| b. Their respect and attention to your privacy. (Would you say excellent, good, fair, or poor?) | b. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 9 <input type="checkbox"/> | 47 | |
| c. Their personal interest in you and your condition. (Would you say excellent, good, fair, or poor?) | c. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 9 <input type="checkbox"/> | 48 | |
| d. Availability in an emergency. (Would you say excellent, good, fair, or poor?) | d. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 9 <input type="checkbox"/> | 49 | |
| e. Office hours for appointments. (Would you say excellent, good, fair, or poor?) | e. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 9 <input type="checkbox"/> | 50 | |
| f. Being able to receive answers to questions over the telephone. (Would you say excellent, good, fair, or poor?) | f. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 9 <input type="checkbox"/> | 51 | |
| g. Being able to make appointments over the telephone. (Would you say excellent, good, fair, or poor?) | g. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 9 <input type="checkbox"/> | 52 | |
| h. Wait time for an appointment. (Would you say excellent, good, fair, or poor?) | h. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 9 <input type="checkbox"/> | 53 | |
| i. Wait time to see the doctor. (Would you say excellent, good, fair, or poor?) | i. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 9 <input type="checkbox"/> | 54 | |
| j. The location of the office or clinic. (Would you say excellent, good, fair, or poor?) | j. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 9 <input type="checkbox"/> | 55 | |
| k. The accessibility of transportation to the office. (Would you say excellent, good, fair, or poor?) | k. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 9 <input type="checkbox"/> | 56 | |
| l. Their handling of insurance claims. (Would you say excellent, good, fair, or poor?) | l. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 9 <input type="checkbox"/> | 57 | |
| 36. Has a medical professional told you that because you did not have follow-up care — | Yes | No | DK | | | | | |
| a. Your condition worsened? | a. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | | | | | 58 |
| b. You need to be hospitalized? | b. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | | | | | 59 |
| c. You need more medical care? | c. 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | | | | | 60 |

Notes

| | | RT 80 3-4 | | RT 80 3-4 |
|--|---|---|---|--|
| Section I – OTHER SERVICES – Continued | A | | B | |
| <p>The next questions are about other services you may have received.</p> <p>37a. During the past 12 months, did you receive any services from ____?</p> <p>-----</p> <p>b. Did you need the services of ____ in the past 12 months?</p> | <p>01 A physical therapist</p> <p>37a.</p> <p>1 <input type="checkbox"/> Yes (Skip to 38) 7</p> <p>2 <input type="checkbox"/> No } (Go to 37b)</p> <p>9 <input type="checkbox"/> DK }</p> <p>-----</p> <p>b.</p> <p>1 <input type="checkbox"/> Yes (Skip to 41) 8</p> <p>2 <input type="checkbox"/> No } (Go to 37a for next service)</p> <p>9 <input type="checkbox"/> DK }</p> | <p>02 An occupational therapist</p> <p>37a.</p> <p>1 <input type="checkbox"/> Yes (Skip to 38) 7</p> <p>2 <input type="checkbox"/> No } (Go to 37b)</p> <p>9 <input type="checkbox"/> DK }</p> <p>-----</p> <p>b.</p> <p>1 <input type="checkbox"/> Yes (Skip to 41) 8</p> <p>2 <input type="checkbox"/> No } (Go to 37a for next service)</p> <p>9 <input type="checkbox"/> DK }</p> | <p>01 A physical therapist</p> <p>37a.</p> <p>1 <input type="checkbox"/> Yes (Skip to 38) 7</p> <p>2 <input type="checkbox"/> No } (Go to 37b)</p> <p>9 <input type="checkbox"/> DK }</p> <p>-----</p> <p>b.</p> <p>1 <input type="checkbox"/> Yes (Skip to 41) 8</p> <p>2 <input type="checkbox"/> No } (Go to 37a for next service)</p> <p>9 <input type="checkbox"/> DK }</p> | <p>02 An occupational therapist</p> <p>37a.</p> <p>1 <input type="checkbox"/> Yes (Skip to 38) 7</p> <p>2 <input type="checkbox"/> No } (Go to 37b)</p> <p>9 <input type="checkbox"/> DK }</p> <p>-----</p> <p>b.</p> <p>1 <input type="checkbox"/> Yes (Skip to 41) 8</p> <p>2 <input type="checkbox"/> No } (Go to 37a for next service)</p> <p>9 <input type="checkbox"/> DK }</p> |
| <p>38a. During the past 12 months, in how many months did you receive services from ____?</p> <p>-----</p> <p>b. What was the total number of times you received services from ____ during [that/those] month(s)?</p> | <p>38a.</p> <p>____ Months 9-10</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK</p> <p>-----</p> <p>b.</p> <p>____ Times 11-12</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK</p> | <p>38a.</p> <p>____ Months 9-10</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK</p> <p>-----</p> <p>b.</p> <p>____ Times 11-12</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK</p> | <p>38a.</p> <p>____ Months 9-10</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK</p> <p>-----</p> <p>b.</p> <p>____ Times 11-12</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK</p> | <p>38a.</p> <p>____ Months 9-10</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK</p> <p>-----</p> <p>b.</p> <p>____ Times 11-12</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK</p> |
| <p><i>HAND CARD A1. Read categories if telephone interview.</i></p> <p>39a. Who paid or will pay for the services received from ____ in the past 12 months? (Anyone else?)</p> <p>Mark (X) all that apply.</p> <p>-----</p> <p>b. Who paid most of the cost for the services received from ____ in the past 12 months? Record number of main source.</p> <p>-----</p> <p><i>Ask if more than one source in 39a. If only one, transcribe number of box marked without asking.</i></p> <p>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.</p> | <p>39a.</p> <p>01 <input type="checkbox"/> Self or family in household 13-14</p> <p>02 <input type="checkbox"/> Family NOT in household 15-16</p> <p>03 <input type="checkbox"/> Private health insurance 17-18</p> <p>04 <input type="checkbox"/> Medicare 19-20</p> <p>05 <input type="checkbox"/> Medicaid 21-22</p> <p>06 <input type="checkbox"/> Rehabilitation program 23-24</p> <p>07 <input type="checkbox"/> Employer 25-26</p> <p>08 <input type="checkbox"/> School system 27-28</p> <p>09 <input type="checkbox"/> VA program 29-30</p> <p>10 <input type="checkbox"/> Other military 31-32</p> <p>11 <input type="checkbox"/> Other private source 33-34</p> <p>12 <input type="checkbox"/> Other public source 35-36</p> <p>13 <input type="checkbox"/> No one/Free } (Skip to 40) 37-38</p> <p>99 <input type="checkbox"/> DK } 39-40</p> <p>-----</p> <p>b.</p> <p><input type="checkbox"/> Paid most 41-42</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK</p> <p>-----</p> <p>c.</p> <p>00000 <input type="checkbox"/> None 43-47</p> <p>\$ _____ 00</p> <p>99999 <input type="checkbox"/> DK</p> | <p>39a.</p> <p>01 <input type="checkbox"/> Self or family in household 13-14</p> <p>02 <input type="checkbox"/> Family NOT in household 15-16</p> <p>03 <input type="checkbox"/> Private health insurance 17-18</p> <p>04 <input type="checkbox"/> Medicare 19-20</p> <p>05 <input type="checkbox"/> Medicaid 21-22</p> <p>06 <input type="checkbox"/> Rehabilitation program 23-24</p> <p>07 <input type="checkbox"/> Employer 25-26</p> <p>08 <input type="checkbox"/> School system 27-28</p> <p>09 <input type="checkbox"/> VA program 29-30</p> <p>10 <input type="checkbox"/> Other military 31-32</p> <p>11 <input type="checkbox"/> Other private source 33-34</p> <p>12 <input type="checkbox"/> Other public source 35-36</p> <p>13 <input type="checkbox"/> No one/Free } (Skip to 40) 37-38</p> <p>99 <input type="checkbox"/> DK } 39-40</p> <p>-----</p> <p>b.</p> <p><input type="checkbox"/> Paid most 41-42</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK</p> <p>-----</p> <p>c.</p> <p>00000 <input type="checkbox"/> None 43-47</p> <p>\$ _____ 00</p> <p>99999 <input type="checkbox"/> DK</p> | <p>39a.</p> <p>01 <input type="checkbox"/> Self or family in household 13-14</p> <p>02 <input type="checkbox"/> Family NOT in household 15-16</p> <p>03 <input type="checkbox"/> Private health insurance 17-18</p> <p>04 <input type="checkbox"/> Medicare 19-20</p> <p>05 <input type="checkbox"/> Medicaid 21-22</p> <p>06 <input type="checkbox"/> Rehabilitation program 23-24</p> <p>07 <input type="checkbox"/> Employer 25-26</p> <p>08 <input type="checkbox"/> School system 27-28</p> <p>09 <input type="checkbox"/> VA program 29-30</p> <p>10 <input type="checkbox"/> Other military 31-32</p> <p>11 <input type="checkbox"/> Other private source 33-34</p> <p>12 <input type="checkbox"/> Other public source 35-36</p> <p>13 <input type="checkbox"/> No one/Free } (Skip to 40) 37-38</p> <p>99 <input type="checkbox"/> DK } 39-40</p> <p>-----</p> <p>b.</p> <p><input type="checkbox"/> Paid most 41-42</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK</p> <p>-----</p> <p>c.</p> <p>00000 <input type="checkbox"/> None 43-47</p> <p>\$ _____ 00</p> <p>99999 <input type="checkbox"/> DK</p> | |
| <p>40. During (month), did you receive services from ____?</p> | <p>40.</p> <p>1 <input type="checkbox"/> Yes (Skip to 37a for next service) 48</p> <p>2 <input type="checkbox"/> No (Go to 41)</p> <p>9 <input type="checkbox"/> DK (Skip to 37a for next service)</p> | <p>40.</p> <p>1 <input type="checkbox"/> Yes (Skip to 37a for next service) 48</p> <p>2 <input type="checkbox"/> No (Go to 41)</p> <p>9 <input type="checkbox"/> DK (Skip to 37a for next service)</p> | <p>40.</p> <p>1 <input type="checkbox"/> Yes (Skip to 37a for next service) 48</p> <p>2 <input type="checkbox"/> No (Go to 41)</p> <p>9 <input type="checkbox"/> DK (Skip to 37a for next service)</p> | <p>40.</p> <p>1 <input type="checkbox"/> Yes (Skip to 37a for next service) 48</p> <p>2 <input type="checkbox"/> No (Go to 41)</p> <p>9 <input type="checkbox"/> DK (Skip to 37a for next service)</p> |
| <p><i>HAND CARD A7. Read categories if telephone interview.</i></p> <p>41. Why didn't you receive services from ____ [in (month)] in the past 12 months? (Anything else?)</p> <p>Mark (X) all that apply.</p> | <p>41.</p> <p>00 <input type="checkbox"/> Didn't need services 49-50</p> <p>01 <input type="checkbox"/> Provider thinks no longer needed 51-52</p> <p>02 <input type="checkbox"/> Too expensive/can't afford 53-54</p> <p>03 <input type="checkbox"/> Insurance doesn't cover 55-56</p> <p>04 <input type="checkbox"/> Insurance no longer covers 57-58</p> <p>05 <input type="checkbox"/> No longer on Medicaid 59-60</p> <p>06 <input type="checkbox"/> Provider not available 61-62</p> <p>07 <input type="checkbox"/> Didn't like provider 63-64</p> <p>08 <input type="checkbox"/> Transportation problems 65-66</p> <p>09 <input type="checkbox"/> Could not take time off from work 67-68</p> <p>10 <input type="checkbox"/> Other 69-70</p> <p>99 <input type="checkbox"/> DK 71-72</p> | <p>41.</p> <p>00 <input type="checkbox"/> Didn't need services 49-50</p> <p>01 <input type="checkbox"/> Provider thinks no longer needed 51-52</p> <p>02 <input type="checkbox"/> Too expensive/can't afford 53-54</p> <p>03 <input type="checkbox"/> Insurance doesn't cover 55-56</p> <p>04 <input type="checkbox"/> Insurance no longer covers 57-58</p> <p>05 <input type="checkbox"/> No longer on Medicaid 59-60</p> <p>06 <input type="checkbox"/> Provider not available 61-62</p> <p>07 <input type="checkbox"/> Didn't like provider 63-64</p> <p>08 <input type="checkbox"/> Transportation problems 65-66</p> <p>09 <input type="checkbox"/> Could not take time off from work 67-68</p> <p>10 <input type="checkbox"/> Other 69-70</p> <p>99 <input type="checkbox"/> DK 71-72</p> | <p>41.</p> <p>00 <input type="checkbox"/> Didn't need services 49-50</p> <p>01 <input type="checkbox"/> Provider thinks no longer needed 51-52</p> <p>02 <input type="checkbox"/> Too expensive/can't afford 53-54</p> <p>03 <input type="checkbox"/> Insurance doesn't cover 55-56</p> <p>04 <input type="checkbox"/> Insurance no longer covers 57-58</p> <p>05 <input type="checkbox"/> No longer on Medicaid 59-60</p> <p>06 <input type="checkbox"/> Provider not available 61-62</p> <p>07 <input type="checkbox"/> Didn't like provider 63-64</p> <p>08 <input type="checkbox"/> Transportation problems 65-66</p> <p>09 <input type="checkbox"/> Could not take time off from work 67-68</p> <p>10 <input type="checkbox"/> Other 69-70</p> <p>99 <input type="checkbox"/> DK 71-72</p> | <p>41.</p> <p>00 <input type="checkbox"/> Didn't need services 49-50</p> <p>01 <input type="checkbox"/> Provider thinks no longer needed 51-52</p> <p>02 <input type="checkbox"/> Too expensive/can't afford 53-54</p> <p>03 <input type="checkbox"/> Insurance doesn't cover 55-56</p> <p>04 <input type="checkbox"/> Insurance no longer covers 57-58</p> <p>05 <input type="checkbox"/> No longer on Medicaid 59-60</p> <p>06 <input type="checkbox"/> Provider not available 61-62</p> <p>07 <input type="checkbox"/> Didn't like provider 63-64</p> <p>08 <input type="checkbox"/> Transportation problems 65-66</p> <p>09 <input type="checkbox"/> Could not take time off from work 67-68</p> <p>10 <input type="checkbox"/> Other 69-70</p> <p>99 <input type="checkbox"/> DK 71-72</p> |

| | | RT 80 | | | RT 80 | | | RT 80 | | | RT 80 |
|-----------------------|---|-------|--|---|-------|---------------------------------|---|-------|-------------------------|---|-------|
| C | | 3-4 | D | | 3-4 | E | | 3-4 | F | | 3-4 |
| 03 | | 5-6 | 04 | | 5-6 | 05 | | 5-6 | 06 | | 5-6 |
| An audiologist | | | A speech therapist or pathologist | | | A recreational therapist | | | A visiting nurse | | |
| 37a. | 1 <input type="checkbox"/> Yes (Skip to 38) 2 <input type="checkbox"/> No } (Go to 37b) 9 <input type="checkbox"/> DK } | 7 | 37a. | 1 <input type="checkbox"/> Yes (Skip to 38) 2 <input type="checkbox"/> No } (Go to 37b) 9 <input type="checkbox"/> DK } | 7 | 37a. | 1 <input type="checkbox"/> Yes (Skip to 38) 2 <input type="checkbox"/> No } (Go to 37b) 9 <input type="checkbox"/> DK } | 7 | 37a. | 1 <input type="checkbox"/> Yes (Skip to 38) 2 <input type="checkbox"/> No } (Go to 37b) 9 <input type="checkbox"/> DK } | 7 |
| b. | 1 <input type="checkbox"/> Yes (Skip to 41) 2 <input type="checkbox"/> No } (Go to 37a for next service) 9 <input type="checkbox"/> DK } | 8 | b. | 1 <input type="checkbox"/> Yes (Skip to 41) 2 <input type="checkbox"/> No } (Go to 37a for next service) 9 <input type="checkbox"/> DK } | 8 | b. | 1 <input type="checkbox"/> Yes (Skip to 41) 2 <input type="checkbox"/> No } (Go to 37a for next service) 9 <input type="checkbox"/> DK } | 8 | b. | 1 <input type="checkbox"/> Yes (Skip to 41) 2 <input type="checkbox"/> No } (Go to 37a for next service on page 64) 9 <input type="checkbox"/> DK } | 8 |
| 38a. | ____ Months (Number) 99 <input type="checkbox"/> DK | 9-10 | 38a. | ____ Months (Number) 99 <input type="checkbox"/> DK | 9-10 | 38a. | ____ Months (Number) 99 <input type="checkbox"/> DK | 9-10 | 38a. | ____ Months (Number) 99 <input type="checkbox"/> DK | 9-10 |
| b. | ____ Times (Number) 99 <input type="checkbox"/> DK | 11-12 | b. | ____ Times (Number) 99 <input type="checkbox"/> DK | 11-12 | b. | ____ Times (Number) 99 <input type="checkbox"/> DK | 11-12 | b. | ____ Times (Number) 99 <input type="checkbox"/> DK | 11-12 |
| 39a. | 01 <input type="checkbox"/> Self or family in household 13-14 02 <input type="checkbox"/> Family NOT in household 15-16 03 <input type="checkbox"/> Private health insurance 17-18 04 <input type="checkbox"/> Medicare 19-20 05 <input type="checkbox"/> Medicaid 21-22 06 <input type="checkbox"/> Rehabilitation program 23-24 07 <input type="checkbox"/> Employer 25-26 08 <input type="checkbox"/> School system 27-28 09 <input type="checkbox"/> VA program 29-30 10 <input type="checkbox"/> Other military 31-32 11 <input type="checkbox"/> Other private source 33-34 12 <input type="checkbox"/> Other public source 35-36 13 <input type="checkbox"/> No one/Free } (Skip to 40) 99 <input type="checkbox"/> DK } 37-38 39-40 | | 39a. | 01 <input type="checkbox"/> Self or family in household 13-14 02 <input type="checkbox"/> Family NOT in household 15-16 03 <input type="checkbox"/> Private health insurance 17-18 04 <input type="checkbox"/> Medicare 19-20 05 <input type="checkbox"/> Medicaid 21-22 06 <input type="checkbox"/> Rehabilitation program 23-24 07 <input type="checkbox"/> Employer 25-26 08 <input type="checkbox"/> School system 27-28 09 <input type="checkbox"/> VA program 29-30 10 <input type="checkbox"/> Other military 31-32 11 <input type="checkbox"/> Other private source 33-34 12 <input type="checkbox"/> Other public source 35-36 13 <input type="checkbox"/> No one/Free } (Skip to 40) 99 <input type="checkbox"/> DK } 37-38 39-40 | | 39a. | 01 <input type="checkbox"/> Self or family in household 13-14 02 <input type="checkbox"/> Family NOT in household 15-16 03 <input type="checkbox"/> Private health insurance 17-18 04 <input type="checkbox"/> Medicare 19-20 05 <input type="checkbox"/> Medicaid 21-22 06 <input type="checkbox"/> Rehabilitation program 23-24 07 <input type="checkbox"/> Employer 25-26 08 <input type="checkbox"/> School system 27-28 09 <input type="checkbox"/> VA program 29-30 10 <input type="checkbox"/> Other military 31-32 11 <input type="checkbox"/> Other private source 33-34 12 <input type="checkbox"/> Other public source 35-36 13 <input type="checkbox"/> No one/Free } (Skip to 40) 99 <input type="checkbox"/> DK } 37-38 39-40 | | 39a. | 01 <input type="checkbox"/> Self or family in household 13-14 02 <input type="checkbox"/> Family NOT in household 15-16 03 <input type="checkbox"/> Private health insurance 17-18 04 <input type="checkbox"/> Medicare 19-20 05 <input type="checkbox"/> Medicaid 21-22 06 <input type="checkbox"/> Rehabilitation program 23-24 07 <input type="checkbox"/> Employer 25-26 08 <input type="checkbox"/> School system 27-28 09 <input type="checkbox"/> VA program 29-30 10 <input type="checkbox"/> Other military 31-32 11 <input type="checkbox"/> Other private source 33-34 12 <input type="checkbox"/> Other public source 35-36 13 <input type="checkbox"/> No one/Free } (Skip to 40) 99 <input type="checkbox"/> DK } 37-38 39-40 | |
| b. | <input type="checkbox"/> Paid most (Number) 99 <input type="checkbox"/> DK | 41-42 | b. | <input type="checkbox"/> Paid most (Number) 99 <input type="checkbox"/> DK | 41-42 | b. | <input type="checkbox"/> Paid most (Number) 99 <input type="checkbox"/> DK | 41-42 | b. | <input type="checkbox"/> Paid most (Number) 99 <input type="checkbox"/> DK | 41-42 |
| c. | 00000 <input type="checkbox"/> None 43-47 \$ _____ 00 99999 <input type="checkbox"/> DK | | c. | 00000 <input type="checkbox"/> None 43-47 \$ _____ 00 99999 <input type="checkbox"/> DK | | c. | 00000 <input type="checkbox"/> None 43-47 \$ _____ 00 99999 <input type="checkbox"/> DK | | c. | 00000 <input type="checkbox"/> None 43-47 \$ _____ 00 99999 <input type="checkbox"/> DK | |
| 40. | 1 <input type="checkbox"/> Yes (Skip to 37a for next service) 48 2 <input type="checkbox"/> No (Go to 41) 9 <input type="checkbox"/> DK (Skip to 37a for next service) | | 40. | 1 <input type="checkbox"/> Yes (Skip 37a for next service) 48 2 <input type="checkbox"/> No (Go to 41) 9 <input type="checkbox"/> DK (Skip 37a for next service) | | 40. | 1 <input type="checkbox"/> Yes (Skip 37a for next service) 48 2 <input type="checkbox"/> No (Go to 41) 9 <input type="checkbox"/> DK (Skip 37a for next service) | | 40. | 1 <input type="checkbox"/> Yes (Skip 37a for next service on page 64) 48 2 <input type="checkbox"/> No (Go to 41) 9 <input type="checkbox"/> DK (Skip 37a for next service on page 64) | |
| 41. | 00 <input type="checkbox"/> Didn't need services 49-50 01 <input type="checkbox"/> Provider thinks no longer needed 51-52 02 <input type="checkbox"/> Too expensive/can't afford 53-54 03 <input type="checkbox"/> Insurance doesn't cover 55-56 04 <input type="checkbox"/> Insurance no longer covers 57-58 05 <input type="checkbox"/> No longer on Medicaid 59-60 06 <input type="checkbox"/> Provider not available 61-62 07 <input type="checkbox"/> Didn't like provider 63-64 08 <input type="checkbox"/> Transportation problems 65-66 09 <input type="checkbox"/> Could not take time off from work 67-68 10 <input type="checkbox"/> Other 69-70 99 <input type="checkbox"/> DK 71-72 | | 41. | 00 <input type="checkbox"/> Didn't need services 49-50 01 <input type="checkbox"/> Provider thinks no longer needed 51-52 02 <input type="checkbox"/> Too expensive/can't afford 53-54 03 <input type="checkbox"/> Insurance doesn't cover 55-56 04 <input type="checkbox"/> Insurance no longer covers 57-58 05 <input type="checkbox"/> No longer on Medicaid 59-60 06 <input type="checkbox"/> Provider not available 61-62 07 <input type="checkbox"/> Didn't like provider 63-64 08 <input type="checkbox"/> Transportation problems 65-66 09 <input type="checkbox"/> Could not take time off from work 67-68 10 <input type="checkbox"/> Other 69-70 99 <input type="checkbox"/> DK 71-72 | | 41. | 00 <input type="checkbox"/> Didn't need services 49-50 01 <input type="checkbox"/> Provider thinks no longer needed 51-52 02 <input type="checkbox"/> Too expensive/can't afford 53-54 03 <input type="checkbox"/> Insurance doesn't cover 55-56 04 <input type="checkbox"/> Insurance no longer covers 57-58 05 <input type="checkbox"/> No longer on Medicaid 59-60 06 <input type="checkbox"/> Provider not available 61-62 07 <input type="checkbox"/> Didn't like provider 63-64 08 <input type="checkbox"/> Transportation problems 65-66 09 <input type="checkbox"/> Could not take time off from work 67-68 10 <input type="checkbox"/> Other 69-70 99 <input type="checkbox"/> DK 71-72 | | 41. | 00 <input type="checkbox"/> Didn't need services 49-50 01 <input type="checkbox"/> Provider thinks no longer needed 51-52 02 <input type="checkbox"/> Too expensive/can't afford 53-54 03 <input type="checkbox"/> Insurance doesn't cover 55-56 04 <input type="checkbox"/> Insurance no longer covers 57-58 05 <input type="checkbox"/> No longer on Medicaid 59-60 06 <input type="checkbox"/> Provider not available 61-62 07 <input type="checkbox"/> Didn't like provider 63-64 08 <input type="checkbox"/> Transportation problems 65-66 09 <input type="checkbox"/> Could not take time off from work 67-68 10 <input type="checkbox"/> Other 69-70 99 <input type="checkbox"/> DK 71-72 | |

| Section I – OTHER SERVICES – Continued | | RT 80 3-4 | RT 80 3-4 |
|---|--|--|--------------------------------|
| | | G | H |
| | | 07 | 08 |
| | | A personal care attendant (other than family or a friend) | A reader or interpreter |
| 37a. During the past 12 months, did you receive any services from _____ ? | 37a. 1 <input type="checkbox"/> Yes (Skip to 38) 2 <input type="checkbox"/> No } (Go to 37b) 9 <input type="checkbox"/> DK } | 7 | 7 |
| b. Did you need the services of _____ in the past 12 months? | b. 1 <input type="checkbox"/> Yes (Skip to 41) 2 <input type="checkbox"/> No } (Go to 37a for next service) 9 <input type="checkbox"/> DK } | 8 | 8 |
| 38a. During the past 12 months, in how many months did you receive services from _____ ? | 38a. _____ Months (Number) 99 <input type="checkbox"/> DK | 9-10 | 9-10 |
| b. What was the total number of times you received services from _____ during [that/those] month(s)? | b. _____ Times (Number) 99 <input type="checkbox"/> DK | 11-12 | 11-12 |
| <i>HAND CARD A1. Read categories if telephone interview.</i> | | | |
| 39a. Who paid or will pay for the services received from _____ in the past 12 months? (Anyone else?) Mark (X) all that apply. | 39a. 01 <input type="checkbox"/> Self or family in household 13-14 02 <input type="checkbox"/> Family NOT in household 15-16 03 <input type="checkbox"/> Private health insurance 17-18 04 <input type="checkbox"/> Medicare 19-20 05 <input type="checkbox"/> Medicaid 21-22 06 <input type="checkbox"/> Rehabilitation program 23-24 07 <input type="checkbox"/> Employer 25-26 08 <input type="checkbox"/> School system 27-28 09 <input type="checkbox"/> VA program 29-30 10 <input type="checkbox"/> Other military 31-32 11 <input type="checkbox"/> Other private source 33-34 12 <input type="checkbox"/> Other public source 35-36 13 <input type="checkbox"/> No one/Free } (Skip to 40) 37-38 99 <input type="checkbox"/> DK } 39-40 | | |
| b. Who paid most of the cost for the services received from _____ in the past 12 months? Record number of main source. Ask only if box 01 marked in 39a; otherwise, skip to 40. | b. <input type="checkbox"/> <input type="checkbox"/> Paid most (Number) 99 <input type="checkbox"/> DK | 41-42 | 41-42 |
| 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 if more than one source in 39a. If only one, transcribe number of box marked without asking. | c. 00000 <input type="checkbox"/> None 43-47 \$ _____ . 00 99999 <input type="checkbox"/> DK | | |
| 40. During (month), did you receive services from _____ ? | 40. 1 <input type="checkbox"/> Yes (Skip to 37a for next service) 2 <input type="checkbox"/> No (Go to 41) 9 <input type="checkbox"/> DK (Skip 37a for next service) | 48 | 48 |
| <i>HAND CARD A7. Read categories if telephone interview.</i> | | | |
| 41. Why didn't you receive services from _____ [in (month)] in the past 12 months? (Anything else?) Mark (X) all that apply. | 41. 00 <input type="checkbox"/> Didn't need services 49-50 01 <input type="checkbox"/> Provider thinks no longer needed 51-52 02 <input type="checkbox"/> Too expensive/can't afford 53-54 03 <input type="checkbox"/> Insurance doesn't cover 55-56 04 <input type="checkbox"/> Insurance no longer covers 57-58 05 <input type="checkbox"/> No longer on Medicaid 59-60 06 <input type="checkbox"/> Provider not available 61-62 07 <input type="checkbox"/> Didn't like provider 63-64 08 <input type="checkbox"/> Transportation problems 65-66 09 <input type="checkbox"/> Could not take time off from work 67-68 10 <input type="checkbox"/> Other 69-70 99 <input type="checkbox"/> DK 71-72 | | |

| | | | |
|-------------|--|---|--|
| | RT 80 | | |
| I | 3-4 | Notes | |
| 09 | An adult day care center or day activity center | 5-6 | |
| 37a. | <input type="checkbox"/> 1 Yes (Skip to 38) <input type="checkbox"/> 2 No } (Go to 37b) <input type="checkbox"/> 9 DK } | 7 | |
| b. | <input type="checkbox"/> 1 Yes (Skip to 41) <input type="checkbox"/> 2 No } (Go to 42 for next service on page 66) <input type="checkbox"/> 9 DK } | 8 | |
| 38a. | _____ Months (Number) <input type="checkbox"/> 99 DK | 9-10 | |
| b. | _____ Times (Number) <input type="checkbox"/> 99 DK | 11-12 | |
| 39a. | <input type="checkbox"/> 01 Self or family in household <input type="checkbox"/> 02 Family NOT in household <input type="checkbox"/> 03 Private health insurance <input type="checkbox"/> 04 Medicare <input type="checkbox"/> 05 Medicaid <input type="checkbox"/> 06 Rehabilitation program <input type="checkbox"/> 07 Employer <input type="checkbox"/> 08 School system <input type="checkbox"/> 09 VA program <input type="checkbox"/> 10 Other military <input type="checkbox"/> 11 Other private source <input type="checkbox"/> 12 Other public source <input type="checkbox"/> 13 No one/Free } (Skip to 40) <input type="checkbox"/> 99 DK } | 13-14 15-16 17-18 19-20 21-22 23-24 25-26 27-28 29-30 31-32 33-34 37-38 39-40 | |
| b. | <input type="text"/> <input type="text"/> Paid most (Number) <input type="checkbox"/> 99 DK | 41-42 | |
| c. | <input type="checkbox"/> 00000 None \$ _____ <input type="text"/> 00 <input type="checkbox"/> 99999 DK | 43-47 | |
| 40. | <input type="checkbox"/> 1 Yes (Skip to 42 for next service on page 66) <input type="checkbox"/> 2 No (Go to 41) <input type="checkbox"/> 9 DK (Skip to 42 for next service on page 66) | 48 | |
| 41. | <input type="checkbox"/> 00 Didn't need services <input type="checkbox"/> 01 Provider thinks no longer needed <input type="checkbox"/> 02 Too expensive/can't afford <input type="checkbox"/> 03 Insurance doesn't cover <input type="checkbox"/> 04 Insurance no longer covers <input type="checkbox"/> 05 No longer on Medicaid <input type="checkbox"/> 06 Provider not available <input type="checkbox"/> 07 Didn't like provider <input type="checkbox"/> 08 Transportation problems <input type="checkbox"/> 09 Could not take time off from work <input type="checkbox"/> 10 Other <input type="checkbox"/> 99 DK | 49-50 51-52 53-54 55-56 57-58 59-60 61-62 63-64 65-66 67-68 69-70 71-72 | |

| Section I - OTHER SERVICES - Continued | | J | | K | |
|---|--|---|--|---|--|
| | | 10 | | 11 | |
| | | Services for alcohol or drug abuse | | Services for a center for independent living | |
| 42a. During the past 12 months, did you receive ____? | | 42a. | | 42a. | |
| 1 <input type="checkbox"/> Yes (Skip to 43) 7 2 <input type="checkbox"/> No } (Go to 42b) 9 <input type="checkbox"/> DK } | | 1 <input type="checkbox"/> Yes (Skip to 43) 7 2 <input type="checkbox"/> No } (Go to 42b) 9 <input type="checkbox"/> DK } | | 1 <input type="checkbox"/> Yes (Skip to 43) 7 2 <input type="checkbox"/> No } (Go to 42b) 9 <input type="checkbox"/> DK } | |
| b. Did you need ____ in the past 12 months? | | b. | | b. | |
| 1 <input type="checkbox"/> Yes (Skip to 46) 8 2 <input type="checkbox"/> No } (Go to 42a for next service) 9 <input type="checkbox"/> DK } | | 1 <input type="checkbox"/> Yes (Skip to 46) 8 2 <input type="checkbox"/> No } (Go to 42a for next service) 9 <input type="checkbox"/> DK } | | 1 <input type="checkbox"/> Yes (Skip to 46) 8 2 <input type="checkbox"/> No } (Go to 42a for next service) 9 <input type="checkbox"/> DK } | |
| 43a. During the past 12 months in how many months did you receive ____? | | 43a. | | 43a. | |
| _____ Months 9-10 (Number) 99 <input type="checkbox"/> DK | | _____ Months 9-10 (Number) 99 <input type="checkbox"/> DK | | _____ Months 9-10 (Number) 99 <input type="checkbox"/> DK | |
| b. What was the total number of times you received ____ during [that/those] month(s)? | | b. | | b. | |
| _____ Times 11-12 (Number) 99 <input type="checkbox"/> DK | | _____ Times 11-12 (Number) 99 <input type="checkbox"/> DK | | _____ Times 11-12 (Number) 99 <input type="checkbox"/> DK | |
| HAND CARD A1. Read categories if telephone interview. 44a. Who paid or will pay for ____ in the past 12 months? (Anyone else?) Mark (X) all that apply. | | 44a. | | 44a. | |
| | | 01 <input type="checkbox"/> Self or family in household 13-14 02 <input type="checkbox"/> Family NOT in household 15-16 03 <input type="checkbox"/> Private health insurance 17-18 04 <input type="checkbox"/> Medicare 19-20 05 <input type="checkbox"/> Medicaid 21-22 06 <input type="checkbox"/> Rehabilitation program 23-24 07 <input type="checkbox"/> Employer 25-26 08 <input type="checkbox"/> School system 27-28 09 <input type="checkbox"/> VA program 29-30 10 <input type="checkbox"/> Other military 31-32 11 <input type="checkbox"/> Other private source 33-34 12 <input type="checkbox"/> Other public source 35-36 13 <input type="checkbox"/> No one/ Free } (Skip to 45) 37-38 99 <input type="checkbox"/> DK } 39-40 | | 01 <input type="checkbox"/> Self or family in household 13-14 02 <input type="checkbox"/> Family NOT in household 15-16 03 <input type="checkbox"/> Private health insurance 17-18 04 <input type="checkbox"/> Medicare 19-20 05 <input type="checkbox"/> Medicaid 21-22 06 <input type="checkbox"/> Rehabilitation program 23-24 07 <input type="checkbox"/> Employer 25-26 08 <input type="checkbox"/> School system 27-28 09 <input type="checkbox"/> VA program 29-30 10 <input type="checkbox"/> Other military 31-32 11 <input type="checkbox"/> Other private source 33-34 12 <input type="checkbox"/> Other public source 35-36 13 <input type="checkbox"/> No one/ Free } (Skip to 45) 37-38 99 <input type="checkbox"/> DK } 39-40 | |
| b. Who paid most of the cost for ____ in the past 12 months? Record number of main source. | | b. | | b. | |
| _____ Paid most 41-42 (Number) 99 <input type="checkbox"/> DK | | _____ Paid most 41-42 (Number) 99 <input type="checkbox"/> DK | | _____ Paid most 41-42 (Number) 99 <input type="checkbox"/> DK | |
| c. During the past 12 months, about how much did you or your family pay for ____? Do not count any money that has been or will be reimbursed by insurance or any other source. | | c. | | c. | |
| 00000 <input type="checkbox"/> None 43-47 \$ _____ 00 99999 <input type="checkbox"/> DK | | 00000 <input type="checkbox"/> None 43-47 \$ _____ 00 99999 <input type="checkbox"/> DK | | 00000 <input type="checkbox"/> None 43-47 \$ _____ 00 99999 <input type="checkbox"/> DK | |
| 45. During (month), did you receive ____? | | 45. | | 45. | |
| | | 1 <input type="checkbox"/> Yes (Skip to 42a for next service) 48 2 <input type="checkbox"/> No (Go to 46) 9 <input type="checkbox"/> DK (Skip to 42a for next service) | | 1 <input type="checkbox"/> Yes (Skip to 42a for next service) 48 2 <input type="checkbox"/> No (Go to 46) 9 <input type="checkbox"/> DK (Skip to 42a for next service) | |
| HAND CARD A7. Read categories if telephone interview. 46. Why didn't you receive ____ [in (month)] in the past 12 months? (Anything else?) Mark (X) all that apply. | | 46. | | 46. | |
| | | 00 <input type="checkbox"/> Didn't need services 49-50 01 <input type="checkbox"/> Provider thinks no longer needed 51-52 02 <input type="checkbox"/> Too expensive/ can't afford 53-54 03 <input type="checkbox"/> Insurance doesn't cover 55-56 04 <input type="checkbox"/> Insurance no longer covers 57-58 05 <input type="checkbox"/> No longer on Medicaid 59-60 06 <input type="checkbox"/> Provider not available 61-62 07 <input type="checkbox"/> Didn't like provider 63-64 08 <input type="checkbox"/> Transportation problems 65-66 09 <input type="checkbox"/> Could not take time off from work 67-68 10 <input type="checkbox"/> Other 69-70 99 <input type="checkbox"/> DK 71-72 | | 00 <input type="checkbox"/> Didn't need services 49-50 01 <input type="checkbox"/> Provider thinks no longer needed 51-52 02 <input type="checkbox"/> Too expensive/ can't afford 53-54 03 <input type="checkbox"/> Insurance doesn't cover 55-56 04 <input type="checkbox"/> Insurance no longer covers 57-58 05 <input type="checkbox"/> No longer on Medicaid 59-60 06 <input type="checkbox"/> Provider not available 61-62 07 <input type="checkbox"/> Didn't like provider 63-64 08 <input type="checkbox"/> Transportation problems 65-66 09 <input type="checkbox"/> Could not take time off from work 67-68 10 <input type="checkbox"/> Other 69-70 99 <input type="checkbox"/> DK 71-72 | |

| RT 80 | | RT 80 | | RT 80 | | Notes |
|--|--|--|--|--|--|-------|
| L | | M | | N | | |
| 12 Respiratory therapy services | | 13 Social work services | | 14 Transportation services | | |
| 42a. 1 <input type="checkbox"/> Yes (Skip to 43) 7 2 <input type="checkbox"/> No } (Go to 42b) 9 <input type="checkbox"/> DK } | | 42a. 1 <input type="checkbox"/> Yes (Skip to 43) 7 2 <input type="checkbox"/> No } (Go to 42b) 9 <input type="checkbox"/> DK } | | 42a. 1 <input type="checkbox"/> Yes (Skip to 43) 7 2 <input type="checkbox"/> No } (Go to 42b) 9 <input type="checkbox"/> DK } | | |
| b. 1 <input type="checkbox"/> Yes (Skip to 46) 8 2 <input type="checkbox"/> No } (Go to 42a for 9 <input type="checkbox"/> DK } next service) | | b. 1 <input type="checkbox"/> Yes (Skip to 46) 8 2 <input type="checkbox"/> No } (Go to 42a for 9 <input type="checkbox"/> DK } next service) | | b. 1 <input type="checkbox"/> Yes (Skip to 46) 8 2 <input type="checkbox"/> No } (Skip to 47 on 9 <input type="checkbox"/> DK } page 68) | | |
| 43a. _____ Months 9-10 (Number) 99 <input type="checkbox"/> DK | | 43a. _____ Months 9-10 (Number) 99 <input type="checkbox"/> DK | | 43a. _____ Months 9-10 (Number) 99 <input type="checkbox"/> DK | | |
| b. _____ Times 11-12 (Number) 99 <input type="checkbox"/> DK | | b. _____ Times 11-12 (Number) 99 <input type="checkbox"/> DK | | b. _____ Times 11-12 (Number) 99 <input type="checkbox"/> DK | | |
| 44a. 01 <input type="checkbox"/> Self or family in household 13-14 02 <input type="checkbox"/> Family NOT in household 15-16 03 <input type="checkbox"/> Private health insurance 17-18 04 <input type="checkbox"/> Medicare 19-20 05 <input type="checkbox"/> Medicaid 21-22 06 <input type="checkbox"/> Rehabilitation program 23-24 07 <input type="checkbox"/> Employer 25-26 08 <input type="checkbox"/> School system 27-28 09 <input type="checkbox"/> VA program 29-30 10 <input type="checkbox"/> Other military 31-32 11 <input type="checkbox"/> Other private source 33-34 12 <input type="checkbox"/> Other public source 35-36 13 <input type="checkbox"/> No one/Free } (Skip to 45) 99 <input type="checkbox"/> DK } 37-38 39-40 | | 44a. 01 <input type="checkbox"/> Self or family in household 13-14 02 <input type="checkbox"/> Family NOT in household 15-16 03 <input type="checkbox"/> Private health insurance 17-18 04 <input type="checkbox"/> Medicare 19-20 05 <input type="checkbox"/> Medicaid 21-22 06 <input type="checkbox"/> Rehabilitation program 23-24 07 <input type="checkbox"/> Employer 25-26 08 <input type="checkbox"/> School system 27-28 09 <input type="checkbox"/> VA program 29-30 10 <input type="checkbox"/> Other military 31-32 11 <input type="checkbox"/> Other private source 33-34 12 <input type="checkbox"/> Other public source 35-36 13 <input type="checkbox"/> No one/Free } (Skip to 45) 99 <input type="checkbox"/> DK } 37-38 39-40 | | 44a. 01 <input type="checkbox"/> Self or family in household 13-14 02 <input type="checkbox"/> Family NOT in household 15-16 03 <input type="checkbox"/> Private health insurance 17-18 04 <input type="checkbox"/> Medicare 19-20 05 <input type="checkbox"/> Medicaid 21-22 06 <input type="checkbox"/> Rehabilitation program 23-24 07 <input type="checkbox"/> Employer 25-26 08 <input type="checkbox"/> School system 27-28 09 <input type="checkbox"/> VA program 29-30 10 <input type="checkbox"/> Other military 31-32 11 <input type="checkbox"/> Other private source 33-34 12 <input type="checkbox"/> Other public source 35-36 13 <input type="checkbox"/> No one/Free } (Skip to 45) 99 <input type="checkbox"/> DK } 37-38 39-40 | | |
| b. <input type="checkbox"/> Paid most 41-42 (Number) 99 <input type="checkbox"/> DK | | b. <input type="checkbox"/> Paid most 41-42 (Number) 99 <input type="checkbox"/> DK | | b. <input type="checkbox"/> Paid most 41-42 (Number) 99 <input type="checkbox"/> DK | | |
| c. 00000 <input type="checkbox"/> None 43-47 \$ _____ 00 99999 <input type="checkbox"/> DK | | c. 00000 <input type="checkbox"/> None 43-47 \$ _____ 00 99999 <input type="checkbox"/> DK | | c. 00000 <input type="checkbox"/> None 43-47 \$ _____ 00 99999 <input type="checkbox"/> DK | | |
| 45. 1 <input type="checkbox"/> Yes (Skip to 42a for next service) 48 2 <input type="checkbox"/> No (Go to 46) 9 <input type="checkbox"/> DK (Skip to 42a for next service) | | 45. 1 <input type="checkbox"/> Yes (Skip to 42a for next service) 48 2 <input type="checkbox"/> No (Go to 46) 9 <input type="checkbox"/> DK (Skip to 42a for next service) | | 45. 1 <input type="checkbox"/> Yes (Skip to 47 on page 68) 48 2 <input type="checkbox"/> No (Go to 46) 9 <input type="checkbox"/> DK (Skip to 47 on page 68) | | |
| 46. 00 <input type="checkbox"/> Didn't need services 49-50 01 <input type="checkbox"/> Provider thinks no longer needed 51-52 02 <input type="checkbox"/> Too expensive/can't afford 53-54 03 <input type="checkbox"/> Insurance doesn't cover 55-56 04 <input type="checkbox"/> Insurance no longer covers 57-58 05 <input type="checkbox"/> No longer on Medicaid 59-60 06 <input type="checkbox"/> Provider not available 61-62 07 <input type="checkbox"/> Didn't like provider 63-64 08 <input type="checkbox"/> Transportation problems 65-66 09 <input type="checkbox"/> Could not take time off from work 67-68 10 <input type="checkbox"/> Other 69-70 99 <input type="checkbox"/> DK 71-72 | | 46. 00 <input type="checkbox"/> Didn't need services 49-50 01 <input type="checkbox"/> Provider thinks no longer needed 51-52 02 <input type="checkbox"/> Too expensive/can't afford 53-54 03 <input type="checkbox"/> Insurance doesn't cover 55-56 04 <input type="checkbox"/> Insurance no longer covers 57-58 05 <input type="checkbox"/> No longer on Medicaid 59-60 06 <input type="checkbox"/> Provider not available 61-62 07 <input type="checkbox"/> Didn't like provider 63-64 08 <input type="checkbox"/> Transportation problems 65-66 09 <input type="checkbox"/> Could not take time off from work 67-68 10 <input type="checkbox"/> Other 69-70 99 <input type="checkbox"/> DK 71-72 | | 46. 00 <input type="checkbox"/> Didn't need services 49-50 01 <input type="checkbox"/> Provider thinks no longer needed 51-52 02 <input type="checkbox"/> Too expensive/can't afford 53-54 03 <input type="checkbox"/> Insurance doesn't cover 55-56 04 <input type="checkbox"/> Insurance no longer covers 57-58 05 <input type="checkbox"/> No longer on Medicaid 59-60 06 <input type="checkbox"/> Provider not available 61-62 07 <input type="checkbox"/> Didn't like provider 63-64 08 <input type="checkbox"/> Transportation problems 65-66 09 <input type="checkbox"/> Could not take time off from work 67-68 10 <input type="checkbox"/> Other 69-70 99 <input type="checkbox"/> DK 71-72 | | |

| Section I – OTHER SERVICES – Continued | | RT 81 | | | | | | | | | | | | | | | |
|---|--|---|-----|-----|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| | | 3-4 | | | | | | | | | | | | | | | |
| <p>HAND CARD A8.</p> <p>47a. Are you currently on a waiting list for any of these services? Read categories in 47b if telephone interview.</p> | <p>1 <input type="checkbox"/> Yes (Go to 47b) 2 <input type="checkbox"/> No } (Skip to 48) 9 <input type="checkbox"/> DK }</p> | 5 | | | | | | | | | | | | | | | |
| <p>b. For which of these services are you on a waiting list? (Any others?) Mark (X) all that apply.</p> | <p>01 <input type="checkbox"/> A physical therapist 02 <input type="checkbox"/> An occupational therapist 03 <input type="checkbox"/> An audiologist 04 <input type="checkbox"/> A speech therapist or pathologist 05 <input type="checkbox"/> A recreational therapist 06 <input type="checkbox"/> A visiting nurse 07 <input type="checkbox"/> A personal care attendant, other than a family member or friend 08 <input type="checkbox"/> A reader or interpreter 09 <input type="checkbox"/> An adult day care center or day activity center 10 <input type="checkbox"/> Services for alcohol or drug abuse 11 <input type="checkbox"/> Services from a center for independent living 12 <input type="checkbox"/> Respiratory therapy services 13 <input type="checkbox"/> Social work services 14 <input type="checkbox"/> Transportation services 99 <input type="checkbox"/> DK</p> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">6-7</td></tr> <tr><td style="text-align: center;">8-9</td></tr> <tr><td style="text-align: center;">10-11</td></tr> <tr><td style="text-align: center;">12-13</td></tr> <tr><td style="text-align: center;">14-15</td></tr> <tr><td style="text-align: center;">16-17</td></tr> <tr><td style="text-align: center;">18-19</td></tr> <tr><td style="text-align: center;">20-21</td></tr> <tr><td style="text-align: center;">22-23</td></tr> <tr><td style="text-align: center;">24-25</td></tr> <tr><td style="text-align: center;">26-27</td></tr> <tr><td style="text-align: center;">28-29</td></tr> <tr><td style="text-align: center;">30-31</td></tr> <tr><td style="text-align: center;">32-33</td></tr> <tr><td style="text-align: center;">34-35</td></tr> </table> | 6-7 | 8-9 | 10-11 | 12-13 | 14-15 | 16-17 | 18-19 | 20-21 | 22-23 | 24-25 | 26-27 | 28-29 | 30-31 | 32-33 | 34-35 |
| 6-7 | | | | | | | | | | | | | | | | | |
| 8-9 | | | | | | | | | | | | | | | | | |
| 10-11 | | | | | | | | | | | | | | | | | |
| 12-13 | | | | | | | | | | | | | | | | | |
| 14-15 | | | | | | | | | | | | | | | | | |
| 16-17 | | | | | | | | | | | | | | | | | |
| 18-19 | | | | | | | | | | | | | | | | | |
| 20-21 | | | | | | | | | | | | | | | | | |
| 22-23 | | | | | | | | | | | | | | | | | |
| 24-25 | | | | | | | | | | | | | | | | | |
| 26-27 | | | | | | | | | | | | | | | | | |
| 28-29 | | | | | | | | | | | | | | | | | |
| 30-31 | | | | | | | | | | | | | | | | | |
| 32-33 | | | | | | | | | | | | | | | | | |
| 34-35 | | | | | | | | | | | | | | | | | |
| <p>48a. During the past 12 months, did you stay OVERNIGHT in a hospital or other facility to receive mental health services? Do not include treatment for substance abuse.</p> | <p>1 <input type="checkbox"/> Yes (Go to 48b) 2 <input type="checkbox"/> No } (Skip to 52 on page 69) 9 <input type="checkbox"/> DK }</p> | 36 | | | | | | | | | | | | | | | |
| <p>HAND CARD A9. Read categories if telephone interview.</p> <p>b. Where did you receive inpatient mental health services in the past 12 months? (Anywhere else?) Mark (X) all that apply.</p> | <p>1 <input type="checkbox"/> Private or public psychiatric hospital 2 <input type="checkbox"/> Psychiatric services in a general hospital 3 <input type="checkbox"/> Other hospital 4 <input type="checkbox"/> Residential treatment center 5 <input type="checkbox"/> Other place 9 <input type="checkbox"/> DK</p> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">37</td></tr> <tr><td style="text-align: center;">38</td></tr> <tr><td style="text-align: center;">39</td></tr> <tr><td style="text-align: center;">40</td></tr> <tr><td style="text-align: center;">41</td></tr> <tr><td style="text-align: center;">42</td></tr> </table> | 37 | 38 | 39 | 40 | 41 | 42 | | | | | | | | | |
| 37 | | | | | | | | | | | | | | | | | |
| 38 | | | | | | | | | | | | | | | | | |
| 39 | | | | | | | | | | | | | | | | | |
| 40 | | | | | | | | | | | | | | | | | |
| 41 | | | | | | | | | | | | | | | | | |
| 42 | | | | | | | | | | | | | | | | | |
| <p>49a. During the past 12 months, how many times altogether were you admitted to (place(s) in 48b) for mental health care?</p> | <p>_____ Times admitted (Number) 99 <input type="checkbox"/> DK</p> | 43-44 | | | | | | | | | | | | | | | |
| <p>b. During the past 12 months, how many nights altogether did you spend in the (place(s) in 48b)?</p> | <p>_____ Nights (Number) 999 <input type="checkbox"/> DK</p> | 45-47 | | | | | | | | | | | | | | | |
| <p>ITEM 14</p> | <p>Refer to question 49a. (Number of admissions)</p> | 48 | | | | | | | | | | | | | | | |
| <p>50a. Was that admission on an emergency basis?</p> | <p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } (Skip to 51 on page 69) 9 <input type="checkbox"/> DK }</p> | 49 | | | | | | | | | | | | | | | |
| <p>b. How many of the (number in 49a) admissions were on an emergency basis?</p> | <p>00 <input type="checkbox"/> None _____ Emergency admissions } (Skip to 51 on page 69) (Number) 99 <input type="checkbox"/> DK }</p> | 50-51 | | | | | | | | | | | | | | | |
| <p>c. Were any of the admissions in the past 12 months on an emergency basis?</p> | <p>1 <input type="checkbox"/> Yes (Go to 50d) 2 <input type="checkbox"/> No } (Skip to 51 on page 69) 9 <input type="checkbox"/> DK }</p> | 52 | | | | | | | | | | | | | | | |
| <p>d. How many admissions were on an emergency basis?</p> | <p>_____ Emergency admissions (Number) 99 <input type="checkbox"/> DK</p> | 53-54 | | | | | | | | | | | | | | | |

Section I - OTHER SERVICES - Continued

| | | |
|--|---|---|
| <p><i>HAND CARD A1. Read categories if telephone interview.</i></p> <p>51a. Who paid or will pay for the inpatient mental health services you received during the past 12 months? (Anyone else?) <i>Mark (X) all that apply.</i></p> | | <p>01 <input type="checkbox"/> Self or family in household 55-56 02 <input type="checkbox"/> Family NOT in household 57-58 03 <input type="checkbox"/> Private health insurance 59-60 04 <input type="checkbox"/> Medicare 61-62 05 <input type="checkbox"/> Medicaid 63-64 06 <input type="checkbox"/> Rehabilitation program 65-66 07 <input type="checkbox"/> Employer 67-68 08 <input type="checkbox"/> School system 69-70 09 <input type="checkbox"/> VA program 71-72 10 <input type="checkbox"/> Other military 73-74 11 <input type="checkbox"/> Other private source 75-76 12 <input type="checkbox"/> Other public source 77-78 13 <input type="checkbox"/> No one/Free } (Skip to 52) 79-80 99 <input type="checkbox"/> DK 81-82</p> |
| <p><i>Ask if more than one source in 51a. If only one source, transcribe number of box marked without asking.</i></p> <p>b. Who paid most of the cost for the inpatient mental health services? <i>Record number of main source.</i></p> | | <p style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> Paid most (Number) </p> <p>99 <input type="checkbox"/> DK 83-84</p> |
| <p><i>Ask only if box 01 marked in 51a; otherwise, skip to 52.</i></p> <p>c. During the past 12 months, about how much did you or your family pay for your inpatient mental health services? Do not count any money that has been or will be reimbursed by insurance or any other source.</p> | | <p>00000 <input type="checkbox"/> None 85-89</p> <p>\$ _____ <input style="width: 30px; text-align: center;" type="text" value="00"/></p> <p>99999 <input type="checkbox"/> DK</p> |
| <p>52a. During the past 12 months, did you receive any outpatient mental health services, including mental health services received from a general practitioner? Do not include treatment for substance abuse or smoking cessation.</p> | | <p>1 <input type="checkbox"/> Yes (Go to 52b) 90 2 <input type="checkbox"/> No } (Skip to 56 on page 70) 9 <input type="checkbox"/> DK</p> |
| <p><i>HAND CARD A10. Read categories if telephone interview.</i></p> <p>b. From whom did you receive outpatient mental health services during the past 12 months? (Anyone else?) <i>Mark (X) all that apply.</i></p> | | <p>1 <input type="checkbox"/> Psychiatrist 91 2 <input type="checkbox"/> Psychologist 92 3 <input type="checkbox"/> Nurse 93 4 <input type="checkbox"/> Social worker 94 5 <input type="checkbox"/> Other mental health counselor or therapist 95 6 <input type="checkbox"/> General practitioner or other medical doctor 96 7 <input type="checkbox"/> Other health professional 97 9 <input type="checkbox"/> DK 98</p> |
| <p><i>HAND CARD A11. Read categories if telephone interview.</i></p> <p>c. Where did you receive outpatient mental health services during the past 12 months? (Anywhere else?) <i>Mark (X) all that apply.</i></p> | | <p>1 <input type="checkbox"/> Doctor's/Other health professional's office, NOT a clinic 99 2 <input type="checkbox"/> Outpatient mental health clinic, such as a community mental health center 100 3 <input type="checkbox"/> Outpatient medical clinic 101 4 <input type="checkbox"/> HMO 102 5 <input type="checkbox"/> Other place 103 9 <input type="checkbox"/> DK 104</p> |
| <p>53a. During the past 12 months, in how many months did you receive outpatient mental health services?</p> | | <p>_____ Month(s) (Number)</p> <p>99 <input type="checkbox"/> DK 105-106</p> |
| <p>b. Altogether, how many outpatient mental health visits did you make during [that/those] (number in 53a) month(s)?</p> | | <p>_____ Outpatient visit(s) (Number)</p> <p>999 <input type="checkbox"/> DK 107-109</p> |
| <p>ITEM 15</p> | <p><i>Refer to question 53b.</i> (Number of visits)</p> | <p>1 <input type="checkbox"/> 1 visit (Go to 54a on page 70) 110 2 <input type="checkbox"/> 2 or more visits (Skip to 54b on page 70) 9 <input type="checkbox"/> All other (Skip to 54c on page 70)</p> |
| <p>Notes</p> | | |

| Section I - OTHER SERVICES - Continued | | RT 82 | | | | | | |
|--|--|---|--|-----------|----------|--|--|-------|
| | | 3-4 | | | | | | |
| 54a. Was that visit on an emergency basis? | <input type="checkbox"/> 1 Yes } <input type="checkbox"/> 2 No } (Skip to 55) <input type="checkbox"/> 9 DK } | 5 | | | | | | |
| b. How many of the (number in 53b) visits were on an emergency basis? | 000 <input type="checkbox"/> None } _____ Emergency visits } (Skip to 55) (Number) 999 <input type="checkbox"/> DK | 6-8 | | | | | | |
| c. Were any of the visits in the past 12 months on an emergency basis? | <input type="checkbox"/> 1 Yes (Go to 54d) <input type="checkbox"/> 2 No } (Skip to 55) <input type="checkbox"/> 9 DK } | 9 | | | | | | |
| d. How many visits were on an emergency basis? | _____ Emergency visits (Number) 999 <input type="checkbox"/> DK | 10-12 | | | | | | |
| <i>HAND CARD A1. Read categories if telephone interview.</i> | | | | | | | | |
| 55a. Who paid or will pay for the outpatient mental health services you received during the past 12 months? (Anyone else?) Mark (X) all that apply. | <input type="checkbox"/> 01 Self or family in household <input type="checkbox"/> 02 Family NOT in household <input type="checkbox"/> 03 Private health insurance <input type="checkbox"/> 04 Medicare <input type="checkbox"/> 05 Medicaid <input type="checkbox"/> 06 Rehabilitation program <input type="checkbox"/> 07 Employer <input type="checkbox"/> 08 School system <input type="checkbox"/> 09 VA program <input type="checkbox"/> 10 Other military <input type="checkbox"/> 11 Other private source <input type="checkbox"/> 12 Other public source <input type="checkbox"/> 13 No one/Free } (Skip to 56) <input type="checkbox"/> 99 DK | 13-14 15-16 17-18 19-20 21-22 23-24 25-26 27-28 29-30 31-32 33-34 35-36 37-38 39-40 | | | | | | |
| b. Who paid for most of the cost of the outpatient mental health services? Record number of the main source. Ask only if box 01 marked in 55a; otherwise, skip to 56. | <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="padding-left: 5px;">Paid most</td> </tr> <tr> <td colspan="2" style="text-align: center;">(Number)</td> <td></td> </tr> </table> 99 <input type="checkbox"/> DK | | | Paid most | (Number) | | | 41-42 |
| | | Paid most | | | | | | |
| (Number) | | | | | | | | |
| c. During the past 12 months, about how much did you or your family pay for the outpatient mental health services? Do not count any money that has been or will be reimbursed by insurance or any other source. | 00000 <input type="checkbox"/> None \$ _____ . 00 99999 <input type="checkbox"/> DK | 43-47 | | | | | | |
| 56. During the past 12 months, did you receive any services from a mental health community support program? Read if necessary: A community support program for clients with mental or emotional problems makes available mental health, health, social and support services based on individual need. | <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 9 DK | 48 | | | | | | |
| 57. During the past 12 months, were you on a waiting list for outpatient mental health services? | <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 9 DK | 49 | | | | | | |
| ITEM 16 | Refer to questions 48a on page 68, 52a on page 69, and question 56 above. (Any mental health services) | <input type="checkbox"/> 1 "Yes" in 48a, 52a, or 56 (Go to 58 on page 71) <input type="checkbox"/> 2 All other (Skip to 59 on page 71) | | | | | | |
| Notes | | | | | | | | |

Section I - OTHER SERVICES - Continued

| | | |
|---|--|--|
| <p>58a. Did you receive any mental health services during (month)? Do not include treatment for substance abuse or smoking cessation.</p> <p><i>HAND CARD A7. Read categories if telephone interview.</i></p> | <p>1 <input type="checkbox"/> Yes (<i>Skip to 59</i>) 2 <input type="checkbox"/> No (<i>Go to 58b</i>) 9 <input type="checkbox"/> DK (<i>Skip to 59</i>)</p> | 51 |
| <p>b. Why didn't you get mental health services during (month)? (Any other reason?)</p> <p><i>Mark (X) all that apply.</i></p> | <p>00 <input type="checkbox"/> Didn't need services 01 <input type="checkbox"/> Provider thinks no longer needed 02 <input type="checkbox"/> Too expensive/can't afford 03 <input type="checkbox"/> Insurance does not cover 04 <input type="checkbox"/> Insurance no longer covers 05 <input type="checkbox"/> No longer on Medicaid 06 <input type="checkbox"/> Provider not available 07 <input type="checkbox"/> Didn't like provider 08 <input type="checkbox"/> Transportation problems 09 <input type="checkbox"/> Could not take time off from work 10 <input type="checkbox"/> Other reasons 99 <input type="checkbox"/> DK</p> | 52-53 54-55 56-57 58-59 60-61 62-63 64-65 66-67 68-69 70-71 72-73 74-75 |
| <p>59a. During the past 12 months, have you needed any mental health services or counseling that you have not received?</p> <p><i>HAND CARD A12. Read categories if telephone interview.</i></p> | <p>1 <input type="checkbox"/> Yes (<i>Go to 59b</i>) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (<i>Skip to 60</i>)</p> | 76 |
| <p>b. Which of these statements explain why you did not receive the mental health services you needed? (Any other reason?)</p> <p><i>Mark (X) all that apply.</i></p> | <p>00 <input type="checkbox"/> Did not try to get mental health services during the past 12 months 01 <input type="checkbox"/> Too expensive/can't afford 02 <input type="checkbox"/> Didn't know where to go to get services 03 <input type="checkbox"/> No mental health services nearby 04 <input type="checkbox"/> No nearby provider who accepts Medicaid 05 <input type="checkbox"/> Private insurance does not cover the services 06 <input type="checkbox"/> Did not have insurance 07 <input type="checkbox"/> Transportation problems 08 <input type="checkbox"/> Trouble finding the right kind of mental health professional 09 <input type="checkbox"/> Language barrier 10 <input type="checkbox"/> Could not take time off from work 11 <input type="checkbox"/> Other reasons 99 <input type="checkbox"/> DK</p> | 77-78 79-80 81-82 83-84 85-86 87-88 89-90 91-92 93-94 95-96 97-98 99-100 101-102 |
| <p>60. Because of a physical, mental or emotional problem, did you receive any training during the past 12 months in social skills, such as making and keeping friends or how to interact with other people?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> | 103 |
| <p>The next questions are about the coordination of services.</p> | | |
| <p>61a. Is there any one doctor who you think of as the one who coordinates your overall medical care? By coordinating, I mean one who keeps in touch with the different doctors or therapists whom you see, who knows the results of all tests and treatments that you have, and who is aware of your different prescription medicines?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> | 104 |
| <p>b. Do your doctors talk to each other about your health and the care you get, including any tests or medications?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Only one doctor 9 <input type="checkbox"/> DK</p> | 105 |
| <p>62a. Is there anyone who is not a doctor who coordinates your medical care?</p> | <p>1 <input type="checkbox"/> Yes (<i>Go to 62b</i>) 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Does by self } (<i>Skip to 63 on page 72</i>) 9 <input type="checkbox"/> DK</p> | 106 |
| <p>b. Who does this for you? Anyone else?</p> <p><i>Mark (X) all that apply.</i></p> | <p>0 <input type="checkbox"/> Self 1 <input type="checkbox"/> Friend/Family member 2 <input type="checkbox"/> Nurse 3 <input type="checkbox"/> Therapist 4 <input type="checkbox"/> Social worker 5 <input type="checkbox"/> Hospital discharge planner 6 <input type="checkbox"/> Case manager 7 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK</p> | 107 108 109 110 111 112 113 114 115 |

| Section I – OTHER SERVICES – Continued | | RT 83 |
|---|---|--|
| | | 3-4 |
| <p>63a. Does any physician or someone in a physician's office help you with arranging non-medical care, like social services and personal care?</p> | <p>1 <input type="checkbox"/> Yes (<i>Go to 63b</i>) 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Does by self } (<i>Skip to 64</i>) 9 <input type="checkbox"/> DK</p> | 5 |
| <p>b. Is this person or does this person work for a general care physician or a specialist?</p> <p><i>Mark (X) only one.</i></p> | <p>1 <input type="checkbox"/> General care physician 2 <input type="checkbox"/> Specialist 3 <input type="checkbox"/> Someone else 9 <input type="checkbox"/> DK</p> | 6 |
| <p>c. Is this person a — (<i>Read each category</i>)</p> <p><i>Mark (X) all that apply.</i></p> | <p>1 <input type="checkbox"/> Physician? 2 <input type="checkbox"/> Therapist? 3 <input type="checkbox"/> Nurse? 4 <input type="checkbox"/> Social worker? 5 <input type="checkbox"/> Hospital discharge planner? 6 <input type="checkbox"/> Case manager? 7 <input type="checkbox"/> Something else? 9 <input type="checkbox"/> DK</p> | 7 8 9 10 11 12 13 14 |
| <p>64a. Does anyone NOT in a physician's office help you with arranging non-medical services?</p> | <p>1 <input type="checkbox"/> Yes (<i>Go to 64b</i>) 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Does by self } (<i>Skip to Item 17</i>) 9 <input type="checkbox"/> DK</p> | 15 |
| <p>b. Who does this for you?</p> <p>Anyone else?</p> <p><i>Mark (X) all that apply.</i></p> | <p>0 <input type="checkbox"/> Self 1 <input type="checkbox"/> Friend/Family member 2 <input type="checkbox"/> Nurse 3 <input type="checkbox"/> Therapist 4 <input type="checkbox"/> Social worker 5 <input type="checkbox"/> Hospital discharge planner 6 <input type="checkbox"/> Case manager 7 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK</p> | 16 17 18 19 20 21 22 23 24 |
| <p>ITEM 17</p> <p><i>Refer to questions 61a and 62a on page 71, 63a and 64a above. (Service coordinator)</i></p> | <p>1 <input type="checkbox"/> "Yes" marked in 61a and/or 63a (<i>Skip to 65</i>) 2 <input type="checkbox"/> "Yes" marked in 62a and/or 64a (<i>Go to Item 18</i>) 3 <input type="checkbox"/> All others (<i>Skip to 69 on page 73</i>)</p> | 25 |
| <p>ITEM 18</p> <p><i>Refer to questions 62b on page 71 and 64b above. (Who arranges services)</i></p> | <p>1 <input type="checkbox"/> Anyone other than "Self" marked in 62b or 64b (<i>Go to 65</i>) 2 <input type="checkbox"/> "Self" only in 62b and 64b (<i>Skip to 70 on page 73</i>)</p> | 26 |
| <i>HAND CARD A13. Read categories if telephone interview.</i> | | |
| <p>65. What kinds of medical or non-medical services are provided for you?</p> <p>(Anything else?)</p> <p><i>Mark (X) all that apply.</i></p> | <p>01 <input type="checkbox"/> Helps make medical appointments with (other) doctors 02 <input type="checkbox"/> Makes appointments with nurses/therapists/dieticians 03 <input type="checkbox"/> Follows up to be sure appointments are kept 04 <input type="checkbox"/> Arranges transportation to appointments 05 <input type="checkbox"/> Makes referrals to doctors 06 <input type="checkbox"/> Makes referrals to nurses/therapists/dieticians 07 <input type="checkbox"/> Checks to see if needs or conditions have changed 08 <input type="checkbox"/> Makes sure I am doing exercises or following diet 09 <input type="checkbox"/> Reviews medications 10 <input type="checkbox"/> Explains medical procedures or terms 11 <input type="checkbox"/> Helps with insurance or other benefits 12 <input type="checkbox"/> Arranges for home care 13 <input type="checkbox"/> Arranges for vocational rehabilitation services 14 <input type="checkbox"/> Helps develop a personal care plan 15 <input type="checkbox"/> Evaluates need for services 16 <input type="checkbox"/> Arranges special education services 17 <input type="checkbox"/> Tries to find volunteers to help me 18 <input type="checkbox"/> Tries to find workers/agencies to help me 19 <input type="checkbox"/> Arranges for home delivered meals 20 <input type="checkbox"/> Makes sure friends/family are able to help me 21 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK</p> | 27-28 29-30 31-32 33-34 35-36 37-38 39-40 41-42 43-44 45-46 47-48 49-50 51-52 53-54 55-56 57-58 59-60 61-62 63-64 65-66 67-68 69-70 |
| <p>ITEM 19</p> <p><i>Refer to questions 64b above. (Who arranges services)</i></p> | <p>1 <input type="checkbox"/> Any of boxes 2–9 marked (<i>Go to 66 on page 73</i>) 2 <input type="checkbox"/> All others (<i>Skip to 70 on page 73</i>)</p> | 71 |

Section I - OTHER SERVICES - Continued

66a. You said that someone not in a physician's office helps you with arranging non-medical services. Was any of this help paid for? 72

1 Yes (Go to 66b)
 2 No } (Skip to 68)
 9 DK }

HAND CARD A1. Read categories if telephone interview.

b. Who paid or will pay for this help?

(Anyone else?)

Mark (X) all that apply.

- 01 Self or family in household 73-74
- 02 Family NOT in household 75-76
- 03 Private health insurance 77-78
- 04 Medicare 79-80
- 05 Medicaid 81-82
- 06 Rehabilitation program 83-84
- 07 Employer 85-86
- 08 School system 87-88
- 09 VA program 89-90
- 10 Other military 91-92
- 11 Other private source 93-94
- 12 Other public source 95-96
- 99 DK (Skip to 67) 97-98

Ask if more than one source in 66b. If only one source, transcribe the number of the box marked without asking.

c. Who paid for most of the cost of this help?

Record number of the main source.

Paid most
 (Number)

99 DK 99-100

67. In the past 6 months, about how many times did you see or talk to the person or persons who help arrange your non-medical services? 101-103

- 000 None
- (Number) } 1 Per week
2 Per month
3 Per six months
- 999 DK

68. Overall, how satisfied are you with the job the person or persons have done to help with arranging your non-medical services? Would you say very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied? 104

Mark (X) only one.

- 1 Very satisfied
 - 2 Somewhat satisfied
 - 3 Somewhat dissatisfied
 - 4 Very dissatisfied
 - 9 DK
- } (Skip to 70)

69. During the past 12 months, have you felt that you NEEDED someone to arrange or coordinate personal care or social services? 105

- 1 Yes
- 2 No
- 3 Never thought about it
- 9 DK

70a. Do you NEED help filling out insurance forms or benefit applications? 106

Mark (X) only one.

- 1 Yes } (Go to 70b)
- 2 No }
- 3 Never filled forms/applications (Skip to Item 110 on page 74)
- 9 DK (Go to 70b)

b. Who helps you fill out insurance forms or applications for public programs or benefits?

Mark (X) all that apply.

- 0 No one 107
- 1 Household member 108
- 2 Friend/Other relative not in household 109
- 3 Paid caregiver 110
- 4 Volunteer from organization 111
- 5 Other 112
- 9 DK 113

Notes

| Section I - OTHER SERVICES - Continued | | RT 84 |
|---|--|--|
| | | 3-4 |
| ITEM 110 | Refer to question 42a, Service K on page 66. (Center for Independent Living) | 5 |
| | | 1 <input type="checkbox"/> "Yes" in 42a for K (Go to 71) 2 <input type="checkbox"/> All others (Skip to Item 111) |
| 71. Did you receive any of the following services from the Center for Independent Living — | | |
| | Yes No DK | |
| a. Peer counseling? | a. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 6 |
| b. Employment counseling, training, or referral? | b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 7 |
| c. Help with accommodations at home? | c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 8 |
| d. Help with accommodations at work? | d. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 9 |
| e. Help with accommodations in transportation? | e. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 10 |
| f. Legal rights counseling? | f. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 11 |
| g. Attendant referral or personal assistant services? | g. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 12 |
| h. Recreational services? | h. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 13 |
| i. Transportation services? | i. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 14 |
| j. Getting assistive technology? | j. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 15 |
| k. Advocacy services? | k. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 16 |
| | | 17 |
| ITEM 111 | Refer to 37a, Service I on page 65. (Adult Day Care) | 17 |
| | | 1 <input type="checkbox"/> "Yes" in 37a for I (Go to 72) 2 <input type="checkbox"/> All others (Skip to Section J on page 75) |
| <i>HAND CARD A14. Read categories if telephone interview.</i> | | |
| 72. Which services did you receive from an adult day care center or day activities center? | | |
| (Anything else?) | | |
| <i>Mark (X) all that apply.</i> | | |
| | 01 <input type="checkbox"/> Transportation | 18-19 |
| | 02 <input type="checkbox"/> Socialization | 20-21 |
| | 03 <input type="checkbox"/> Recreational activities | 22-23 |
| | 04 <input type="checkbox"/> Recreational therapy | 24-25 |
| | 05 <input type="checkbox"/> Speech therapy | 26-27 |
| | 06 <input type="checkbox"/> Physical therapy | 28-29 |
| | 07 <input type="checkbox"/> Occupational therapy | 30-31 |
| | 08 <input type="checkbox"/> Social services | 32-33 |
| | 09 <input type="checkbox"/> Nutritional services | 34-35 |
| | 10 <input type="checkbox"/> Meals | 36-37 |
| | 11 <input type="checkbox"/> Counseling for participants or families | 38-39 |
| | 12 <input type="checkbox"/> Referrals to outside services | 40-41 |
| | 13 <input type="checkbox"/> Nursing services | 42-43 |
| | 14 <input type="checkbox"/> Monitoring medications | 44-45 |
| | 15 <input type="checkbox"/> Coordinating care with physicians | 46-47 |
| | 16 <input type="checkbox"/> Personal care services (such as bathing, feeding) | 48-49 |
| | 17 <input type="checkbox"/> Vocational rehabilitation services | 50-51 |
| | 18 <input type="checkbox"/> Other | 52-53 |
| | 00 <input type="checkbox"/> None | 54-55 |
| | 99 <input type="checkbox"/> DK | 56-57 |
| Notes | | |
| | | |

Section J – SELF DIRECTION

Reminder: If SP is institutionalized, skip to Section K on page 78.

| | | |
|--|---|---|
| <p>1a. Do you give your own consent for medical care, or does someone else do that for you?</p> | <p> <input type="checkbox"/> Gives own consent (<i>Skip to Item J1</i>) <input type="checkbox"/> Someone else gives consent } (<i>Go to 1b</i>) <input type="checkbox"/> It varies <input type="checkbox"/> DK (<i>Skip to Item J1</i>) </p> | 5 |
| <p>b. Who generally gives medical consent for you? <i>Mark (X) only one.</i></p> | <p> <input type="checkbox"/> Family member <input type="checkbox"/> Legal guardian <input type="checkbox"/> Agency or school staff member <input type="checkbox"/> Someone else <input type="checkbox"/> DK </p> | 6 |
| <p>ITEM J1 <i>Refer to SP's age.</i></p> | <p> <input type="checkbox"/> Under 21 (<i>Go to 2</i>) <input type="checkbox"/> Age 21 and over (<i>Skip to Section K on page 78</i>) </p> | 7 |
| <p>2. Do you now have an Individual Education Plan or IEP?</p> | <p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK </p> | 8 |
| <p>3. Do you currently have an Individual Written Rehabilitation Plan or IWRP?</p> | <p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK </p> | 9 |

Notes

Section J – SELF DIRECTION – Continued

Special education is a program designed to meet the individual needs of persons with special needs. It is paid for by the public school system and may take place at a regular school, a special school, a private school, at home, or at a hospital.

10

4a. DURING THE PAST 12 MONTHS, have you received any type of services or benefits through special education? Do not include gifted or talented programs.

- 1 Yes (Go to 4b)
- 2 No
- 9 DK } (Skip to 5 on page 77)

HAND CARD A15. Read categories if telephone interview.

b. DURING THE PAST 12 MONTHS, which of these services or benefits did you receive through special education programs?

(Anything else?)

Mark (X) all that apply.

- 01 Transportation services
- 02 Speech/Language therapy
- 03 Audiology services for hearing problems (such as testing, evaluation, and training)
- 04 Mental health or counseling services
- 05 Developmental testing
- 06 Physical therapy
- 07 Occupational therapy
- 08 Recreational therapy
- 09 Respiratory therapy
- 10 Social work services
- 11 Eyeglasses
- 12 Hearing aids
- 13 Wheelchair
- 14 Other assistive devices and training in their use
- 15 Medical services for diagnostic and evaluation purposes
- 16 Communication services (such as a reader, interpreter, or writer)
- 17 Nursing services
- 18 Other
- 99 DK

- 11-12
- 13-14
- 15-16
- 17-18
- 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
- 47-48

HAND CARD A16. Read categories if telephone interview.

c. DURING THE PAST 12 MONTHS, have you received special education for any of these conditions?

(Anything else?)

Mark (X) all that apply.

- 01 Learning disabilities
- 02 Speech or language problems
- 03 Mental retardation
- 04 Emotional disturbances
- 05 Deaf and blind
- 06 Hearing, including deafness or hard of hearing
- 07 Visual, including blindness and other problems
- 08 Orthopedic problems
- 09 Autism
- 10 Traumatic brain injury
- 11 Developmental delay
- 12 Multiple disabilities
- 13 Other health problem
- 14 Not a specific condition
- 99 DK

- 49-50
- 51-52
- 53-54
- 55-56
- 57-58
- 59-60
- 61-62
- 63-64
- 65-66
- 67-68
- 69-70
- 71-72
- 73-74
- 75-76
- 77-78

HAND CARD A17. Read categories if telephone interview.

d. During the past 12 months, where did you receive these special education services?

Mark (X) all that apply.

- 01 Regular classroom setting
- 02 Resource room in regular school
- 03 Separate class all day or part of a day in regular school
- 04 Special school-day school
- 05 Special school-residential school
- 06 Home
- 07 Hospital or institution
- 08 Provider's office
- 09 Other
- 99 DK

- 79-80
- 81-82
- 83-84
- 85-86
- 87-88
- 89-90
- 91-92
- 93-94
- 95-96
- 97-98

e. Have you received any of these special education services during the past month?

- 1 Yes (Skip to 5 on page 77)
- 2 No (Go to 4f)
- 9 DK (Skip to 5 on page 77)

99

f. Why haven't you received any special education services in the past month?

Any other reason?

Mark (X) all that apply.

- 0 Did not need the service during the past month
- 1 Provider/school thinks services no longer necessary
- 2 On vacation from school
- 3 Provider/service no longer available
- 4 Didn't like provider/service
- 5 Transportation problems
- 6 Could not take time off from work to arrange it
- 7 Other reason
- 9 DK

- 100
- 101
- 102
- 103
- 104
- 105
- 106
- 107
- 108

Section J – SELF DIRECTION – Continued

| | | |
|---|--|---|
| 5. DURING THE PAST 12 MONTHS, did you receive any instruction through special education about how to get and keep a job? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | 5 |
|---|--|---|

| | | |
|--|---|---|
| 6a. DURING THE PAST 12 MONTHS, have you tried to get any (additional) special education services? | <input type="checkbox"/> Yes (Go to 6b) <input type="checkbox"/> No } (Skip to 7) <input type="checkbox"/> DK } | 6 |
|--|---|---|

HAND CARD A15. Read categories if telephone interview.

b. What (additional) special education services did you try to get?

(Anything else?)

Mark (X) all that apply.

- | | |
|--|-------|
| <input type="checkbox"/> Transportation services | 7-8 |
| <input type="checkbox"/> Speech/Language therapy | 9-10 |
| <input type="checkbox"/> Audiology services for hearing problems (such as testing, evaluation, and training) | 11-12 |
| <input type="checkbox"/> Mental health or counseling services | 13-14 |
| <input type="checkbox"/> Developmental testing | 15-16 |
| <input type="checkbox"/> Physical therapy | 17-18 |
| <input type="checkbox"/> Occupational therapy | 19-20 |
| <input type="checkbox"/> Recreational therapy | 21-22 |
| <input type="checkbox"/> Respiratory therapy | 23-24 |
| <input type="checkbox"/> Social work services | 25-26 |
| <input type="checkbox"/> Eyeglasses | 27-28 |
| <input type="checkbox"/> Hearing aids | 29-30 |
| <input type="checkbox"/> Wheelchair | 31-32 |
| <input type="checkbox"/> Other assistive devices and training in their use | 33-34 |
| <input type="checkbox"/> Medical services for diagnostic and evaluation purposes | 35-36 |
| <input type="checkbox"/> Communication services (such as reader, interpreter, writer) | 37-38 |
| <input type="checkbox"/> Nursing services | 39-40 |
| <input type="checkbox"/> Other | 41-42 |
| <input type="checkbox"/> DK | 43-44 |

c. During the past 12 months were you on a waiting list for any special education services?

- Yes
 No
 DK

45

HAND CARD A18. Read categories if telephone interview.

d. What problems did you have trying to get (additional) special education services during the past 12 months?

(Anything else?)

Mark (X) all that apply.

- | | |
|--|----|
| <input type="checkbox"/> No problem getting services | 46 |
| <input type="checkbox"/> Service is not available | 47 |
| <input type="checkbox"/> Had trouble finding the right kind of service | 48 |
| <input type="checkbox"/> Services available are inadequate | 49 |
| <input type="checkbox"/> School did not think services were needed | 50 |
| <input type="checkbox"/> School would not test for disabilities | 51 |
| <input type="checkbox"/> School would not help in finding services | 52 |
| <input type="checkbox"/> Could not take time off from work to arrange it | 53 |
| <input type="checkbox"/> Other problems | 54 |
| <input type="checkbox"/> DK | 55 |

| | | |
|---|---|----|
| 7. Overall, how satisfied are you with the educational services that you receive? Are you very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied? | <input type="checkbox"/> Does not receive any educational services <input type="checkbox"/> Very satisfied <input type="checkbox"/> Somewhat satisfied <input type="checkbox"/> Somewhat dissatisfied <input type="checkbox"/> Very dissatisfied <input type="checkbox"/> DK | 56 |
|---|---|----|

Notes

| | |
|---|--------------|
| Section K – FAMILY STRUCTURE, RELATIONSHIPS, AND LIVING ARRANGEMENTS | RT 87 3-4 |
|---|--------------|

| | | |
|---|--|---|
| <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>1 <input type="checkbox"/> Married – spouse in HH } (Go to 2a)</p> <p>2 <input type="checkbox"/> Married – spouse not in HH } (Go to 2a)</p> <p>3 <input type="checkbox"/> Widowed } (Go to 2b)</p> <p>4 <input type="checkbox"/> Divorced } (Go to 2b)</p> <p>5 <input type="checkbox"/> Separated } (Go to 2b)</p> <p>6 <input type="checkbox"/> Never married } (Skip to Item K1)</p> <p>9 <input type="checkbox"/> DK } (Skip to Item K1)</p> | 5 |
|---|--|---|

| | | |
|--|--|-----|
| <p>2a. How long have you been married to your current spouse?</p> | <p>00 <input type="checkbox"/> Less than 1 year } (Skip to Item K1)</p> <p>_____ Years } (Skip to Item K1)</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK } (Skip to Item K1)</p> | 6-7 |
|--|--|-----|

| | | |
|---|--|-----|
| <p>b. How long have you been [widowed/divorced/separated]?</p> | <p>00 <input type="checkbox"/> Less than 1 year</p> <p>_____ Years</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK</p> | 8-9 |
|---|--|-----|

| | | | |
|----------------|----------------------|---|----|
| ITEM K1 | <p>Status of SP.</p> | <p>1 <input type="checkbox"/> Institutionalized (Skip to 5 on page 79)</p> <p>2 <input type="checkbox"/> All others (Go to 3)</p> | 10 |
|----------------|----------------------|---|----|

| | | |
|---|---|-------|
| <p>3. Including yourself, how many people altogether live in this household?</p> | <p>01 <input type="checkbox"/> SP only (Skip to 5 on page 79)</p> <p>_____ Household members (Go to 4)</p> <p>(Number)</p> <p>99 <input type="checkbox"/> DK (Go to 4a)</p> | 11-12 |
|---|---|-------|

| | |
|--|--|
| <p>4a. What are the names of all persons living in your household?</p> <p><i>Enter SP on line 1, all others on subsequent lines.</i></p> <p><i>If more than 9 household members, continue listing in the Notes space.</i></p> | |
| <p>b. If necessary, ask: What is (name's) sex?</p> | |
| <p>c. If necessary, ask: How is (name) related TO YOU? Record relationship to sample person.</p> | |

| Line No. | 4a. Name (First/Middle initial/Last) | 7-57 | 58 | c. Relationship to SP | |
|-----------|--------------------------------------|------|--|---|-------|
| 3-4 | | | | | 59-60 |
| 5-6 | | | | | |
| 01 | | | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | 77 <input type="checkbox"/> SAMPLE PERSON | |
| 3-4 | | | | | 59-60 |
| 5-6 | | | | | |
| 02 | | | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | |
| 3-4 | | | | | 59-60 |
| 5-6 | | | | | |
| 03 | | | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | |
| 3-4 | | | | | 59-60 |
| 5-6 | | | | | |
| 04 | | | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | |
| 3-4 | | | | | 59-60 |
| 5-6 | | | | | |
| 05 | | | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | |
| 3-4 | | | | | 59-60 |
| 5-6 | | | | | |
| 06 | | | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | |
| 3-4 | | | | | 59-60 |
| 5-6 | | | | | |
| 07 | | | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | |
| 3-4 | | | | | 59-60 |
| 5-6 | | | | | |
| 08 | | | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | |
| 3-4 | | | | | 59-60 |
| 5-6 | | | | | |
| 09 | | | 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | |

| Section K – FAMILY STRUCTURE, RELATIONSHIPS, AND LIVING ARRANGEMENTS – Continued | | RT 89 |
|---|--|-------|
| | | 3-4 |
| 5a. Including step and adopted children, how many LIVING SONS do you have? | <input type="checkbox"/> 00 None _____ Sons (Number) <input type="checkbox"/> 99 DK | 5-6 |
| b. Including step and adopted children, how many LIVING DAUGHTERS do you have? | <input type="checkbox"/> 00 None _____ Daughters (Number) <input type="checkbox"/> 99 DK | 7-8 |
| ITEM K2 <i>Refer to 5a and 5b above. (Living children)</i> | <input type="checkbox"/> 1 1+ living children (Go to Item K3) <input type="checkbox"/> 2 All others (Skip to Item K4 on page 80) | 9 |
| ITEM K3 <i>Refer to question 4 on page 78. (Household composition)</i> | <input type="checkbox"/> 1 Any of SP's child(ren) in HH (Skip to 7) <input type="checkbox"/> 2 All others (Go to 6) | 10 |
| 6a. How quickly can [any of your children/your son/your daughter] get here? <i>If asked, "Here" means where the SP resides.</i> | _____ { (Number) 1 <input type="checkbox"/> Minutes 2 <input type="checkbox"/> Hours 3 <input type="checkbox"/> Days <input type="checkbox"/> 999 DK | 11-13 |
| b. How often do you see [any of your children/your son/your daughter]? | <input type="checkbox"/> 000 Less than once a year/never _____ { (Times) 1 <input type="checkbox"/> Per day 2 <input type="checkbox"/> Per week 3 <input type="checkbox"/> Per month 4 <input type="checkbox"/> Per year <input type="checkbox"/> 999 DK | 14-16 |
| c. How often do you talk on the telephone with [any of your children/your son/your daughter]? | <input type="checkbox"/> 000 Less than once a year/never _____ { (Times) 1 <input type="checkbox"/> Per day 2 <input type="checkbox"/> Per week 3 <input type="checkbox"/> Per month 4 <input type="checkbox"/> Per year <input type="checkbox"/> 999 DK | 17-19 |
| d. How often do you get mail from [any of your children/your son/your daughter]? | <input type="checkbox"/> 000 Less than once a year/never _____ { (Times) 1 <input type="checkbox"/> Per day 2 <input type="checkbox"/> Per week 3 <input type="checkbox"/> Per month 4 <input type="checkbox"/> Per year <input type="checkbox"/> 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? | <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 DK | 23 |
| Notes | | |

| Section K – FAMILY STRUCTURE, RELATIONSHIPS, AND LIVING ARRANGEMENTS – Continued | | | | | | | | | | | | |
|--|---|---|----------------------------|----------------------------|----------------------------|-----------------------------|----------------------------|----------------|----------------------------|------------------------|----------------------------|-----------------|
| ITEM K4 | Refer to question 4 on page 78. (Household composition) Mark (X) first appropriate box. | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; border-right: 1px dashed black; padding: 2px;">1 <input type="checkbox"/></td> <td style="padding: 2px;">SP is institutionalized</td> <td rowspan="4" style="font-size: 2em; vertical-align: middle; padding: 0 10px;">}</td> <td rowspan="4" style="vertical-align: middle;">(Skip to 11)</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">2 <input type="checkbox"/></td> <td style="padding: 2px;">SP lives alone</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">3 <input type="checkbox"/></td> <td style="padding: 2px;">SP lives w/spouse only</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">4 <input type="checkbox"/></td> <td style="padding: 2px;">Other (Go to 8)</td> </tr> </table> | 1 <input type="checkbox"/> | SP is institutionalized | } | (Skip to 11) | 2 <input type="checkbox"/> | SP lives alone | 3 <input type="checkbox"/> | SP lives w/spouse only | 4 <input type="checkbox"/> | Other (Go to 8) |
| 1 <input type="checkbox"/> | SP is institutionalized | } | (Skip to 11) | | | | | | | | | |
| 2 <input type="checkbox"/> | SP lives alone | | | | | | | | | | | |
| 3 <input type="checkbox"/> | SP lives w/spouse only | | | | | | | | | | | |
| 4 <input type="checkbox"/> | Other (Go to 8) | | | | | | | | | | | |
| 8. (Other than your spouse) [is/are any of] the person(s) living with you 18 years of age or older? | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; border-right: 1px dashed black; padding: 2px;">1 <input type="checkbox"/></td> <td style="padding: 2px;">Yes (Go to 9)</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">2 <input type="checkbox"/></td> <td style="padding: 2px;">No</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">9 <input type="checkbox"/></td> <td style="padding: 2px;">DK</td> </tr> </table> | 1 <input type="checkbox"/> | Yes (Go to 9) | 2 <input type="checkbox"/> | No | 9 <input type="checkbox"/> | DK | 24 | | | | |
| 1 <input type="checkbox"/> | Yes (Go to 9) | | | | | | | | | | | |
| 2 <input type="checkbox"/> | No | | | | | | | | | | | |
| 9 <input type="checkbox"/> | DK | | | | | | | | | | | |
| 9. Do you live with [these people/this person] NOW because YOU need to share living expenses? | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; border-right: 1px dashed black; padding: 2px;">1 <input type="checkbox"/></td> <td style="padding: 2px;">Yes</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">2 <input type="checkbox"/></td> <td style="padding: 2px;">No</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">9 <input type="checkbox"/></td> <td style="padding: 2px;">DK</td> </tr> </table> | 1 <input type="checkbox"/> | Yes | 2 <input type="checkbox"/> | No | 9 <input type="checkbox"/> | DK | 25 | | | | |
| 1 <input type="checkbox"/> | Yes | | | | | | | | | | | |
| 2 <input type="checkbox"/> | No | | | | | | | | | | | |
| 9 <input type="checkbox"/> | DK | | | | | | | | | | | |
| 10. Do you live with [these people/this person] NOW because of a health or physical problem YOU have? | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; border-right: 1px dashed black; padding: 2px;">1 <input type="checkbox"/></td> <td style="padding: 2px;">Yes</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">2 <input type="checkbox"/></td> <td style="padding: 2px;">No</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">9 <input type="checkbox"/></td> <td style="padding: 2px;">DK</td> </tr> </table> | 1 <input type="checkbox"/> | Yes | 2 <input type="checkbox"/> | No | 9 <input type="checkbox"/> | DK | 26 | | | | |
| 1 <input type="checkbox"/> | Yes | | | | | | | | | | | |
| 2 <input type="checkbox"/> | No | | | | | | | | | | | |
| 9 <input type="checkbox"/> | DK | | | | | | | | | | | |
| 11. Including step and adopted brothers, how many LIVING brothers do you have? | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; border-right: 1px dashed black; padding: 2px;">00 <input type="checkbox"/></td> <td style="padding: 2px;">None</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;"></td> <td style="padding: 2px;">_____ Brothers (Number)</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">99 <input type="checkbox"/></td> <td style="padding: 2px;">DK</td> </tr> </table> | 00 <input type="checkbox"/> | None | | _____ Brothers (Number) | 99 <input type="checkbox"/> | DK | 27 | | | | |
| 00 <input type="checkbox"/> | None | | | | | | | | | | | |
| | _____ Brothers (Number) | | | | | | | | | | | |
| 99 <input type="checkbox"/> | DK | | | | | | | | | | | |
| 12. Including step and adopted sisters, how many LIVING sisters do you have? | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; border-right: 1px dashed black; padding: 2px;">00 <input type="checkbox"/></td> <td style="padding: 2px;">None</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;"></td> <td style="padding: 2px;">_____ Sisters (Number)</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">99 <input type="checkbox"/></td> <td style="padding: 2px;">DK</td> </tr> </table> | 00 <input type="checkbox"/> | None | | _____ Sisters (Number) | 99 <input type="checkbox"/> | DK | 28-29 | | | | |
| 00 <input type="checkbox"/> | None | | | | | | | | | | | |
| | _____ Sisters (Number) | | | | | | | | | | | |
| 99 <input type="checkbox"/> | DK | | | | | | | | | | | |
| 13a. Is your mother still living? | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; border-right: 1px dashed black; padding: 2px;">1 <input type="checkbox"/></td> <td style="padding: 2px;">Yes</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">2 <input type="checkbox"/></td> <td style="padding: 2px;">No</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">9 <input type="checkbox"/></td> <td style="padding: 2px;">DK</td> </tr> </table> | 1 <input type="checkbox"/> | Yes | 2 <input type="checkbox"/> | No | 9 <input type="checkbox"/> | DK | 30-31 | | | | |
| 1 <input type="checkbox"/> | Yes | | | | | | | | | | | |
| 2 <input type="checkbox"/> | No | | | | | | | | | | | |
| 9 <input type="checkbox"/> | DK | | | | | | | | | | | |
| b. Is your father still living? | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; border-right: 1px dashed black; padding: 2px;">1 <input type="checkbox"/></td> <td style="padding: 2px;">Yes</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">2 <input type="checkbox"/></td> <td style="padding: 2px;">No</td> </tr> <tr> <td style="border-right: 1px dashed black; padding: 2px;">9 <input type="checkbox"/></td> <td style="padding: 2px;">DK</td> </tr> </table> | 1 <input type="checkbox"/> | Yes | 2 <input type="checkbox"/> | No | 9 <input type="checkbox"/> | DK | 32 | | | | |
| 1 <input type="checkbox"/> | Yes | | | | | | | | | | | |
| 2 <input type="checkbox"/> | No | | | | | | | | | | | |
| 9 <input type="checkbox"/> | DK | | | | | | | | | | | |
| Notes | | 33 | | | | | | | | | | |

| Section K – FAMILY STRUCTURE, RELATIONSHIPS, AND LIVING ARRANGEMENTS – Continued | | |
|--|---|--|
| ITEM K5 | Refer to Item K4. (SP's living arrangements) | <div style="text-align: right;">34</div> 1 <input type="checkbox"/> Box 1, 2, or 3 marked (Go to 14) 2 <input type="checkbox"/> Box 4 marked (Skip to 15) |
| The next few questions are about contact you have with family members (other than your spouse or children). | | |
| 35-37 | | |
| 14a. How quickly can any member of your family (other than your spouse or children) get here? <i>If asked, "Here" means where the SP resides.</i> | | |
| 000 <input type="checkbox"/> No other family (Skip to Section L on page 82) _____ { 1 <input type="checkbox"/> Minutes (Number) { 2 <input type="checkbox"/> Hours 3 <input type="checkbox"/> Days 999 <input type="checkbox"/> DK | | |
| 38-40 | | |
| 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 | | |
| 41-43 | | |
| 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 | | |
| 44-46 | | |
| 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 | | |
| 47 | | |
| 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 | | |
| Notes | | |

RT 93
3-4

Section O - UPDATE CONTACT PERSON INFORMATION

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

**ITEM
O1**

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 Refused 109

Notes

Section P – INTERVIEWER OBSERVATIONS

| | | | |
|--|--|--|-----|
| ITEM P1 | Mark (X) the one that best represents this interview. | 1 <input type="checkbox"/> Self response without assistance (<i>Skip to Item P2</i>) 2 <input type="checkbox"/> Self response with assistance (<i>Go to 1a</i>) 3 <input type="checkbox"/> Proxy (<i>Skip to 1b</i>) | 5 |
| ASK OR VERIFY: 1a. How is (assistant) related to you? <i>If more than one assistant, indicate the relationship of the one you consider to be the main assistant.</i> | | 00 <input type="checkbox"/> Parent 01 <input type="checkbox"/> Spouse 02 <input type="checkbox"/> Son/Daughter 03 <input type="checkbox"/> Son-in-law/Daughter-in-law 04 <input type="checkbox"/> Grandchild/Great grandchild 05 <input type="checkbox"/> Brother/Sister 06 <input type="checkbox"/> Brother-in-law/Sister-in-law 07 <input type="checkbox"/> Aunt/Uncle/Cousin 08 <input type="checkbox"/> Niece/Nephew 09 <input type="checkbox"/> Other relative 10 <input type="checkbox"/> Roommate/Friend/Neighbor 11 <input type="checkbox"/> Other non-relative | 6-7 |
| ----- b. How are you related to (sample person)? <i>If more than one proxy, direct this question to the one you consider to be the main proxy.</i> | | 00 <input type="checkbox"/> Parent 01 <input type="checkbox"/> Spouse 02 <input type="checkbox"/> Son/Daughter 03 <input type="checkbox"/> Son-in-law/Daughter-in-law 04 <input type="checkbox"/> Grandchild/Great grandchild 05 <input type="checkbox"/> Brother/Sister 06 <input type="checkbox"/> Brother-in-law/Sister-in-law 07 <input type="checkbox"/> Aunt/Uncle/Cousin 08 <input type="checkbox"/> Niece/Nephew 09 <input type="checkbox"/> Other relative 10 <input type="checkbox"/> Roommate/Friend/Neighbor 11 <input type="checkbox"/> Other non-relative | 8-9 |
| ----- ASK OR VERIFY: c. Do(es) [you/(assistant)] live here? | | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK | 10 |
| Mark each to indicate why a proxy/assistant was needed. | | Yes No | |
| 2a. | Sample person hospitalized | 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 |
| ITEM P2 | Refer to SP's age. | 1 <input type="checkbox"/> 70+ (<i>Go to 3</i>) 2 <input type="checkbox"/> Under 70 (<i>END interview</i>) | 21 |
| 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. | | Yes No DK | |
| 3. | Do you feel the — | | |
| a. | Respondent was intellectually capable of responding? | a. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 22 |
| b. | Respondent's answers were reasonably accurate? | b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 23 |
| c. | Respondent understood the questions? | c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> | 24 |

Section P – INTERVIEWER OBSERVATIONS – Continued

| | | |
|---|--|--|
| <p>4a. Was there a section which seemed to be particularly upsetting or problematic to the respondent?</p> | <p>1 <input type="checkbox"/> Yes (<i>Go to 4b</i>) 2 <input type="checkbox"/> No (<i>Skip to 5</i>)</p> | <p>25</p> |
| <p>b. Which section(s)? Mark (X) all that apply.</p> | <p>01 <input type="checkbox"/> A. Housing and long-term care services 02 <input type="checkbox"/> B. Transportation 03 <input type="checkbox"/> C. Social activity 04 <input type="checkbox"/> D. Work history/employment 05 <input type="checkbox"/> E. Vocational rehabilitation 06 <input type="checkbox"/> F. Assistive devices and technologies 07 <input type="checkbox"/> G. Health insurance 08 <input type="checkbox"/> H. Assistance with key activities 09 <input type="checkbox"/> I. Other services 10 <input type="checkbox"/> J. Self direction 11 <input type="checkbox"/> K. Family structure, relationships, and living arrangements 12 <input type="checkbox"/> L. Conditions and impairments 13 <input type="checkbox"/> M. Health opinions and behaviors 14 <input type="checkbox"/> N. Community services 15 <input type="checkbox"/> O. Contact person</p> | <p>26-27 28-29 30-31 32-33 34-35 36-37 38-39 40-41 42-43 44-45 46-47 48-49 50-51 52-53 54-55</p> |
| <p>5. How tiring did the interview seem to be for the respondent?</p> | <p>1 <input type="checkbox"/> Very tiring 2 <input type="checkbox"/> A little tiring 3 <input type="checkbox"/> Not tiring</p> | <p>56</p> |
| <p>6. Did the respondent have difficulty hearing you during the interview?</p> | <p>1 <input type="checkbox"/> Yes (<i>Go to 7</i>) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (<i>END interview</i>)</p> | <p>57</p> |
| <p>7. Do you feel the respondent's hearing difficulty affected the interview?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> | <p>58</p> |

Notes