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

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

CURRENT RESIDENT QUESTIONNAIRE

1999 NATIONAL NURSING HOME SURVEY

NOTICE – Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; Paperwork Reduction Project (0920-0353) 1600 Clifton Road, MSD-24, Atlanta, GA 30333. Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

Section A – ADMINISTRATIVE INFORMATION

1. Field representative name	**2.** FR code	**3.** Date of interview		
		Month	Day	Year

Section B – SAMPLE INFORMATION

Current resident line number

Section C – STATUS OF INTERVIEW

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

Notes/Comments section
01 ☐ *Check this box if comments are written in this section or any other place on this questionnaire.*

Read to each new respondent.

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

The identifying information you provide will be held in strict confidence and will be used ONLY by persons involved in the survey and only for the purposes of the survey.

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

If not, ask the respondent to get it/them prior to beginning the interview. Fill sections A and B on the front of all the current resident forms while the respondent gets the records. If no record is available for a resident, try to obtain as much information as possible from whatever administrative records are available and/or from the respondent's memory.

1. What is the resident's sex?

- 01 ☐ Male
- 02 ☐ Female

2. What is (his/her) date of birth?

Month		Day		Year			

OR Current age ______ Years

3a. Is (he/she) of Hispanic or Latino origin?

- 01 ☐ Yes
- 02 ☐ No
- 03 ☐ Don't know

HAND FLASHCARD 1.

b. Which of these best describes (his/her) race?

Mark (X) one or more boxes.

- 01 ☐ American Indian or Alaska Native
- 02 ☐ Asian
- 03 ☐ Black or African American
- 04 ☐ Native Hawaiian or Other Pacific Islander
- 05 ☐ White
- 06 ☐ Other – *Specify* ______
- 07 ☐ Don't know

4. What is (his/her) current marital status?

Mark (X) only one box.

- 01 ☐ Married
- 02 ☐ Widowed
- 03 ☐ Divorced
- 04 ☐ Separated
- 05 ☐ Never married
- 06 ☐ Single
- 07 ☐ Don't know

HAND FLASHCARD 2.

5a. Where was (he/she) staying immediately before entering this facility?

Mark (X) only one box.

- 01 ☐ Private residence (house or apartment)
- 02 ☐ Rented room, boarding house
- 03 ☐ Retirement home
- 04 ☐ Board and care, assisted living or residential care facility
- 05 ☐ Nursing home
- 06 ☐ Hospital
- 07 ☐ Rehabilitation facility
- 08 ☐ Other inpatient health facility (including mental health facility)

(05–08: *SKIP to item 6*)

- 09 ☐ Other – *Specify* ______
- 10 ☐ Don't know

b. At that time, was (he/she) living with family members, nonfamily members, both family and nonfamily members, or alone?

- 01 ☐ With family members
- 02 ☐ With nonfamily members
- 03 ☐ With both family members and nonfamily members
- 04 ☐ Alone
- 05 ☐ Don't know

6. **What was the date of (his/her) most recent admission with your facility, that is, the date on which (he/she) was admitted for the current episode of care?**	Month _ _ Day _ _ Year _ _ _ _
7. **Has (he/she) previously been a resident in this facility?**	01 ☐ Yes 02 ☐ No
8a. **According to (his/her) medical record, what were the primary and other diagnoses at the time of admission on** *(date in item 6)***?** *PROBE:* **Any other diagnoses?**	Primary: 1 ______ Others: 2 ______ 3 ______ 4 ______ 5 ______ 6 ______
b. **According to (his/her) medical record, what are (his/her) CURRENT primary and other diagnoses?** *PROBE:* **Any other diagnoses?**	00 ☐ Same as 8a Primary: 1 ______ Others: 2 ______ 3 ______ 4 ______ 5 ______ 6 ______
9. **What level of care is (he/she) currently receiving from your facility? Is it skilled care, intermediate care or residential care?**	01 ☐ Skilled care 02 ☐ Intermediate care 03 ☐ Residential care

Notes/Comments

Question	Response
HAND FLASHCARD 3. **10. Which of these aids does (he/she) currently use?** *Mark (X) all that apply.* *PROBE:* **Any other aids?**	00 ☐ No aids used 01 ☐ Eye glasses (including contact lenses) 02 ☐ Hearing aid 03 ☐ Dentures 04 ☐ Transfer equipment 05 ☐ Wheelchair 06 ☐ Cane 07 ☐ Walker 08 ☐ Crutches 09 ☐ Brace (any type) 10 ☐ Oxygen 11 ☐ Bedside commode 12 ☐ Other aids or devices – *Specify* ↙ ________________ 13 ☐ Don't know
For items 11a-12b, refer to item 10. **11a. Does (he/she) have any difficulty in seeing (when wearing glasses)?**	01 ☐ Yes 02 ☐ No . . . . } 03 ☐ Not applicable (e.g., comatose) . } *SKIP to item 12a* 04 ☐ Don't know . . . . }
HAND FLASHCARD 4. **b. Is (his/her) sight (when wearing glasses) partially, severely, or completely impaired as defined on this card?**	01 ☐ Partially impaired 02 ☐ Severely impaired 03 ☐ Completely lost, blind 04 ☐ Don't know
12a. Does (he/she) have any difficulty in hearing (when wearing a hearing aid)?	01 ☐ Yes 02 ☐ No . . . . } 03 ☐ Not applicable (e.g., comatose) . } *SKIP to item 13a* 04 ☐ Don't know . . . . }
HAND FLASHCARD 5. **b. Is (his/her) hearing (when wearing a hearing aid) partially, severely, or completely impaired, as defined on this card?**	01 ☐ Partially impaired 02 ☐ Severely impaired 03 ☐ Completely lost, deaf 04 ☐ Don't know
13a. Does (he/she) currently receive any assistance in bathing or showering?	01 ☐ Yes 02 ☐ No – *SKIP to item 14a*
b. Does (he/she) bathe or shower with the help of: **(1) Special equipment?** . . . . **(2) Another person?**	Yes No 01 ☐ 02 ☐ 01 ☐ 02 ☐
14a. Does (he/she) currently receive any assistance in dressing?	01 ☐ Yes 02 ☐ No – *SKIP to item 15a*
b. Does (he/she) dress with the help of: **(1) Special equipment?** . . . . **(2) Another person?**	Yes No 01 ☐ 02 ☐ 01 ☐ 02 ☐

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

21. Does (he/she) currently have any difficulty in controlling (his/her) bowels?	01 ☐ Yes 02 ☐ No 03 ☐ Not applicable (e.g., infant, had a colostomy)
22. Does (he/she) currently have any difficulty in controlling (his/her) bladder?	01 ☐ Yes 02 ☐ No 03 ☐ Not applicable (e.g., infant, has an indwelling catheter, had an ostomy)

HAND FLASHCARD 6.

23. Does (he/she) currently receive personal help or supervision in any of the following activities:

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

24. During the past 12 months, has (he/she) had a flu shot at this facility or any other location?	01 ☐ Yes 02 ☐ No 03 ☐ Don't know
25. Has (he/she) EVER had a pneumococcal vaccine, that is, pneumonia vaccination?	01 ☐ Yes 02 ☐ No 03 ☐ Don't know
26. During the past 10 years has (he/she) had a Tetanus-Diphtheria (Td) Toxoid booster at this facility or any other location?	01 ☐ Yes 02 ☐ No 03 ☐ Don't know

Notes/Comments

INSTRUCTION BOX

For questions 27, 29, 30, and 31, use the phrase "LAST MONTH" *if the resident was admitted last month or earlier. Use the phrase* "SINCE ADMISSION" *if the resident was admitted this month.*

HAND FLASHCARD 7.

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

Mark (X) all that apply.

PROBE: **Any other services?**

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

____

HAND FLASHCARD 8.

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

Refer to item 6 on page 3.

Mark (X) only one source.

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

____

- 11 ☐ Don't know

HAND FLASHCARD 8.

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

Mark (X) only one source.

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

____

HAND FLASHCARD 8.

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

Mark (X) all that apply.

PROBE: **Any other sources?**

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

____

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

Mark (X) only one box.

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

$ __________ per ↙

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

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

Month	Day	Year		Month	Day	Year
			TO			

- 05 ☐ Not billed yet
- 00 ☐ No charge was made

FILL SECTION C ON THE COVER OF THIS FORM

FR Date Check – *Prior to leaving the facility, you must verify the dates you entered in other sections of this questionnaire. Copy the dates below to the space provided. Check that the dates go from the oldest to the newest and are logical. Correct errors by referring to the resident records and/or facility staff.*

	Month	Day	Year
Date of Birth – Question 2 on page 2			
Date of Admission – Question 6 on page 3			
Date of Interview – Item A3 on cover			

Notes/Comments