

2004 NATIONAL NURSING HOME SURVEY CURRENT RESIDENT QUESTIONNAIRE

Link to the first page within this document of each module:

- 1. Health Status (HA) Module**
- 2. Health Status – Non-MDS Items (HN) Module**
- 3. Prescribed Medications (PM) Module**
- 4. Sources of Payment (PA) Module**

(Content of questionnaire, beginning with the Health Status (HA) Module, starts on the next page.)

2004 NATIONAL NURSING HOME SURVEY CURRENT RESIDENT QUESTIONNAIRE

Health Status (HA) Module

HAPRE.

THIS IS THE FIRST PAGE OF THE HEALTH STATUS —MDS (HA) SECTION. STATUS = {STATUS}

IF THIS SECTION HAS ALREADY BEEN COMPLETED, RETURN TO THE CHOOSE PERSON SCREEN.

PRESS 1 AND ENTER TO CONTINUE.

IF RECORDS FOR THIS PERSON ARE NOT AVAILABLE (RP), PRESS 2 AND ENTER.

IF CONSENT REQUIRED AND NOT OBTAINED FOR THIS PERSON (CP), PRESS 3 AND ENTER.

HA1A1.

On what date was {SP} admitted to {FACILITY} for the stay that includes last night?

ENTER MONTH.

|_|_|
MM

HA1A2.

[On what date was {SP} admitted to {FACILITY} for the stay that includes last night?]

ENTER DAY.

|_|_|
DD

HA1A3.

[On what date was {SP} admitted to {FACILITY} for the stay that includes last night?]

ENTER A 4-DIGIT YEAR.

|_|_|_|
YYYY

HA1A4.

When {SP} was admitted to {FACILITY}, was {he/she} married, widowed, divorced, separated, or never married?

PRESS F1 FOR HELP SCREEN.

- MARRIED 1
- WIDOWED..... 2
- DIVORCED..... 3
- SEPARATED..... 4
- NEVER MARRIED..... 5
- SIGNIFICANT OTHER 6
- SINGLE..... 7
- DK
- RF

HA1B.

ASK IF NOT OBVIOUS:

Is {SP} male or female?

- MALE 1
- FEMALE 2

HA1C1.

What is {SP}'s date of birth?

ENTER MONTH.

|_|_|
MM

HA1C2.

[What is {SP}'s date of birth?]

ENTER DAY.

|_|_|
DD

HA1C3.

[What is {SP}'s date of birth?]

ENTER A 4-DIGIT YEAR.

|_|_|_|_|
YYYY

HA1C4.

Approximately, how old is {SP}?

ENTER AGE.

|_|_|_|

HA1C5.

Is {SP} of Hispanic or Latino origin?

- YES..... 1
- NO 2
- DK
- RF

HA1C6.

Please look at this card and tell me what {SP}'s race is.

SELECT ALL THAT APPLY.

SHOW CARD HA1.

- AMERICAN INDIAN OR ALASKA NATIVE 1
- ASIAN 2
- BLACK OR AFRICAN AMERICAN..... 3
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER 4
- WHITE 5
- ANOTHER RACE (SPECIFY).....91
- DK
- RF

HA1C6A.

SPECIFY OTHER RACE.

HA1C7.

Is {SP} a veteran of U.S. military service?

PRESS F1 FOR HELP SCREEN.

YES..... 1
NO 2
DK
RF

HA1DPRE.

Now please look at {SP}'s Social Security number and tell me if it begins with a letter or a number.

LETTER..... 1
NUMBER 2
DK
RF

HA1DA.

What is {SP}'s Social Security number?

HA1D.

What is {SP}'s Social Security number?

|_|_|_| - |_|_| - |_|_|_|_|

HA1D1.

I have entered {HA1DA/HASSNLt/HA1D/HASSN}. Is this correct?

YES..... 1
NO 2
DK
RF

HA1F1.

Does {SP} have a middle name?

YES..... 1
NO 2
DK
RF

HA1F2.

What is it?

HA1H.

Is {SP} enrolled in Medicare?

PRESS F1 FOR HELP SCREEN.

YES..... 1
NO 2
DK
RF

HA2.

What is {his/her} Medicare ID number?

PRESS F1 FOR HELP SCREEN.

{INTERVIEWER: {SP}'S SOCIAL SECURITY NUMBER IS {HA1DA/HASSNLt/HN1DA/HNSSNLt/
HA1D/HASSN/HN1D/HNSSN}

HA2A.

I have entered {HA2/CareNum}. Is this correct?

YES..... 1
NO 2

HA2C.

Is {SP} enrolled in {'PREFERRED NAME FOR MEDICAID} {or 'ALLOWED FOR' NAME FOR
MEDICAID}?

PRESS F1 FOR HELP SCREEN.

YES..... 1
NO 2
DK
RF

HA3.

What is {his/her} {'PREFERRED' NAME FOR MEDICAID} {or 'ALLOWED FOR' NAME FOR
MEDICAID} ID number?

IF NO MEDICAID NUMBER, ENTER 000.

MEDICAID ID NUMBER

HA3A.

I have entered {ANSWER AT HA3/CaidNum}. Is this correct?

YES..... 1
NO 2

HA7.

Where was {SP} staying immediately before entering this facility?

SHOW CARD HA2.

PRIVATE HOME/APT..... 1
ASSISTED LIVING/BOARD AND CARE/GROUP HOME
/ADULT CARE HOME..... 2
NURSING HOME 3
HOSPITAL SKILLED CARE UNIT..... 4
ACUTE CARE HOSPITAL..... 5
PSYCHIATRIC HOSPITAL, MR/DD FACILITY 6
REHABILITATION FACILITY 7
OTHER 8
DK
RF

HA7A.

Where was {SP} before entering the {{HA7/Admit}/place you just mentioned}?

HOME 1
OTHER PLACE 2
DK
RF

HA7B.

Please look at this card and tell me whom {SP} was living with immediately before entering {FACILITY}.

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA3.

- ALONE..... 1
- SPOUSE..... 2
- SIGNIFICANT OTHER 3
- CHILD(REN) 4
- OTHER FAMILY MEMBER (NOT SPOUSE OR CHILDREN) 5
- NON-FAMILY MEMBER(S) 6
- DK
- RF

HA7C.

Now, please look at this card and tell me which of the following advanced directives were listed in {SP}'s {current} record or chart.

SELECT ALL THAT APPLY.

SHOW CARD HA4.

- LIVING WILL..... 1
- DO NOT RESUSCITATE (DNR) 2
- DO NOT HOSPITALIZE 3
- ORGAN DONATION..... 4
- AUTOPSY REQUEST 5
- FEEDING RESTRICTIONS..... 6
- MEDICATION RESTRICTIONS 7
- OTHER TREATMENT RESTRICTIONS 8
- NO ADVANCED DIRECTIVES PROVIDED..... 9
- DK
- RF

HA8.

Do the medical records contain any MDS Assessment Forms?

PRESS F1 FOR HELP SCREEN.

- YES, FORM AVAILABLE AND COMPLETE..... 1
- NO, FORM NOT AVAILABLE..... 2
- FORM NOT COMPLETED..... 3
- DK
- RF

HA8A.

What is the assessment date on the most recent MDS form completed for {SP}?

ENTER MONTH.

|_|_|_|
MM

HA8B.

[What is the assessment date on the most recent MDS form completed for {SP}?]

ENTER DAY.

|_|_|_|
DD

HA8C.

[What is the assessment date on the most recent MDS form completed for {SP}?]

ENTER A 4-DIGIT YEAR.

|_|_|_|_|
YYYY

HA10PRE.

{The answers to the following questions about {SP}'s health status can be found on the MDS form you just located./The following questions are about {SP}'s health status. When answering these questions, please use whatever medical or other records or other knowledgeable sources you have available.}

PRESS ENTER TO CONTINUE.

HA10.

Is {SP} comatose?

YES..... 1
NO 2
DK
RF

HA11.

Please describe how {SP} makes decisions regarding tasks of daily life. Is {he/she} independent, does {he/she} exhibit modified independence, is {he/she} moderately impaired, or is {he/she} severely impaired?

PRESS F1 FOR HELP SCREEN.

INDEPENDENT 0
MODIFIED INDEPENDENCE 1
MODERATELY IMPAIRED 2
SEVERELY IMPAIRED 3
DK
RF

HA12.

Does {SP} show any indicators of depressed, sad or anxious mood that are not easily altered by attempts to 'cheer up', console, or reassure?

PRESS F1 FOR HELP SCREEN.

NO MOOD INDICATORS..... 0
INDICATORS PRESENT, EASILY ALTERED 1
INDICATORS PRESENT, NOT EASILY ALTERED 2
DK
RF

HA13.

Does {SP} {currently} display any behavioral symptoms, such as wandering, verbally abusive language, physically abusive actions, socially inappropriate or disruptive symptoms, or resisting care?

PRESS F1 FOR HELP SCREEN.

- YES..... 1
- NO 2
- DK
- RF

HA14PRE.

The next questions are about {SP}'s ability to perform Activities of Daily Living or ADLs.

I will read you a list of activities and would like you to tell me if {SP}'s self-performance is independent, requires supervision, requires limited assistance, requires extensive assistance, is totally dependent, or if the activity did not occur.

PRESS ENTER TO CONTINUE.

HA14A.

Please tell me {SP}'s level of self-performance in bed mobility.

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA5.

- INDEPENDENT 0
- SUPERVISION 1
- LIMITED ASSISTANCE..... 2
- EXTENSIVE ASSISTANCE..... 3
- TOTAL DEPENDENCE 4
- ACTIVITY DID NOT OCCUR DURING
ENTIRE 7 DAYS..... 8
- DK
- RF

HA14B.

What about transfer?

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA5.

INDEPENDENT 0
SUPERVISION 1
LIMITED ASSISTANCE..... 2
EXTENSIVE ASSISTANCE..... 3
TOTAL DEPENDENCE 4
ACTIVITY DID NOT OCCUR DURING
ENTIRE 7 DAYS..... 8
DK
RF

HA14C.

Walking in room?

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA5.

INDEPENDENT 0
SUPERVISION 1
LIMITED ASSISTANCE..... 2
EXTENSIVE ASSISTANCE..... 3
TOTAL DEPENDENCE 4
ACTIVITY DID NOT OCCUR DURING
ENTIRE 7 DAYS..... 8
DK
RF

HA14D.

Walking in corridor?

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA5.

INDEPENDENT	0
SUPERVISION	1
LIMITED ASSISTANCE.....	2
EXTENSIVE ASSISTANCE.....	3
TOTAL DEPENDENCE	4
ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS.....	8
DK	
RF	

HA14E.

What about locomotion on unit?

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA5.

INDEPENDENT	0
SUPERVISION	1
LIMITED ASSISTANCE.....	2
EXTENSIVE ASSISTANCE.....	3
TOTAL DEPENDENCE	4
ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS.....	8
DK	
RF	

HA14F.

Locomotion off unit?

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA5.

INDEPENDENT 0
SUPERVISION 1
LIMITED ASSISTANCE..... 2
EXTENSIVE ASSISTANCE..... 3
TOTAL DEPENDENCE 4
ACTIVITY DID NOT OCCUR DURING
ENTIRE 7 DAYS..... 8
DK
RF

HA14G.

Dressing?

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA5.

INDEPENDENT 0
SUPERVISION 1
LIMITED ASSISTANCE..... 2
EXTENSIVE ASSISTANCE..... 3
TOTAL DEPENDENCE 4
ACTIVITY DID NOT OCCUR DURING
ENTIRE 7 DAYS..... 8
DK
RF

HA14H.

Eating?

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA5.

INDEPENDENT	0
SUPERVISION	1
LIMITED ASSISTANCE.....	2
EXTENSIVE ASSISTANCE.....	3
TOTAL DEPENDENCE	4
ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS.....	8
DK	
RF	

HA14I.

Using the toilet?

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA5.

INDEPENDENT	0
SUPERVISION	1
LIMITED ASSISTANCE.....	2
EXTENSIVE ASSISTANCE.....	3
TOTAL DEPENDENCE	4
ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS.....	8
DK	
RF	

HA14J.

Personal hygiene?

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA5.

INDEPENDENT	0
SUPERVISION	1
LIMITED ASSISTANCE.....	2
EXTENSIVE ASSISTANCE.....	3
TOTAL DEPENDENCE	4
ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS.....	8
DK	
RF	

HA15.

What is {SP}'s level of self-performance when bathing: is {he/she} independent, does {he/she} require supervision, require physical help limited to transfer only, require physical help in part of the bathing activity, is {he/she} totally dependent, or does the activity not occur?

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA6.

INDEPENDENT	0
SUPERVISION	1
PHYSICAL HELP LIMITED TO TRANSFER ONLY	2
PHYSICAL HELP IN PART OF BATHING ACTIVITY	3
TOTAL DEPENDENCE	4
ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS.....	8
DK	
RF	

HA16.

What has been {SP}'s level of bowel control over the past 14 days (since {DATE OF CURRENT INTERVIEW - 14 DAYS})? Is {he/she} continent, usually continent, occasionally incontinent, frequently incontinent, or incontinent?

PRESS F1 FOR HELP SCREEN.

CONTINENT..... 0
USUALLY CONTINENT 1
OCCASIONALLY INCONTINENT 2
FREQUENTLY INCONTINENT 3
INCONTINENT 4
DK
RF

HA17.

What has been {SP}'s level of bladder control over the past 14 days (since {DATE OF CURRENT INTERVIEW - 14 DAYS})? Is {he/she} continent, usually continent, occasionally incontinent, frequently incontinent, or incontinent?

PRESS F1 FOR HELP SCREEN.

CONTINENT..... 0
USUALLY CONTINENT 1
OCCASIONALLY INCONTINENT 2
FREQUENTLY INCONTINENT 3
INCONTINENT 4
DK
RF

HA18.

Please look at this card and tell me what appliances or programs {SP} has used to prevent or manage incontinence.

SELECT ALL THAT APPLY.

SHOW CARD HA7.

- CONTINENT/NO PROGRAMS/APPLIANCES NEEDED 0
- ANY SCHEDULED TOILETING PLAN..... 1
- BLADDER RETRAINING PROGRAM..... 2
- EXTERNAL (CONDOM) CATHETER 3
- INDWELLING CATHETER..... 4
- OTHER APPLIANCES/PROGRAMS..... 5
- OSTOMY PRESENT 6
- DK
- RF

HA19.

Please look at this card and tell me if {SP} had any of these accidents during the past 6 months (since {PAST 6 MONTHS}).

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA8.

- FELL IN PAST 30 DAYS 1
- FELL IN PAST 31-180 DAYS 2
- HIP FRACTURE IN LAST 180 DAYS..... 3
- OTHER FRACTURE IN LAST 180 DAYS..... 4
- NONE OF THE ABOVE..... 5
- DK
- RF

HA19A.

Has {SP} had WEIGHT LOSS of 5% or more during the past 30 days or 10% or more during the past 180 days?

- NO 0
- YES..... 1
- DK
- RF

HA19B.

Has {SP} had WEIGHT GAIN of 5% or more during the past 30 days or 10% or more during the past 180 days?

NO 0
YES..... 1
DK
RF

HA20.

Please look at this card and tell me what nutritional approaches {SP} has been receiving.

SELECT ALL THAT APPLY.

SHOW CARD HA9.

FEEDING TUBE 1
ON A PLANNED WEIGHT CHANGE PROGRAM 2
OTHER NUTRITIONAL APPROACHES, such as
mechanically altered diet, therapeutic diet, or dietary
supplement between meals 3
NONE 4
DK
RF

HA21.

Please look at this card and tell me the HIGHEST STAGE of ANY pressure ulcer {SP} now has...

IF NO PRESSURE ULCER, ENTER 0.

PRESS F1 FOR HELP SCREEN.

SHOW CARD HA10.

NO PRESSURE ULCER 0
STAGE 1..... 1
STAGE 2..... 2
STAGE 3..... 3
STAGE 4..... 4
DK
RF

HA22PRE.

Now, I will read you a list of devices and restraints. Please tell me if they are not used, used less than daily, or used daily for {SP}.

PRESS ENTER TO CONTINUE.

HA22A.

Are any full bed rails on all open sides of bed used for {SP}?

Side rails, including half rails, or one side rail?

Trunk restraint?

Limb restraint?

Chairs that prevent rising?

PRESS F1 FOR HELP SCREEN.

{SHOW CARD HA11.}

NOT USED 0
USED LESS THAN DAILY 1
USED DAILY 2
DK
RF

HA22B.

Are any full bed rails on all open sides of bed used for {SP}?

Side rails, including half rails, or one side rail?

Trunk restraint?

Limb restraint?

Chairs that prevent rising?

{SHOW CARD HA11.}

NOT USED 0
USED LESS THAN DAILY 1
USED DAILY 2
DK
RF

HA22C.

Are any full bed rails on all open sides of bed used for {SP}?
Side rails, including half rails, or one side rail?

Trunk restraint?

Limb restraint?

Chairs that prevent rising?

{SHOW CARD HA11.}

NOT USED 0
USED LESS THAN DAILY 1
USED DAILY 2
DK
RF

HA22D.

Are any full bed rails on all open sides of bed used for {SP}?
Side rails, including half rails, or one side rail?

Trunk restraint?

Limb restraint?

Chairs that prevent rising?

{SHOW CARD HA11.}

NOT USED 0
USED LESS THAN DAILY 1
USED DAILY 2
DK
RF

HA22E.

Are any full bed rails on all open sides of bed used for {SP}?
Side rails, including half rails, or one side rail?

Trunk restraint?

Limb restraint?

Chairs that prevent rising?

{SHOW CARD HA11.}

NOT USED 0
USED LESS THAN DAILY 1
USED DAILY 2
DK
RF

HAEND.

YOU HAVE COMPLETED HA FOR {SP}. PRESS 1 AND ENTER TO CONTINUE.

HANAV.

YOU HAVE COMPLETED THE HA SECTION. YOUR OPTIONS ARE TO:

- CONTINUE WITH HN {STATUS} FOR {SP}..... 1
- CHOOSE A DIFFERENT SECTION FOR {SP} 2
- CHOOSE A DIFFERENT PERSON 3

Health Status Section Help Screens

HA1A4

'Significant other' refers to long-standing supportive relationship, e.g., opposite sex or same-sex partner or companion.

HA1C7

A "veteran" is someone who has served on active duty in the U.S. military and who is not now on active duty. This includes anyone who has served in the Army, Navy, Marine Corps, Air Force, Coast Guard, Nursing Corps, Women's Army Corps (WAC), Women Accepted for Volunteer Emergency Services (WAVES) or was called into active duty, not including initial basic training or yearly summer camp, from the Military Reserves or National Guard.

HA1H

Include persons as enrolled in MEDICARE, even if he/she has Part B only, or does not use MEDICARE as a source of payment.

HA2

If the respondent gave you the person's Medicare HMO number, ask for the **Medicare ID number**. A person's Medicare ID number is not the same as his/her Medicare HMO number. Every Medicare beneficiary has a Medicare ID number, whether or not he/she is enrolled in a Medicare HMO.

HA2C

If the person is in the process of applying for MEDICAID, code 'yes'.

HA7B

'Significant other' refers to long-standing supportive relationship, e.g., opposite sex or same-sex partner or companion.

HA8

MDS Assessment Forms may include full MDS Forms, Medicare PPA Assessment Forms (MPAF), or Quarterly Review Forms.

If the person has a completed MDS form that is either not in the file or not available for retrieval, code 2 (NO, FORM NOT AVAILABLE).

If the person does not have a completed MDS form, code 3 (FORM NOT COMPLETED).

HA11

- 0 INDEPENDENT – decisions consistent/reasonable
- 1 MODIFIED INDEPENDENCE – some difficulty in new situations only
- 2 MODERATELY IMPAIRED – decisions poor; cues/supervision required
- 3 SEVERELY IMPAIRED – never/rarely made decisions

HA12

Indicators of depression, anxiety, or sad mood include the followings:

Verbal expressions of distress, such as negative statements; repetitive questions; repetitive verbalizations; persistent anger with self or others; self depreciation; expressions of what appear to be unrealistic fears; recurrent statements that something terrible is about to happen; repetitive health complaints; or repetitive anxious complaints or concerns that are non-health related.

Sleep-cycle issues, such as unpleasant mood in the morning; or insomnia / change in usual sleep pattern.

Sad, apathetic, anxious appearance, such as sad, pained, or worried facial expressions; crying or tearfulness; or repetitive physical movements.

Loss of interest, such as withdrawal from activities of interest, or reduced social interaction.

HA13

Examples of behavioral symptoms:

Behavioral symptoms, such as disruptive behaviors.

Physically abusive actions, such as hitting, shoving, etc.

Socially inappropriate or disruptive symptoms, such as noisiness, screaming, sexual behavior, etc.

Resisting care, such as resisting ADL assistance, etc.

HA14A–HA14J

A BED MOBILITY – how resident moves to and from lying position, turns side to side, and positions body while in bed

B TRANSFER – how resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)

C WALK IN ROOM – how resident walks between locations in his/her room

D WALK IN CORRIDOR – how resident walks in corridor on unit

E LOCOMOTION ON UNIT – how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair

F LOCOMOTION OFF UNIT – how resident moves to and returns from off unit locations (e.g. areas set aside for dining, activities, or treatments.) **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair

G DRESSING – how resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis

H EATING – how resident eats and drinks (regardless of skill), includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition).

I TOILET USE – how resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes

J PERSONAL HYGIENE – how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)

O INDEPENDENT – no help or oversight OR help/oversight provided only 1 or 2 times during last 7 days.

1 SUPERVISION – oversight, encouragement or cueing provided 3 or more times during last 7 days OR supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days.

2 LIMITED ASSISTANCE – resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance three or more times OR more help provided only 1 or 2 times during last 7 days.

3 EXTENSIVE ASSISTANCE – while resident performed part of activity, over last 7-day period, with help of following type(s) provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 days.

4 TOTAL DEPENDENCE – full staff performance of activity during entire 7 days

8 ACTIVITY DID NOT OCCUR during entire 7 days.

HA15

BATHING – how resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair). Code for most dependent in self-performance.

- 0 INDEPENDENT – no help provided
- 1 SUPERVISION – oversight help only
- 2 PHYSICAL HELP LIMITED TO TRANSFER ONLY
- 3 PHYSICAL HELP IN PART OF BATHING ACTIVITY
- 4 TOTAL DEPENDENCE
- 8 ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS

HA16

BOWEL CONTINENCE – control of bowel movement, with appliance or bowel continence programs, if employed

- 0 CONTINENT – complete control (includes use of ostomy device that does not leak stool)
- 1 USUALLY CONTINENT – incontinent episodes less than weekly
- 2 OCCASIONALLY INCONTINENT – once a week
- 3 FREQUENTLY INCONTINENT – 2-3 times a week
- 4 INCONTINENT – had inadequate control all (or almost all) of the time

HA17

BLADDER CONTINENCE – control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g. foley) or continence programs, if employed

- 0 CONTINENT – complete control (includes use of indwelling urinary catheter that does not leak urine)
- 1 USUALLY CONTINENT – incontinent episodes once a week or less
- 2 OCCASIONALLY INCONTINENT – two or more times a week but not daily
- 3 FREQUENTLY INCONTINENT – tended to be incontinent daily but some control present (e.g., on day shift)
- 4 INCONTINENT – had inadequate control; multiple daily episodes

HA19

Include falls that occurred in the past 6 months, regardless of where they occurred (e.g. not in the facility).

HA21

A pressure ulcer is any lesion caused by pressure, resulting in damage of underlying tissue.

HA22A

Include bed rails used as 'enablers' if respondent volunteered this information.

Health Status – Non-MDS Items (HN) Module

HNPRES.

THIS IS THE FIRST PAGE OF THE HEALTH STATUS – NON-MDS (HN) SECTION. STATUS = {STATUS}

IF THIS SECTION HAS ALREADY BEEN COMPLETED, RETURN TO THE CHOOSE PERSON SCREEN.

PRESS 1 AND ENTER TO CONTINUE.

IF RECORDS FOR THIS PERSON ARE NOT AVAILABLE (RP), PRESS 2 AND ENTER.

IF CONSENT REQUIRED AND NOT OBTAINED FOR THIS PERSON (CP), PRESS 3 AND ENTER.

HN1A1.

On what date was {SP} admitted to {FACILITY} for the stay that includes last night?

ENTER MONTH.

PRESS F1 FOR HELP SCREEN.

|_|_|
MM

HN1A2.

[On what date was {SP} admitted to {FACILITY} for the stay that includes last night?]

ENTER DAY.

|_|_|
DD

HN1A3.

[On what date was {SP} admitted to {FACILITY} for the stay that includes last night?]

ENTER A 4-DIGIT YEAR.

YYYY				

HN1B.

ASK IF NOT OBVIOUS:

Is {SP} male or female?

MALE	1
FEMALE	2

HN1C1.

What is {SP}'s date of birth?

ENTER MONTH.

MM		

HN1C2.

[What is {SP}'s date of birth?]

ENTER DAY.

DD		

HN1C3.

[What is {SP}'s date of birth?]

ENTER A 4-DIGIT YEAR.

|_|_|_|_|
YYYY

HN1C4.

Approximately, how old is {SP}?

ENTER AGE.

|_|_|_|

HN1DPRE.

Now please look at {SP}'s Social Security number and tell me if it begins with a letter or a number.

- LETTER 1
- NUMBER 2
- DK
- RF

HN1DA.

What is {SP}'s Social Security number?

HN1D.

What is {SP}'s Social Security number?

|_|_|_| - |_|_| - |_|_|_|_|

HN1D1.

I have entered {HN1DA/HNSSNLt/HN1D/HNSSN}. Is this correct?

- YES..... 1
- NO 2
- DK
- RF

HN2A.

Is {SP} {currently} assigned to a bed on a specialty unit?

PRESS F1 FOR HELP SCREEN.

- YES..... 1
- NO 2
- DK
- RF

HN2B.

What condition is the specialty unit for?

PRESS F1 FOR HELP SCREEN.

- ALZHEIMER'S AND RELATED DEMENTIAS 1
- AIDS/HIV 2
- BEHAVIORAL HEALTH UNIT (NON-ALZHEIMER'S) 3
- DISEASE-SPECIFIC 4
- CHILDREN WITH DISABILITIES, MENTALLY RETARDED/DD.. 5
- HOSPICE..... 6
- REHABILITATION (CARDIAC, FUNCTIONAL) 7
- SUB-ACUTE CARE 8
- VENTILATOR/PULMONARY 9
- OTHER 10
- DK
- RF

HN3.

Is {SP} {currently} receiving services from a special program for any of these conditions on this card?

READ ONCE or IF ASKED: Special programs have one or more specially trained professionals or staff dedicated to the program. This does not include special training and services provided by all staff members. Do not include specialty units, e.g., a physically distinct or designated cluster of beds, or segregated wing or unit used exclusively for a particular disease or condition.

SELECT ALL THAT APPLY.

SHOW CARD HN1.

- HOSPICE/PALLIATIVE CARE/END OF LIFE (END STAGE /
TERMINAL CONDITION)..... 1
- PAIN MANAGEMENT..... 2
- BEHAVIORAL PROBLEMS 3
- SKIN/WOUNDS 4
- CONTINENCE MANAGEMENT 5
- DEMENTIA (INCLUDING ALZHEIMER'S DISEASE) 6
- RESTORATIVE CARE 7
- OTHER 8
- NO SPECIALTY PROGRAMS 9
- DK
- RF

HN4A.

According to {SP}'s medical record, what was the primary diagnosis at the time of admission, that is, on or around {FAD}?

TYPE THE FIRST 3 LETTERS OF THE DIAGNOSIS. THEN USE ARROW KEYS TO LOCATE DIAGNOSIS, AND PRESS ENTER TO SELECT. IF DIAGNOSIS IS NOT LISTED, ENTER ZZZ.

HN4A1.

SPECIFY PRIMARY DIAGNOSIS.

HN5A.

What is the {current} primary diagnosis?

TYPE THE FIRST 3 LETTERS OF THE DIAGNOSIS. THEN USE ARROW KEYS TO LOCATE DIAGNOSIS, AND PRESS ENTER TO SELECT. IF DIAGNOSIS IS NOT LISTED, ENTER ZZZ.

HN5A1.

SPECIFY PRIMARY DIAGNOSIS.

HN5B_a-o.

{According to {SP}'s medical record, what are the {current} secondary diagnoses?}

{Anything else?}

{TYPE THE FIRST 3 LETTERS OF THE DIAGNOSIS. THEN USE ARROW KEYS TO LOCATE DIAGNOSIS, AND PRESS ENTER TO SELECT. IF DIAGNOSIS IS NOT LISTED, ENTER ZZZ.}
{IF NO SECONDARY DIAGNOSES, ENTER AAA.}

{ENTER 999 TO LEAVE ROSTER.}

DIAGNOSIS	DIAGNOSIS (OTHER)

HN5B1-15.

SPECIFY SECONDARY DIAGNOSES.

HN7A.

{Since admission ({FAD})/In the past 90 days, that is, since {PAST 90 DAYS}},has {SP} had one or more hospital emergency department visits?

PROBE: Please include visits that occurred after {SP}'s most recent admission to the nursing home.

YES..... 1
NO 2
DK
RF

HN7B.

How many times has {SP} had a hospital emergency department visit {since admission ({FAD})/in the past 90 days, that is, since {PAST 90 DAYS}}?

ENTER NUMBER OF VISITS.

HN7C.

What was the primary reason for the {first/second/third/fourth/fifth} visit?

ENTER DISEASE/CONDITION.

	PRIMARY REASON
1 st visit	
2 nd visit	
3 rd visit.	
4 th visit.	
5 th visit	

HN7D.

{Since admission ({FAD})/In the past 90 days, that is, since {PAST 90 DAYS}}, has {SP} had a hospital admission that required an overnight stay where {he/she} was not formally discharged from the facility?

PROBE: Include only the hospital admissions that occurred after the resident's most recent admission to the nursing home.

YES..... 1
NO 2
DK
RF

HN7E.

How many times has {SP} been admitted to a hospital {since admission ({FAD})/in the past 90 days, that is, since {PAST 90 DAYS}}?

PROBE: Please include only the hospital admissions that involve an overnight stay where {SP} was not formally discharged from the facility.

ENTER NUMBER OF ADMISSIONS.

HN7F.

What was the primary reason for the {first/second/third/fourth/fifth} hospitalization?

ENTER DISEASE/CONDITION.

	PRIMARY REASON
1 st hospitalization	
2 nd hospitalization	
3 rd hospitalization	
4 th hospitalization	
5 th hospitalization	

HN8.

Please look at this card and tell me which category best describes {SP}'s documented vaccination status for a flu shot during the past 12 months, that is, since {PAST 12 MONTHS}.

SHOW CARD HN2.

- VACCINATED WHILE RESIDING AT THIS FACILITY.....1
- VACCINATED BEFORE ADMISSION TO THIS FACILITY 2

- NOT VACCINATED – NO RECORD OF DOCTOR'S ORDER
OR OF VACCINATION OFFERED..... 3
- NOT VACCINATED-VACCINATION MEDICALLY
CONTRAINDICATED..... 4
- NOT VACCINATED-RESIDENT/FAMILY REFUSED
VACCINATION..... 5
- NOT VACCINATED – OTHER REASON..... 6
- NOT VACCINATED – REASON UNKNOWN 7
- DID NOT RESIDE IN THE FACILITY DURING THE MOST RECENT
FLU SEASON..... 8

- DK
- RF

HN9.

Which statement on this card best describes the documented vaccination status for whether {SP} has ever had a pneumococcal vaccine?

SHOW CARD HN2.

- VACCINATED WHILE RESIDING AT THIS FACILITY.....1
- VACCINATED BEFORE ADMISSION TO THIS FACILITY 2

- NOT VACCINATED – NO RECORD OF DOCTOR'S ORDER
OR OF VACCINATION OFFERED..... 3
- NOT VACCINATED-VACCINATION MEDICALLY
CONTRAINDICATED..... 4
- NOT VACCINATED-RESIDENT/FAMILY REFUSED
VACCINATION..... 5
- NOT VACCINATED – OTHER REASON..... 6
- NOT VACCINATED – REASON UNKNOWN 7

- DK
- RF

HN11D.

Is {SP} comatose?

- YES..... 1
- NO 2
- DK
- RF

HN12.

{Since admission ({FAD})/In the past 7 days, that is, since {PAST 7 DAYS}}, has {SP} reported or shown evidence of pain? Please include grimacing or other non-verbal signs that suggest pain.

- YES..... 1
- NO 2
- DK
- RF

HN13.

Please look at this card and tell me what type of pain assessment tool is used to assess {SP}'s pain.

SHOW CARD HN3.

- VERBAL NUMERICAL SCALE 1
- WORD SCALE..... 2
- VISUAL ANALOGUE SCALES..... 3
- FACE SCALE 4
- OTHER ASSESSMENT TOOL..... 5
- NO ASSESSMENT TOOL USED/RESIDENT'S DESCRIPTION
OF PAIN ONLY 6
- OBSERVATION OF RESIDENT BEHAVIOR (RESIDENT
UNABLE TO VERBALIZE PAIN) 7
- DK
- RF

HN14.

What is the numerical range of the pain assessment tool you used to assess {SP}'s pain.

- 0 – 5..... 1 (Range 1)
- 0 – 10..... 2 (Range 2)
- OTHER 3 (other)
- DK
- RF

HN14B2.

What was {his/her} highest or most intense rating recorded {since admission ({FAD})/over the last 7 days}?

ENTER RATING.

HN14C.

How would you describe {SP}'s highest or most intense pain level? Would you say...

- Mild, 1
- Moderate,..... 2
- Severe, or 3
- Excruciating or horrible? 4
- DK
- RF

HN15.

What strategies are used to manage {SP}'s pain, according to {SP}'s medical record?

PROBE: Any other strategies?

SELECT ALL THAT APPLY.

SHOW CARD HN4.

- STANDING ORDER FOR PAIN MEDICATION 1
- PRN ORDER FOR PAIN MEDICATION 2
- NON-PHARMACOLOGICAL METHODS (e.g. DISTRACTION,
HEAT/COLD MASSAGE, POSITIONING, MUSIC
THERAPY) 3
- OTHER 4
- DK
- RF

HN19PRE.

The next set of questions asks about {SP}'s palliative or hospice care.

PRESS ENTER TO CONTINUE.

HN19.

Did {SP} start receiving palliative or hospice care before or after admission to the facility?

- BEFORE ADMISSION..... 1
- AFTER ADMISSION..... 2
- DK
- RF

HN19A.

On what date did {SP} start receiving palliative or hospice care?

ENTER MONTH.

|_|_|
MM

HN19B.

[On what date did {SP} start receiving palliative or hospice care?]

ENTER DAY.

|_|_|
DD

HN19C.

[On what date did {SP} start receiving palliative or hospice care?]

ENTER A 4-DIGIT YEAR.

|_|_|_|
YYYY

DK
RF

HN20.

Has Medicare hospice coverage been initiated for {SP}'s hospice care?

- YES..... 1
- NO 2
- NOT ELIGIBLE FOR MEDICARE 3
- DK
- RF

HN21.

Please look at this card and tell me what type of end-of-life, palliative, or hospice services {SP} has received during the past week (7 days).

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

SHOW CARD HN5.

- SYMPTOM MANAGEMENT..... 1
- PAIN MANAGEMENT..... 2
- COUNSELING/ASSISTANCE WITH ETHICAL/LEGAL
ISSUES 3
- GRIEF, LOSS, & BEREAVEMENT COUNSELING
(RESIDENT OR FAMILY) 4
- DEATH PREPARATION..... 5
- EMOTIONAL SUPPORT FOR FAMILY 6
- PASTORAL/SPIRITUAL CARE..... 7
- OTHER 8
- DK
- RF

HN22.

Please look at this card and tell me what types of symptoms {he/she} has.

SELECT ALL THAT APPLY.

SHOW CARD HN6.

DIFFICULTY WITH COUGHING & SECRETIONS.....	1
SHORTNESS OF BREATH.....	2
CONSTIPATION.....	3
DIARRHEA	4
DRY MOUTH.....	5
FECAL IMPACTION.....	6
NAUSEA/VOMITING	7
ANOREXIA	8
CHANGE IN SLEEP PATTERNS.....	9
END STAGE RESTLESSNESS	10
URINARY RETENTION.....	11
FEVER.....	12
IMPAIRED ENDURANCE (TIRES EASILY, POOR TASK ENDURANCE).....	13
OFFENSIVE ODOR TO PATIENT/FAMILY	14
OPEN LESIONS OR INFECTIONS OF MOUTH	15
PRURITIS/ITCHING	16
OTHER	17
DK	
RF	

HN23.

Please look at this card and tell me what formal care or treatments {SP} has received in the past week (7days, since {PAST WEEK}).

SELECT ALL THAT APPLY

SHOW CARD HN7.

- TERMINAL SEDATION 1
- OXYGEN-RESPIRATORY THERAPY 2
- DURABLE MEDICAL EQUIPMENT (E.G., PUMP) 3
- CHEMOTHERAPY 4
- RADIATION FOR PAIN RELIEF 5
- PHYSICAL THERAPY/OCCUPATIONAL THERAPY 6
- IV THERAPY 7
- SUBCUTANEOUS THERAPY..... 8
- BOWEL REGIMEN 9
- AGGRESSIVE PAIN MANAGEMENT 10
- ARTIFICIAL NUTRITION..... 11
- PARENTERAL HYDRATION 12
- DK
- RF

HNEND.

YOU HAVE COMPLETED HN FOR {SP}. PRESS 1 AND ENTER TO CONTINUE.

HNNAV.

YOU HAVE COMPLETED THE HN SECTION. YOUR OPTIONS ARE TO:

- CONTINUE WITH PM {STATUS} FOR {SP}..... 1
- CHOOSE A DIFFERENT SECTION FOR {SP} 2
- CHOOSE A DIFFERENT PERSON 3

Health Status – Non-MDS Items Section Help Screens

HN1A1

Please include any days where the person went into a hospital directly from the nursing home, AND if the nursing home was holding a bed, in anticipation of his/her return.

HN2A

A specialty unit contains a bed or designated clusters of beds in segregated wings or units used exclusively for a particular disease or condition, such as Alzheimer's Disease or related dementias, AIDS/HIV, behavioral health, dialysis, etc.

HN2B

Examples of disease-specific unit include those specifically for dialysis, brain injury (traumatic or acquired), and Huntington's Disease, etc.

HN21

Symptom management

Examples of symptoms include difficulty with coughing & secretions, shortness of breath, constipation, diarrhea, dry mouth, fecal impaction, nausea/vomiting, anorexia, change in sleep patterns, restlessness, urinary retention, fever, impaired endurance (tires easily, poor task endurance), offensive odor to patient/family, open lesions or infections of mouth, pruritis or itching.

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Prescribed Medications (PM) Module

PMPRE.

THIS IS THE FIRST PAGE OF THE PRESCRIBED MEDICATIONS (PM) SECTION. STATUS = {STATUS}.

IF THIS SECTION HAS ALREADY BEEN COMPLETED, RETURN TO THE CHOOSE PERSON SCREEN.

PRESS 1 AND ENTER TO CONTINUE.

IF RECORDS FOR THIS PERSON ARE NOT AVAILABLE (RP), PRESS 2 AND ENTER.

IF CONSENT REQUIRED AND NOT OBTAINED FOR THIS PERSON (CP), PRESS 3 AND ENTER.

PM1A.

{Please give me the names of all the medications {SP} received yesterday, that is, from 12:01 AM to 12:00 midnight {DATE BEF CURRENT INTERVIEW}. Please include all the standing or routine medications, or PRN medications.}

{Any other medications?}

{TYPE THE FIRST 3 LETTERS OF THE MEDICATION. THEN USE ARROW KEYS TO LOCATE MEDICATIONS, AND PRESS ENTER TO SELECT. {IF NO MEDICATIONS TAKEN, ENTER AAA.} IF MEDICATION IS NOT LISTED, ENTER ZZZ.

{ENTER 999 TO LEAVE ROSTER.}

MEDICATION	MEDICATION (OTHER)	REASON PRESCRIBED
PM [1-25]	PM OS [1-25]	WhyPM[1-25]

PM1B.

SPECIFY MEDICATION.

PM1C.

Why was this medication prescribed for {SP}?

ENTER REASON.

PM2.

Does {SP} receive any medications on a regularly scheduled basis that were not administered yesterday? Please include only medications with standing orders for administration. Please do not include PRN medications.

PRESS F1 FOR HELP SCREEN.

YES.....	1
NO	2
DK	
RF	

PM2A.

{Please give me the names of all of these medications.}

{Any other medications?}

{TYPE THE FIRST 3 LETTERS OF THE MEDICATION. THEN USE ARROW KEYS TO LOCATE MEDICATIONS, AND PRESS ENTER TO SELECT. IF MEDICATION IS NOT LISTED, ENTER ZZZ.

{ENTER 999 TO LEAVE ROSTER.}

MEDICATION	MEDICATION (OTHER)	REASON PRESCRIBED
OthrPM [1-15]	OthrPMOS [1-15]	WhyOthPM[1-15]

PM2B.

SPECIFY MEDICATION.

PM2C.

Why was this medication prescribed for {SP}?

ENTER REASON(S).

PM3.

{Since admission {FAD}/During the past 30 days, that is, since {PAST 30 DAYS}}, did {SP} have any type of reaction to a drug or medication?

PRESS F1 FOR HELP SCREEN.

YES.....	1
NO	2
DK	
RF	

PM3A.

{Please give me the names of all the drug or medications to which {SP} had a reaction.}

{Any other medications?}

{TYPE THE FIRST 3 LETTERS OF THE MEDICATION. THEN USE ARROW KEYS TO LOCATE MEDICATIONS, AND PRESS ENTER TO SELECT. IF MEDICATION IS NOT LISTED, ENTER ZZZ.

{ENTER 999 TO LEAVE ROSTER.}

MEDICATION	MEDICATION (OTHER)	REACTION
Drug Name[1-5]	Drug Name OS[1-5]	Reaction[1-5]

PM3B.

SPECIFY MEDICATION.

PM3C.

What kind of reaction did {SP} have?

ENTER REACTION.

PMEND.

YOU HAVE COMPLETED PM FOR {SP}. PRESS 1 AND ENTER TO CONTINUE.

PMNAV.

YOU HAVE COMPLETED THE PM SECTION FOR {SP}. YOUR OPTIONS ARE TO:

- CONTINUE WITH PA {STATUS} FOR {SP} 1
- CHOOSE A DIFFERENT SECTION FOR {SP} 2
- CHOOSE A DIFFERENT PERSON 3

Prescribed Medications Section Help Screens

PM2

The following are types of medications to include: Vitamin B-12, bisphosphonates (alendronate and risedronate), Lupron depot, depo provera, methotrexate.

PM3

A drug reaction includes any unexpected, unintended, undesired, or excessive response to a medication that

- Requires discontinuing the medicine (therapeutic or diagnostic)
- Requires changing the medication therapy
- Requires modifying the dose (except for minor dosage adjustments)
- Necessitates admission to a hospital (e.g., an ED visit)
- Prolongs stay in a health care facility
- Necessitates supportive treatment
- Significantly complicates diagnosis
- Negatively affects prognosis
- Results in temporary permanent harm, disability, or death

Sources of Payment (PA) Module

PAPRE.

THIS IS THE FIRST PAGE OF THE SOURCES OF PAYMENT (PA) SECTION.
STATUS = {STATUS}.

IF THIS SECTION HAS ALREADY BEEN COMPLETED, RETURN TO THE CHOOSE PERSON SCREEN.

PRESS 1 AND ENTER TO CONTINUE.

IF RECORDS FOR THIS PERSON ARE NOT AVAILABLE (RP), PRESS 2 AND ENTER.

IF CONSENT REQUIRED AND NOT OBTAINED FOR THIS PERSON (CP), PRESS 3 AND ENTER.

PA1PRE.

The next questions ask about {SP's} charges and payments for nursing home care.

PRESS ENTER TO CONTINUE.

PA1.

For the {most recent} admission {(that is, {FAD})}, what were all of the sources of payment that covered or will cover the cost of {SP}'s care for that first month or billing period?

PRESS F1 FOR HELP SCREEN.

SELECT ALL THAT APPLY.

SHOW CARD PA1.

PRIVATE INSURANCE (INCLUDE HMO AND PPO)	1
LIFE CARE	2
SELF/PRIVATE PAY/OUT-OF-POCKET	3
MEDICARE (INCLUDE MEDICARE HMO)	4
MEDICAID (INCLUDE MEDICAID HMO)	5
WELFARE OR OTHER GOVERNMENT ASSISTANCE	6
DEPARTMENT OF VETERANS AFFAIRS CONTRACT OR OTHER DEPARTMENT OF VETERANS AFFAIRS PROGRAMS	7
OTHER	8
PAYMENT SOURCE NOT YET DETERMINED	9
ADMISSION BILLING RECORDS NOT AVAILABLE	10
DK	
RF	

PA2.

What was the total amount of the charges billed for {SP}'s first month or billing period of care received at {FACILITY}?

ENTER TOTAL AMOUNT OF CHARGES IN WHOLE DOLLAR.

IF NO CHARGES BILLED TO DATE, ENTER 0.

PRESS F1 FOR HELP SCREEN.

\$ |_|_|_|_|_|_|_|_|

PA2A.

What was the beginning date of the time period covered by this amount?

ENTER MONTH.

|_|_|_|
MM

PA2B.

[What was the beginning date of the time period covered by this amount?]

ENTER DAY.

|_|_|_|
DD

PA2C.

[What was the beginning date of the time period covered by this amount?]

ENTER YEAR.

|_|_|_|_|_|_|_|_|
YYYY

PA2D.

What was the ending date of the time period covered by this amount?

ENTER MONTH.

MM			

PA2E.

[What was the ending date of the time period covered by this amount?]

ENTER DAY.

DD			

PA2F.

[What was the ending date of the time period covered by this amount?]

ENTER YEAR.

YYYY					

PA3B.

Of the \${PA2/TotAdm} in charges billed for that first month or billing period of care, how much has {SP} or {his/her} family paid or will pay of that amount?

ENTER WHOLE DOLLAR.

--	--	--	--	--	--

PA5.

What were all the sources of payment that covered or will cover the cost of {SP}'s care for the past month or billing period?

PRESS F1 FOR HELP SCREEN.

SELECT ALL THAT APPLY.

SHOW CARD PA2.

- PRIVATE INSURANCE (INCLUDE HMO AND PPO) 1
 - LIFE CARE 2
 - SELF/PRIVATE PAY/OUT-OF-POCKET 3
 - MEDICARE (INCLUDE MEDICARE HMO) 4
 - MEDICAID (INCLUDE MEDICAID HMO) 5
 - WELFARE OR OTHER GOVERNMENT ASSISTANCE 6
 - DEPARTMENT OF VETERANS AFFAIRS CONTRACT
OR OTHER DEPARTMENT OF VETERANS AFFAIRS
PROGRAMS 7
 - OTHER 8
 - PAYMENT SOURCE NOT YET DETERMINED 9
 - ONLY ONE BILLING PERIOD SINCE ADMISSION 10
- DK
RF

PA6.

What was the total amount of the charges billed for {SP}'s care received at {FACILITY} for the past month or billing period?

ENTER TOTAL AMOUNT OF CHARGES IN WHOLE DOLLAR.

IF CHARGES NOT BILLED TO DATE, ENTER 0.

PRESS F1 FOR HELP SCREEN.

\$ |_|_|_|_|_|_|_|

PA6A.

What was the beginning date of the time period covered by this amount?

ENTER MONTH.

|_|_|_|
MM

PA6B.

[What was the beginning date of the time period covered by this amount?]

ENTER DAY.

|_|_|
DD

PA6C.

[What was the beginning date of the time period covered by this amount?]

ENTER YEAR.

|_|_|_|
YYYY

PA6D.

What was the ending date of the time period covered by this amount?

ENTER MONTH.

|_|_|
MM

PA6E.

[What was the ending date of the time period covered by this amount?]

ENTER DAY.

|_|_|
DD

PA6F.

[What was the ending date of the time period covered by this amount?]

ENTER YEAR.

|_|_|_|
YYYY

PA7B.

Of the \${PA6/TotPM} in charges for {his/her} care for the past month or billing period, how much has {SP} or {his/her} family paid?

ENTER WHOLE DOLLAR.

|_|_|_|_|_|_|

PA8B.

Altogether, about how much of the \${PA6/TotPM} in charges do you expect {SP} or {his/her} family will pay for that the past month or billing period?

ENTER WHOLE DOLLAR.

|_|_|_|_|_|_|

PAEND.

YOU HAVE COMPLETED PA FOR {SP}. PRESS 1 AND ENTER TO CONTINUE.

Sources of Payment Section Help Screens

PA1, PA5

Self pay, private pay, or out-of-pocket expenses includes SP's own income, family support, social security, or retirement funds.

Code 'Medicare (Include Medicare HMO)' even if the person has Medicare Part B only.

PA2, PA6

IF ASKED: Please include medications in the calculation of total charges.