

FORM **HHCS-3**  
(3-29-96)U.S. DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
ACTING AS COLLECTING AGENT FOR THE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
U.S. PUBLIC HEALTH SERVICE  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
NATIONAL CENTER FOR HEALTH STATISTICS**NOTICE** – Public reporting burden for 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to DHHS Reports Clearance Officer; Paperwork Reduction Project (0920-0298) Room 531-H; Hubert H. Humphrey Bldg.; 200 Independence Ave., SW; Washington, DC 20201. 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).**CURRENT PATIENT QUESTIONNAIRE****1996 NATIONAL HOME AND  
HOSPICE CARE SURVEY****Section A – ADMINISTRATIVE INFORMATION**

1. Field representative name	2. FR code	3. Date of interview Month/Day/Year / /
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**Section B – PATIENT INFORMATION**

1. Patient name or other identifier First   M.I.   Last	2. Patient line number
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**Section C – STATUS OF INTERVIEW**

- 01  Complete  
02  Partial  
03  Patient included in sampling list in error  
04  Incorrect sample line number selected  
05  Refused  
06  Assessment only  
07  Unable to locate record  
08  Less than 6 patients selected  
09  Other noninterview – *Specify* \_\_\_\_\_  
10  No current patients

NOTES

NOTES

Read to each new respondent.

In order to obtain national level data about the patients of hospices and home health agencies such as this one, we are collecting information about a sample of current patients. I will be asking questions about the background, health status, treatment, social contacts, and billing information for each sampled patient.

The 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.

In answering these questions, it is especially important to locate the information in the patient's medical record. Do you have the medical file(s) and record(s) for (Read name(s) of selected current patient(s))?

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 patient forms while the respondent gets the records. If no record is available for a patient, try to obtain as much information as possible from whatever administrative records are available and/or from the respondent's memory.

1. What is ...'s sex?

- 01  Male  
02  Female

2. What is ...'s date of birth?

Age (at admission)

Month	Day	Year	OR	Years	OR	Months

HAND FLASHCARD 1.

3a. Which of these best describes ...'s race?

Mark (X) only one box.

- 01  White  
02  Black  
03  American Indian, Eskimo, Aleut  
04  Asian, Pacific Islander  
05  Other - Specify \_\_\_\_\_  
06  Don't know

b. Is ... of Hispanic origin?

- 01  Yes  
02  No  
03  Don't know

4. What is ...'s 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 is ... currently living?

Mark (X) only one box.

- 01  Private residence  
02  Rented room, boarding house  
03  Retirement home  
04  Board and care assisted living or residential care facility  
05  Other type of health facility (including mental health facility) - SKIP to item 6 Introduction  
06  Other - Specify \_\_\_\_\_

b. Is ... 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

Read the introductory paragraph for the Social Security Number only once for each respondent.

As part of this survey, we would like to have . . . 's Social Security Number. Provision of this number is voluntary and providing or not providing the number will have no effect in any way on . . . 's benefits. This number will be useful in conducting future followup studies. It will be used to match against the vital statistics records maintained by the National Center for Health Statistics. This information is collected under the authority of Section 306 of the Public Health Service Act.

6. What is . . . 's Social Security Number?

Social Security Number

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- 01  Refused  
02  Don't know

HAND FLASHCARD 3.

7. Who referred . . . to this agency?

Mark (X) all that apply.

PROBE: Any other sources?

- 01  Self/Family  
02  Nursing home  
03  Hospital  
04  Physician  
05  Health department  
06  Social service agency  
07  Home health agency  
08  Hospice  
09  Religious organization  
10  Other - Specify \_\_\_\_\_  
11  Don't know

8. What was the date of . . . 's most recent admission with your agency, that is, the date on which . . . was admitted for the current episode of care?

Month	Day	Year

- 00  Only an assessment was done for this patient (patient was not provided services by this agency)

9a. According to . . . 's medical record, what were the primary and other diagnoses at the time of that (admission/assessment)?

PROBE: Any other diagnoses?

- 00  No diagnosis

Primary: 1 \_\_\_\_\_  
Others: 2 \_\_\_\_\_  
3 \_\_\_\_\_  
4 \_\_\_\_\_  
5 \_\_\_\_\_  
6 \_\_\_\_\_

Refer to Q8. If **ONLY** an assessment was done for this patient, END THE INTERVIEW AND COMPLETE SECTION C ON THE COVER. THEN GO TO the next current patient questionnaire.

If the patient was admitted to the agency and provided services by the agency, CONTINUE this interview.

b. According to . . . 's medical records, what are . . . 's CURRENT primary and other diagnoses?

PROBE: Any other diagnoses?

- 00  No diagnosis  
01  Same as 9a

Primary: 1 \_\_\_\_\_  
Others: 2 \_\_\_\_\_  
3 \_\_\_\_\_  
4 \_\_\_\_\_  
5 \_\_\_\_\_  
6 \_\_\_\_\_





**15. PART I - Continued**

Which of the following items does . . . have in (his/her) home?

**e. Dialysis equipment?**

(1) Peritoneal Dialysis - Manual (continuous) . . . 01  Yes

(2) Peritoneal Dialysis - Automated (intermittent/continuous cyclic) . . . . . 01  Yes

(3) Peritoneal - unspecified . . . . . 01  Yes

(4) Hemodialysis . . . . . 01  Yes

**f. Blood glucose monitor?** . . . . . 01  Yes

**g. Drainage devices?** . . . . . 01  Yes

(1) Wound/bile duct/ureteral drainage catheter . . . 01  Yes

(2) Foley catheter . . . . . 01  Yes

(3) Intermittent bladder catheterization . . . . . 01  Yes

(4) External urinary collection devices (e.g. condom catheter) . . . . . 01  Yes

(5) Urostomy . . . . . 01  Yes

(6) Ileostomy/Colostomy . . . . . 01  Yes

**h. Protective restraints (e.g. vests, belts)?** . . . . . 01  Yes

**i. Pediatric care?** . . . . . 01  Yes

(1) Apnea monitor . . . . . 01  Yes

(2) Phototherapy lights/equipment . . . . . 01  Yes

**j. Prenatal uterine monitoring?** . . . . . 01  Yes

**k. Other? - Specify** \_\_\_\_\_ . . . . . 01  Yes

**15. PART II - Continued**

Does . . . receive assistance from your agency staff in caring for or using:

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

01  Yes . . . . . 02  No . . . . . 03  Don't know

**16. Does . . . have any difficulty in controlling (his/her) bowels?**

- 01  Yes
- 02  No
- 03  Not applicable (e.g. infant, has an ostomy)
- 04  Don't know

**17. Does . . . have any difficulty in controlling (his/her) bladder?**

- 01  Yes
- 02  No
- 03  Not applicable (e.g. infant, has an indwelling catheter, has an ostomy)
- 04  Don't know

NOTES

<i>HAND FLASHCARD 10.</i>							
<b>18. Does . . . currently receive personal help from this agency in any of the following activities as defined on this card --</b>				Yes	No	Don't know	Not applicable (e.g., patient is bedfast)
<i>Mark (X) one box for each activity.</i>							
<b>a. Bathing or showering?</b>				01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
<b>b. Dressing?</b>				01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
<b>c. Eating?</b>				01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
<b>d. Transferring in or out of beds or chairs?</b>				01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
<b>e. Walking?</b>				01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
<b>f. Using the toilet room?</b>				01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
<i>HAND FLASHCARD 11.</i>							
<b>19. Does . . . receive personal help from your agency in any of the following activities --</b>				Yes	No	Don't know	Not applicable (e.g., patient is bedfast)
<i>Mark (X) one box for each activity.</i>							
<b>a. Doing light housework?</b>				01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
<b>b. Managing money?</b>				01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
<b>c. Shopping for groceries or clothes?</b>				01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
<b>d. Using the telephone (dialing or receiving calls)?</b>				01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
<b>e. Preparing meals?</b>				01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
<b>f. Taking medications?</b>				01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
<i>HAND FLASHCARD 12.</i>							
<b>20a. Which of these services does . . . currently receive FROM YOUR AGENCY?</b>				00 <input type="checkbox"/> None			
<i>Mark (X) all that apply.</i>				01 <input type="checkbox"/> Continuous home care			
<b>PROBE: Any other services?</b>				02 <input type="checkbox"/> Counseling			
				03 <input type="checkbox"/> Homemaker-household services			
				04 <input type="checkbox"/> Medications			
				05 <input type="checkbox"/> Mental health services			
				06 <input type="checkbox"/> Nursing services			
				07 <input type="checkbox"/> Nutritionist services			
				08 <input type="checkbox"/> Occupational therapy			
				09 <input type="checkbox"/> Physical therapy			
				10 <input type="checkbox"/> Physician services			
				11 <input type="checkbox"/> Social services			
				12 <input type="checkbox"/> Speech therapy/Audiology			
				13 <input type="checkbox"/> Transportation			
				14 <input type="checkbox"/> Volunteers			
				15 <input type="checkbox"/> Other services – <i>Specify</i> ↗			
				_____			

NOTES



HAND FLASHCARD 13.

**20b. Which of these service providers FROM YOUR AGENCY visited . . . during the last 30 days?**

Mark (X) all that apply.

**PROBE: Any other providers?**

- 00  None
- 01  Chaplain
- 02  Dietitians/Nutritionists
- 03  Home health aides
- 04  Homemakers/Personal caretakers
- 05  Licensed practical or vocational nurses
- 06  Nursing aides and attendants
- 07  Occupational therapists
- 08  Physical therapists
- 09  Physicians
- 10  Registered nurses
- 11  Respiratory therapists
- 12  Social workers
- 13  Speech pathologists/audiologists
- 14  Volunteers
- 15  Other providers - Specify

HAND FLASHCARD 14.

**21. What is the PRIMARY expected source of payment for . . . 's care?**

Mark (X) only one source.

For the source of payment ask:  
**Is the (source of payment) for home health care or hospice care?**

- |  | Home Health<br>Care         | Hospice<br>Care             |
|--|-----------------------------|-----------------------------|
| 01 <input type="checkbox"/> Private insurance  | 01 <input type="checkbox"/> | 01 <input type="checkbox"/> |
| 02 <input type="checkbox"/> Own income, family support, Social Security benefits, retirement funds, or welfare | 02 <input type="checkbox"/> | 02 <input type="checkbox"/> |
| 03 <input type="checkbox"/> Supplemental Security Income (SSI)   | 03 <input type="checkbox"/> | 03 <input type="checkbox"/> |
| 04 <input type="checkbox"/> Medicare   | 04 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| 05 <input type="checkbox"/> Medicaid   | 05 <input type="checkbox"/> | 05 <input type="checkbox"/> |
| 06 <input type="checkbox"/> Other government medical assistance  | 06 <input type="checkbox"/> | 06 <input type="checkbox"/> |
| 07 <input type="checkbox"/> Religious organizations, foundations, agencies                                     | 07 <input type="checkbox"/> | 07 <input type="checkbox"/> |
| 08 <input type="checkbox"/> VA contract, pensions, or other VA compensation                                    | 08 <input type="checkbox"/> | 08 <input type="checkbox"/> |
| 09 <input type="checkbox"/> No charge made for care  | 09 <input type="checkbox"/> | 09 <input type="checkbox"/> |
| 10 <input type="checkbox"/> Payment source not yet determined  | 10 <input type="checkbox"/> | 10 <input type="checkbox"/> |
| 11 <input type="checkbox"/> Other - Specify <input type="checkbox"/>   | 11 <input type="checkbox"/> | 11 <input type="checkbox"/> |
| <hr/>  |                             |                             |
| 12 <input type="checkbox"/> Don't know   |                             |                             |

NOTES

HAND FLASHCARD 14.

**22. What are ALL the secondary sources of payment for . . . 's care?**

Mark (X) all that apply.

**PROBE: Any other sources of payment?**

For the source of payment ask:  
**Is the (source of payment) for home health care or hospice care?**

- |  | Home Health<br>Care         | Hospice<br>Care             |
|--|-----------------------------|-----------------------------|
| 01 <input type="checkbox"/> Private insurance  | 01 <input type="checkbox"/> | 01 <input type="checkbox"/> |
| 02 <input type="checkbox"/> Own income, family support, Social Security benefits, retirement funds, or welfare | 02 <input type="checkbox"/> | 02 <input type="checkbox"/> |
| 03 <input type="checkbox"/> Supplemental Security Income (SSI)   | 03 <input type="checkbox"/> | 03 <input type="checkbox"/> |
| 04 <input type="checkbox"/> Medicare   | 04 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| 05 <input type="checkbox"/> Medicaid   | 05 <input type="checkbox"/> | 05 <input type="checkbox"/> |
| 06 <input type="checkbox"/> Other government medical assistance  | 06 <input type="checkbox"/> | 06 <input type="checkbox"/> |
| 07 <input type="checkbox"/> Religious organizations, foundations, agencies                                     | 07 <input type="checkbox"/> | 07 <input type="checkbox"/> |
| 08 <input type="checkbox"/> VA contract, pensions, or other VA compensation                                    | 08 <input type="checkbox"/> | 08 <input type="checkbox"/> |
| 09 <input type="checkbox"/> No charge made for care  | 09 <input type="checkbox"/> | 09 <input type="checkbox"/> |
| 10 <input type="checkbox"/> Payment source not yet determined  | 10 <input type="checkbox"/> | 10 <input type="checkbox"/> |
| 11 <input type="checkbox"/> Other - Specify <i>Z</i>   | 11 <input type="checkbox"/> | 11 <input type="checkbox"/> |
| 12 <input type="checkbox"/> Don't know   |                             |                             |

**23. When was the last time service was provided?**

Month	Day	Year

**FILL SECTION C ON THE COVER OF THIS FORM AND CONTINUE WITH THE NEXT CURRENT PATIENT QUESTIONNAIRE.**

NOTES