OMB # 0938-0568

Expires: 11/97

SP 1 ID _____

SP 2 ID _____

SP 3 ID _____

SP 4 ID _____

RESPONDENT: _____

TITLE: _____

FACILITY ID #: **FACILID**

FACILITY NAME: **FACILNAM**

DATE OF INTERVIEW: **FACINTMM** **FACINTDD** **FACINTYY**

INTERVIEWER NAME: _____

INTERVIEWER ID: **FACINTID**

TIME INTERVIEW BEGAN: **FACINTIM** AM/PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

MEDICARE CURRENT BENEFICIARY SURVEY

CONDUCTED BY WESTAT

FACILITY ELIGIBILITY SCREENER

F Q

ASSURANCE OF CONFIDENTIALITY

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 by Westat and HCFA, will be used only for purposes stated in this study, and will not be disclosed or released to anyone other than authorized staff of HCFA without the consent of the individual or the establishment in accordance with the Privacy Act of 1974.

SEPTEMBER 1996

FQ1. Which **one** of the categories on this card **best** describes the ownership of your facility?

SHOW CARD FQ1

FACOWNED

FACOWNOS

FOR PROFIT (AN INDIVIDUAL, PARTNERSHIP OR CORPORATION)...	1
PRIVATE NONPROFIT (RELIGIOUS GROUP, NONPROFIT CORPORATION, ETC.)	2
CITY/COUNTY GOVERNMENT	3
STATE GOVERNMENT	4
VETERANS ADMINISTRATION	5
OTHER (SPECIFY)	91

FQ2. Which category best describes your facility?

SHOW CARD FQ2

FACDISC

FACDIOS

HOSPITAL	1
NURSING HOME	2
RETIREMENT HOME	3
DOMICILIARY OR PERSONAL CARE FACILITY	4
MENTAL HEALTH FACILITY	5
INSTITUTION FOR THE MENTALLY RETARDED/ DEVELOPMENTALLY DISABLED	6
MENTAL HEALTH CENTER	7
LIFE CARE/CONTINUING CARE FACILITY	8
ASSISTED LIVING FACILITY	9
REHABILITATION FACILITY	10
SOME OTHER PLACE (SPECIFY)	91

FQ3. Does this facility provide long-term care for any of its residents?

FACLONGT

YES	1	(FQ5)
NO	2	(FQ6)

FQ4. Omitted

FQ5. How many beds are regularly maintained for long-term care residents? Include all beds staffed and set up for residents. Do not include beds used by staff or owners or beds used only for day care patients or emergency care.

FACLTBED _____

BEDS

FQ6. How many beds are there in the entire facility? [Please include those beds just mentioned as regularly maintained for long-term care residents.]

FACTOBED _____

BEDS

FQ7. Does this (facility/unit) have any beds certified by Medicare as SNF (that is, Skilled Nursing Facility) beds?

MCARCERT

YES 1 (FQ8)
NO 2 (FQ9)

FQ8. How many beds are certified under Medicare as SNF beds?

SNFBEDN _____

BEDS

FQ9. Does this (facility/unit) have any beds certified by Medicaid as NF (that is, Nursing Facility) beds?

MCADCERT

YES 1 (FQ10)
NO 2 (FQ11)

FQ10. How many beds are certified under Medicaid as NF beds?

MCDSNFN _____

BEDS

FQ11. Does this (facility/unit) have any beds certified by Medicaid as ICF-MR (that is, Intermediate Care Facility for the Mentally Retarded) beds?

MCADICF

YES 1 (FQ13)
NO ..... 2 ***BOX FQ1***
DON'T KNOW ..... -8 **BOX FQ1**

BOX FQ1	REFER TO FQ7 AND FQ9. CHECK BOX FQ7 OR FQ9 = 1 (YES) • (SKIP TO FQ14) BOTH FQ7 AND FQ9 = 2 (NO) • (SKIP TO FQ16)

FQ12. OMITTED

FQ13. How many beds are certified under Medicaid as ICF-MR beds?
IF NO ICF-MR BEDS, ENTER 0.

MCDICFMR _____

BEDS

FQ14. Do you have any beds that are not certified by either Medicare or Medicaid?

CERTMCMD

YES 1 (FQ15)
NO 2 (FQ16)

FQ15. How many of these beds does this (facility/unit) have?

CERTBEDS _____
BEDS

FQ16. Does this facility provide different levels of care to its residents?

PROVLEVL
YES 1 (FQ17)
NO ..... 2 ***BOX FQ1A***

FQ17. What are the different levels of care provided at this facility? (That is, how are the levels of care classified?)

LEVLSKIL Skilled 1
LEVLINTR Intermediate 2
LEVLOTH1 Other (SPECIFY) 3
LEVLOTS1 _____
LEVLOTH2 Other (SPECIFY) 4
LEVLOTS2 _____
LEVLOTH3 Other (SPECIFY) 5
LEVLOTS3 _____

BOX FQ1A	a. REFER TO FQ7:		
	FQ7 CODED 1 (YES)	1	(GO TO FQ17a)
	FQ7 CODED 2 (NO)	2	(GO TO ***BOX FQ1B***)

FQ17a. May I please have this facility's Medicare Provider Number? If you have more than one number, please give me all of them. We need this number to access Medicare claims files to supplement the expenditure data we will be collecting. This information will be used only for research purposes. Providing this number will in no way affect this facility's certification status.

_____ _____
MEDICARE PROVIDER # MEDICARE PROVIDER #

BOX FQ1B	a. REFER TO FQ9 AND FQ11:		
	FQ9 OR FQ11 CODED 1 (YES)	1	(GO TO FQ17b)
	FQ9 OR FQ11 CODED 2 (NO)	2	(GO TO INTRO ABOVE FQ18)

FQ17b. May I please have this facility's Medicaid Provider Number? If you have more than one number, please give me all of them. This information will allow us to augment facility data that we will be collecting. This information will be used only for research purposes. Providing this number will in no way affect this facility's certification status.

_____ _____
MEDICAID PROVIDER # MEDICAID PROVIDER #

We are interested in your rates (for different levels of care and/or sources of payment).

FQ18. Could you tell me the name and briefly describe each of your rates.	FQ19. What is the amount of the rate and how is it charged -- is it daily, monthly or for some other period?
BASIC RATES	
Name and description of rate: [DESCRIBE ALL RATE DISTINCTIONS AND CLASSIFICATIONS. USE LEVELS OF CARE AND SOURCES OF PAYMENT AS APPROPRIATE.]	Amount: [RECORD THE LOWEST AMOUNT CHARGED FOR EACH LEVEL OF CARE AND SOURCE OF PAYMENT NAMED IN FQ18.]
1. **RATENAME** _____ _____ _____	**RATEAMT** $ _____ **RATEPER** PER: _____ DAY _____ MONTH _____ OTHER: **RATEPOS** _____ (SPECIFY)
2. _____ _____ _____	$ _____ PER: _____ DAY _____ MONTH _____ OTHER: _____ (SPECIFY)
3. _____ _____ _____	$ _____ PER: _____ DAY _____ MONTH _____ OTHER: _____ (SPECIFY)
4. _____ _____ _____	$ _____ PER: _____ DAY _____ MONTH _____ OTHER: _____ (SPECIFY)
5. _____ _____ _____	$ _____ PER: _____ DAY _____ MONTH _____ OTHER: _____ (SPECIFY)
6. _____ _____ _____	$ _____ PER: _____ DAY _____ MONTH _____ OTHER: _____ (SPECIFY)

FQ20. Does this (facility/unit) primarily or exclusively cover any of the following groups of persons? CIRCLE ALL THAT APPLY.

SHOW CARD FQ3

PRIMDEAF	A.	DEAF	1
PRIMBLND	B.	BLIND	1
PRIMUWED	C.	UNWED MOTHERS	1
PRIMABUS	D.	ALCOHOLICS OR DRUG ABUSERS	1
PRIMORPH	E.	ORPHANS OR OTHER DEPENDENT CHILDREN	1
PRIMMENT	F.	MENTALLY ILL ONLY	1
PRIMMDEF	G.	MENTALLY ILL AND DEAF	1
PRIMMEDD	H.	MENTALLY RETARDED OR DEVELOPMENTALLY DISABLED ONLY	1
PRIMMIMR	I.	MENTALLY ILL AND MENTALLY RETARDED	1
PRIMNEUR	J.	OTHER NEUROLOGICALLY OR PHYSICALLY HANDICAPPED	1
PRIMGERI	K.	GERIATRIC (ELDERLY OR AGED)	1
PRIMOTHR	L.	SOME OTHER SPECIAL GROUP (SPECIFY)	1
PRIMOS		_____	
PRIMGRP	M.	DOES NOT SERVE ONE GROUP PRIMARILY OR EXCLUSIVELY	1

FQ21. In addition to room and board, does this (facility/unit) routinely provide . . .

			YES	NO
ROOMCARE	a.	Nursing or medical care?	1	2
SUPRVMED	b.	Supervision over residents who administer their own medications?	1	2
FHLPBATH	c.	Help with bathing?	1	2
FHLPDRES	d.	Help with dressing?	1	2
FHLPSHOP	e.	Help with correspondence or shopping?	1	2
FHLPWALK	f.	Help with walking or getting about?	1	2
FHLPEAT	g.	Help with eating?	1	2
FHLPCOMM	h.	Help with communication (such as hearing, speaking, sign language, writing)?	1	2

FQ22. Does this (facility/unit) provide 24-hour-a-day, seven-day-a-week supervision or nursing coverage for its residents?

FHLPNURS	YES	1
	NO	2

GO TO BOX FQ2

BOX FQ2	ELIGIBILITY CHECK A. DOES FACILITY HAVE 3 OR MORE LONG-TERM CARE BEDS (FQ5 = 3 OR MORE)? YES ..... 1 (B) NO ..... 2 ***BOX FQ3*** DK (FQ5 = NOT ANSWERED) ..... 3 (B) B. DOES FACILITY PROVIDE PERSONAL CARE SERVICES TO RESIDENTS (FQ21 = AT LEAST ONE "YES" RESPONSE), OR PROVIDE CONTINUOUS SUPERVISION OF RESIDENTS (FQ22 = YES), OR PROVIDE ANY LONG TERM CARE (FQ3 = YES)? YES ..... 1 (FQ23) NO ..... 2 ***BOX FQ3***

BOX FQ3	That completes the interview about the facility. I need to conduct an interview with the individual(s) we have listed as living here. COMPLETE COMMUNITY QUESTIONNAIRE WITH SPs.

That completes the questions about the facility. I have a few questions about the individual(s) we have listed as living here.

FQ23. [I have the following people listed as living at this facility.] [Does/did] (SP) reside in [the long-term/personal care portion of] the facility?

SP1
NAME: _____

SPRESID

YES 1
NO 2

SP2
NAME: _____

YES 1
NO 2

SP3
NAME: _____

YES 1
NO 2

SP4
NAME: _____

YES 1
NO 2

SP5
NAME: _____

YES 1
NO 2

SP6
NAME: _____

YES 1
NO 2

BOX FQ4	CONDUCT A FACILITY INTERVIEW FOR EACH SP LIVING IN LONG-TERM CARE/ PERSONAL CARE PORTION OF FACILITY. CONDUCT COMMUNITY INTERVIEW WITH EACH SP NOT LIVING IN LONG-TERM CARE/PERSONAL CARE PORTION OF FACILITY. CONDUCT A COMMUNITY INTERVIEW FOR EACH SP LIVING IN A SITUATION WHICH YOU ARE NOT ABLE TO CLASSIFY AS LONG-TERM CARE OR NOT.

INTETIME TIME INTERVIEW ENDED: _____ AM/PM