OMB # 0938-0568

Expires: 11/97

RESPONDENT 1: _____ SP ID #: _____

TITLE: _____ SP NAME: _____

FCORINIT DATE OF INTERVIEW: _____

RESPONDENT 2: _____

INTERVIEWER NAME: _____

TITLE: _____

FCORINIT INTERVIEWER ID: _____

RESPONDENT 3: _____ **FCORFID** FACILITY ID: _____

TITLE: _____ **FCORBTIM** START TIME: _____ AM/PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

MEDICARE CURRENT BENEFICIARY SURVEY
CONDUCTED BY WESTAT

FACILITY COMPONENT **CORE** QUESTIONNAIRE

In this questionnaire we will be collecting information about (SP's) stay in this facility.

Do you have the medical files and records for (SP)? [IF NOT, ASK RESPONDENT TO GET RECORDS.]

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.

MAY 1996

A. RESIDENCE HISTORY

BOX A1	IS THIS THE FIRST FACILITY INTERVIEW ROUND FOR SP?
	YES ..... 1 (ENTER ADMISSION DATE AND DISCHARGE DATES FROM BASELINE QUESTIONNAIRE ON FLAP, THEN GO TO SECTION B, PROVIDER PROBES)
	NO ..... 2 (A1) **FFIRSRND**

A1. Is (SP) currently a resident of this (facility/home)?

CURRESID
- YES ..... 1 (ENTER 00/00/00 AS DISCHARGE DATE AND CIRCLE "ALIVE" ON FLAP. THEN GO TO ***BOX A2***)
- NO 2 (A2)
- DON'T KNOW ..... -8 (A3)

A2. When was (SP) formally discharged? **DISCHMM** **DISCHDD** **DISCHYY**

ENTER "DISCHARGE DATE" ON FLAP, AND SKIP TO A4. IF (SP) WAS NOT FORMALLY DISCHARGED, ASK A3.

A3. Is a bed being held for (SP) at this facility?

BEDHELD
- YES ..... 1 (ENTER 00/00/00 AS DISCHARGE DATE AND CIRCLE "ALIVE" ON FLAP. THEN GO TO ***BOX A2***)
- NO ..... 2 (ASK A2 AND RECODE)
- DON'T KNOW ..... -8 (ENTER 00/00/00 AS DISCHARGE DATE AND GO TO A4)

A4. Was (SP) discharged alive?

ALIVE
- YES ..... 1 (CIRCLE "ALIVE" ON FLAP)
- NO ..... 2 (CIRCLE "DECEASED" ON FLAP)
- DON'T KNOW ..... -8 (CIRCLE "UNKNOWN" ON FLAP)

BOX A2	REFER TO CASE INFORMATION SHEET. WAS SP A RESIDENT OF THIS FACILITY ON REFERENCE DATE?
	YES 1 (A8)
	NO 2 (A5)

A5. When was (SP) most recently admitted to this (facility/home)?

ENTER DATE AS "ADMISSION DATE" ON FLAP.

BOX A3	IS ADMISSION DATE ON OR BEFORE REFERENCE DATE? YES ..... 1 (SECTION B) NO 2

A6. Was (SP) a resident of this (facility/home) at any other time since (REFERENCE DATE)? **FRND.OTHRTIME**

OTHRTIME

YES 1 (A7)
NO ..... 2 (SECTION B)
DON'T KNOW ..... -8 (SECTION B)

A7. What were the admission and discharge dates of any other stays in this (facility/home) since (REFERENCE DATE)?

	ADMISSION DATE				DISCHARGE DATE		
	FDISCMM	**FDISCDD**	**FDISCYY**		**FREADMM**	**FREADDD**	**FREADYY**
STAY 1:	_____/	_____/	_____	THROUGH	_____/	_____/	_____
	(MONTH)	(DAY)	(YEAR)		(MONTH)	(DAY)	(YEAR)
STAY 2:	_____/	_____/	_____	THROUGH	_____/	_____/	_____
	(MONTH)	(DAY)	(YEAR)		(MONTH)	(DAY)	(YEAR)

GO TO SECTION B, PROVIDER PROBES

A8. Between (REFERENCE DATE) and [(DATE IN A2)/today], was (SP) ever formally discharged from this (facility/home) and readmitted?

FRND.CFACDISC

YES	1	(A9)
NO	2	(SECTION B)
DON'T KNOW	-8	(SECTION B)

A9. I'd like to ask about <u>each</u> time (SP) was discharged and readmitted here. What were the discharge and readmission dates for any periods between (REFERENCE DATE) and [(DATE IN A2)/today] that (SP) was not a resident here?

	DISCHARGE DATE				READMISSION DATE		
	FDISCMM	**FDISCDD**	**FDISCYY**		**FREADMM**	**FREADDD**	**FREADYY**
PERIOD 1:	_____/	_____/	_____	THROUGH	_____/	_____/	_____
	(MONTH)	(DAY)	(YEAR)		(MONTH)	(DAY)	(YEAR)
PERIOD 1:	_____/	_____/	_____	THROUGH	_____/	_____/	_____
	(MONTH)	(DAY)	(YEAR)		(MONTH)	(DAY)	(YEAR)

GO TO SECTION B, PROVIDER PROBES

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B. PROVIDER PROBES

BOX B1	TO ESTABLISH END DATE, REVIEW SP'S CURRENT RESIDENCE STATUS. IN FACILITY ..... 1 (ENTER DATE OF INTERVIEW AS END DATE ON FLAP. GO TO B1.) NOT IN FACILITY ..... 2 (ENTER DISCHARGE DATE AS END DATE ON FLAP GO TO B1.)

These next questions are about the health care that (SP) may have received between (REFERENCE DATE) and (END DATE). The questions include any care that (SP) received outside this facility as well as care from any providers who saw (SP) here.

B1. (Besides what you have already mentioned,) Between (REFERENCE DATE) and (END DATE), did (SP):	B2. Between (REFERENCE DATE) and (END DATE), how many: **FCRE.**	B3. (How many of those times were/Was that time) here in this facility or in the long term care unit of this facility? **FCRE**
a. see any of the types of dental providers listed on this card? [Dental providers include dentists, dental surgeons, endodontists, orthodontists, periodontists, and dental hygienists.] SHOW CARD B1 **FHCR** **FSEEDENT** YES ..... 1 (B2) NO ..... 2 (B1b) DK ..... -8 (B1b) FCRE.FCRETYPE = DE	times did (SP) see someone for dental care? **HLTHCNUM** _____ (B3) # OF TIMES DK ..... -8 (B4)	**HLTHCFAC** _____ # OF TIMES NONE ..... 0 DK ..... -8 (B4)
b. go to a hospital emergency room for medical care? **FEMROOM** YES ..... 1 (B2) NO ..... 2 (B1c) DK ..... -8 (B1c) FCRE.FCRETYPE = ER	times did (SP) visit a hospital emergency room? _____ (B1c) # OF TIMES DK ..... -8 (B1d)	
c. go to a hospital clinic or hospital outpatient department or unit for medical care? **FCLINIC** YES ..... 1 (B2) NO ..... 2 (B1d) DK ..... -8 (B1d) FCRE.FCRETYPE = OP	times did (SP) visit a hospital clinic or outpatient department? _____ (B1d) # OF TIMES DK ..... -8 (B1d)	
d. have any private duty nursing or attendant care? **FPRINURS** YES ..... 1 (B2) NO ..... 2 (B1e) DK ..... -8 (B1e) FCRE.FCRETYPE = PN	weeks did (SP) have private duty nursing or attendant care? **HLTHWNUM** _____ (B1d) # OF WEEKS DK ..... -8 How many days a week, on average , did (SP) have private duty nursing or attendant care? **HLTHDNUM** _____ (B4) # DAYS A WEEK DK ..... -8 (B4)	

B4. Was the care provided by an employee, someone on contract, or someone else? (CIRCLE ALL THAT APPLY)	B5. Did the facility bill or did the provider bill directly? (CIRCLE ALL THAT APPLY)	B6. Why was there no charge?
FCRE. **HLTHCEMP** **HLTHCCON** **HLTHCELS** EMPLOYEE ..... 1 - ON CONTRACT..... 2 : SOMEONE ELSE .. 3 ° DON'T KNOW..... -8 ® (B5)	**FCRE.** **HLTHFBIL** **HLTHPBIL** **HLTHNCH** BILLED BY FACILITY ..... 1 (B1b) BILLED BY PROVIDER ... 2 (B1b) NO CHARGE ..... 3 (B6) DON'T KNOW .....-8 (B1b)	**FCRE.** **HLTHYNCH** BAD DEBT ..... 1 - THIRD PARTY DOES NOT : REIMBURSE IN FULL ..... 2 . OTHER REASON ..... 3 ° (B1b) FREE FROM PROVIDER . 4 : INCLUDED IN PER DIEM . 5 . DON'T KNOW ..... -8 ®
EMPLOYEE ..... 1 - ON CONTRACT..... 2 : SOMEONE ELSE .. 3 ° DON'T KNOW..... -8 ® (B5)	BILLED BY FACILITY ..... 1 (B1e) BILLED BY PROVIDER ... 2 (B1e) NO CHARGE ..... 3 (B6) DON'T KNOW .....-8 (B1e)	BAD DEBT ..... 1 - THIRD PARTY DOES NOT : REIMBURSE IN FULL ..... 2 . OTHER REASON ..... 3 ° (B1e) FREE FROM PROVIDER . 4 : INCLUDED IN PER DIEM . 5 . DON'T KNOW ..... -8 ®

B1. (Besides what you have already mentioned,) Between (REFERENCE DATE) and (END DATE), did (SP):	B2. Between (REFERENCE DATE) and (END DATE), how many:	B3. (How many of those times were/Was that time) here in this facility or in the long term care unit of this facility?
e. see a medical doctor like any of the ones listed on this card? [Medical doctors include general practitioners, such as a family physician or internist, or specialists, such as cardiologists, neurologists, opthalmologist, or radiologist.] **FSEEMD** SHOW CARD B2 YES..... 1 NO..... 2 (B1f) DK..... -8 (B1f) What type of medical doctor was that? **(CODE ALL THAT APPLY)** **FCRE.FCRETYPE** = MD GENERAL PRACTITIONERS: FAMILY PHYSICIAN ..... 1 **FAMILYPH** INTERNIST..... 2 **FINTRNST** OTHER GENERAL PRACTITIONER..... 92 (SPECIFY) _____ **FOTHPRAC** **FOTHPRACOS** SPECIALIST: CARDIOLOGIST ..... 3 **FCARDIOL** NEUROLOGIST ..... 4 **FNEUROLG** EAR-NOSE-THROAT SPECIALIST..... 5 **FENT**	**HLTHCNUM** times did (SP) see a medical doctor? _____ (B3) # OF TIMES DK ..... -8 (B4) _____ (B3) # OF TIMES DK ..... -8 (B4) _____ (B3) # OF TIMES DK ..... -8 (B4) _____ (B3) # OF TIMES DK ..... -8 (B4) _____ (B3) # OF TIMES DK ..... -8 (B4) _____ (B3) # OF TIMES DK ..... -8 (B4)	**HLTHCFAC** _____ # OF TIMES NONE ..... 0 DK..... -8 (B4) _____ # OF TIMES NONE ..... 0 DK..... -8 (B4) _____ # OF TIMES NONE ..... 0 DK..... -8 (B4) _____ # OF TIMES NONE ..... 0 DK..... -8 (B4) _____ # OF TIMES NONE ..... 0 DK..... -8 (B4) _____ # OF TIMES NONE ..... 0 DK..... -8 (B4)

CONTINUED ON PAGE 10

B4. Was the care provided by an employee, someone on contract, or someone else? (CIRCLE ALL THAT APPLY)	B5. Did the facility bill or did the provider bill directly? (CIRCLE ALL THAT APPLY)	B6. Why was there no charge?
EMPLOYEE ..... 1 ON CONTRACT..... 2 SOMEONE ELSE .. 3 (B5) DON'T KNOW..... -8	BILLED BY FACILITY ..... 1 (B1f) BILLED BY PROVIDER ... 2 (B1f) NO CHARGE ..... 3 (B6) DON'T KNOW .....-8 (B1f)	BAD DEBT ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 (B1f) FREE FROM PROVIDER . 4 INCLUDED IN PER DIEM . 5 DON'T KNOW .....-8

B1. (Besides what you have already mentioned,) Between (REFERENCE DATE) and (END DATE), did (SP):	B2. Between (REFERENCE DATE) and (END DATE), how many:	B3. (How many of those times were/Was that time) here in this facility or in the long term care unit of this facility?
What type of medical doctor was that? (CODE ALL THAT APPLY) FHCR.	**FCRE.HLTHCNUM** times did (SP) see a medical doctor?	**FCRE.HLTHCFAC**
GYNECOLOGIST ..... 6 **FGYN**	_____ (B3) # OF TIMES DK ..... -8 (B4)	_____ # OF TIMES NONE ..... 0 DK ..... -8 (B4)
OPHTHALMOLOGIST ..... 7 **FOPHTHAL**	_____ (B3) # OF TIMES DK ..... -8 (B4)	_____ # OF TIMES NONE ..... 0 DK ..... -8 (B4)
RADIOLOGIST ..... 8 **FRADIOLO**	_____ (B3) # OF TIMES DK ..... -8 (B4)	_____ # OF TIMES NONE ..... 0 DK ..... -8 (B4)
PROCTOLOGIST ..... 9 **FPROCTOL**	_____ (B3) # OF TIMES DK ..... -8 (B4)	_____ # OF TIMES NONE ..... 0 DK ..... -8 (B4)
ORTHOPEDIST ..... 10 **FORTHO**	_____ (B3) # OF TIMES DK ..... -8 (B4)	_____ # OF TIMES NONE ..... 0 DK ..... -8 (B4)
THORACIC SURGEON .... 11 **FTHORACI**	_____ (B3) # OF TIMES DK ..... -8 (B4)	_____ # OF TIMES NONE ..... 0 DK ..... -8 (B4)
UROLOGIST ..... 12 **FUROLOGI**	_____ (B3) # OF TIMES DK ..... -8 (B4)	_____ # OF TIMES NONE ..... 0 DK ..... -8 (B4)
OTHER (SPECIFY) ..... 91 **FMDOTHER** **FMDOS** _____ **FMDOTHER** **FMDOS**	_____ (B3) # OF TIMES DK ..... -8 (B4)	_____ # OF TIMES NONE ..... 0 DK ..... -8 (B4)

B4. Was the care provided by an employee, someone on contract, or someone else? (CIRCLE ALL THAT APPLY)	B5. Did the facility bill or did the provider bill directly? (CIRCLE ALL THAT APPLY)	B6. Why was there no charge?

RECORD ANSWERS TO B4, B5, AND B6 ON PAGE 9

B1. (Besides what you have already mentioned,) Between (REFERENCE DATE) and (END DATE), did (SP):	B2. Between (REFERENCE DATE) and (END DATE), how many: FCRE.	B3. (How many of those times were/Was that time) here in this facility or in the long term care unit of this facility? FCRE.
f. see a health practitioner like any of the ones listed on this card? [Health practitioners include audiologist, optometrist, chiropractor, podiatrist (foot doctor), pharmacist, or any kind of health provider who is not a medical doctor.] **FHLTHPRA** SHOW CARD B3 YES..... 1 NO ..... 2 (B1g) DK.....-8 (B1g)		
What type of health practitioner was that? (CODE ALL THAT APPLY) **FAUDIOLD** AUDIOLOGIST..... 1 **FOPTOMET** OPTOMETRIST ..... 2 **FCHIROPR** CHIROPRACTOR ..... 3 **FOPDIATR** PODIATRIST (FOOT DOCTOR) ..... 4 **FPHARMAC** PHARMACIST..... 5 **FHPOTHER** OTHER (SPECIFY).....91 _____ **FHPOS** (B2)	times did (SP) see a medical person or persons? (ENTER TOTAL # FOR ALL TYPES OF PROVIDERS) **HLTHCNUM** _____ (B3) # OF TIMES DK ..... -8 (B1g)	**HLTHCFAC** _____ # OF TIMES NONE ..... 0 DK ..... -8 (B1g)
g. see a mental health professional such as those on this card? [Mental health professional includes psychiatrist, psychologist, and clinical social worker.] **FMENTAL** SHOW CARD B4 YES..... 1 (B2) NO ..... 2 (B1h) DK.....-8 (B1h)	times did (SP) see a mental health professional? _____ (B3) # OF TIMES DK ..... -8 (B4)	_____ # OF TIMES NONE ..... 0 DK ..... -8 (B4)
h. see a therapist such as those on this card? [Therapist includes physical therapist, speech therapist, I.V. therapist, occupational therapist, and respiratory therapist.] **FTHERAPI** SHOW CARD B5 YES..... 1 (B2) NO ..... 2 (B1i) DK.....-8 (B1i)	times did (SP) see a therapist? _____ (B3) # OF TIMES DK ..... -8 (B4)	_____ # OF TIMES NONE ..... 0 DK ..... -8 (B4)

B4. Was the care provided by an employee, someone on contract, or someone else? (CIRCLE ALL THAT APPLY)	B5. Did the facility bill or did the provider bill directly? (CIRCLE ALL THAT APPLY)	B6. Why was there no charge?
EMPLOYEE ..... 1 ON CONTRACT..... 2 SOMEONE ELSE .. 3 DON'T KNOW..... -8 (B5)	BILLED BY FACILITY ..... 1 (B1h) BILLED BY PROVIDER ... 2 (B1h) NO CHARGE ..... 3 (B6) DON'T KNOW .....-8 (B1h)	BAD DEBT ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 (B1h) FREE FROM PROVIDER . 4 INCLUDED IN PER DIEM . 5 DON'T KNOW .....-8
EMPLOYEE ..... 1 ON CONTRACT..... 2 SOMEONE ELSE .. 3 DON'T KNOW..... -8 (B5)	BILLED BY FACILITY ..... 1 (B1i) BILLED BY PROVIDER ... 2 (B1i) NO CHARGE ..... 3 (B6) DON'T KNOW .....-8 (B1i)	BAD DEBT ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 (B1i) FREE FROM PROVIDER . 4 INCLUDED IN PER DIEM . 5 DON'T KNOW .....-8

B1. (Besides what you have already mentioned,) Between (REFERENCE DATE) and (END DATE), did (SP):	B2. Between (REFERENCE DATE) and (END DATE), how many:	B3. (How many of those times were/Was that time) here in this facility or in the long term care unit of this facility?
i. see or visit any other medical person such as those on this card? [Other medical person includes paramedic, physician's assistant, and dietician.] SHOW CARD B6 **FOTHERMP** YES..... 1 (B2) NO..... 2 (B1j) DK..... -8 (B1j)	times did (SP) see such a medical person? _____ (B3) # OF TIMES DK ..... -8 (B1j)	_____ # OF TIMES NONE ..... 0 DK..... -8 - . ° . ® (B1j)
j. have any of these procedures at this facility or long term care unit, at a doctor's office, clinic, or lab? [Procedures include examination, tests, injections, x-rays, and treatments.] SHOW CARD B7 **FPROCDUR** YES..... 1 (B2) NO..... 2 (B1k) DK..... -8 (B1k)	times did (SP) have these procedures here or some other place? _____ (B4) # OF TIMES DK ..... -8 (B4)	
k. visit any of the other types of medical places listed on this card? [Other types of medical places include health clinic, neighborhood health center, rural health clinic, infirmary, mental health clinic, urgent care center, or any other place.] SHOW CARD B8 **FOTMEDPL** YES..... 1 (B2) NO..... 2 (B7) DK..... -8 (B7)	times did (SP) visit these other places? _____ (B7) # OF TIMES DK ..... -8 (B7)	

B4. Was the care provided by an employee, someone on contract, or someone else? (CIRCLE ALL THAT APPLY)	B5. Did the facility bill or did the provider bill directly? (CIRCLE ALL THAT APPLY)	B6. Why was there no charge?
EMPLOYEE ..... 1 ON CONTRACT..... 2 SOMEONE ELSE .. 3 DON'T KNOW..... -8 (B5)	BILLED BY FACILITY ..... 1 (B1k) BILLED BY PROVIDER ... 2 (B1k) NO CHARGE ..... 3 (B6) DON'T KNOW .....-8 (B1k)	BAD DEBT ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 (B1k) FREE FROM PROVIDER . 4 INCLUDED IN PER DIEM . 5 DON'T KNOW .....-8

B7. Now I'd like to talk to you about any kind of supplies or other types of medical services (SP) received. (Besides what you have already mentioned,) between (REFERENCE DATE) and (END DATE), did (SP) receive any . . .

		YES	NO	DK
FDIABEQP	a. Diabetic equipment or supplies?	1	2	-8
FEYEGLAS	b. Eye glasses or contact lenses?	1	2	-8
FHEARAID	c. Hearing aid or other communication device?	1	2	-8
FORTHOIT	d. Orthopedic items?	1	2	-8
FEQSDIAL	e. Equipment or supplies for kidney dialysis?	1	2	-8
FOSTOMY	f. Ostomy supplies?	1	2	-8
FDIAPER	g. Disposable diapers?	1	2	-8
FAMBSERV	h. Ambulance service?	1	2	-8
FPROSTHE	i. Prosthesis?	1	2	-8
FOXYGEN	j. Oxygen?	1	2	-8
FOTHRDVE	k. Other medical devices or equipment?	1	2	-8

FOTHDVOS (IF B7K = YES, SPECIFY)

_____
_____
_____
_____

Between (REFERENCE DATE) and (END DATE), did (SP) receive . . .

FTURNPOS	l. Turning and positioning?	1	2	-8
FTUBFEED	m. Tubefeeding?	1	2	-8
FRESTRNT	n. Restraints?	1	2	-8
FINJECT	o. Injections?	1	2	-8
FOMDSERV	p. Any other medically necessary items or provider services that we haven't talked about already?	1	2	-8

FOMDSEOS (IF B7P = YES, SPECIFY)

_____
_____
_____
_____

GO TO SECTION C,
PRESCRIBED MEDICINE

C. PRESCRIBED MEDICINE

[READ IF THIS CASE HAS A PRESCRIBED MEDICINE SUMMARY PAGE: We recorded the names of prescribed medicines that (SP) was taking the last time we were here. You might want to refer to this list to see whether (SP) has taken any of these medicines since then.]

C1. Between (REFERENCE DATE) and (END DATE) was (SP) given medicine prescribed by a doctor?

FGIVEMED

YES	1	(C2)
NO	2	(GO TO SECTION D)
DON'T KNOW	-8	(GO TO SECTION D)

C2.	What is the name of the medicine? PROBE FOR CORRECT SPELLING OF MEDICINE. PROBE: Was (SP) given any other prescribed medicines? RECORD NAME OF MEDICINE IN MEDICINE COLUMN. IF MORE THAN 12, USE SUPPLEMENTAL GRID.	MEDICINE NAME: **FMEDNAM** _____
C3.	In what form is the medicine? CIRCLE ONE ONLY. **FMEDFORM** SHOW CARD C1 **FMEDFOOS**	PILLS/CAPSULES/TABLETS ..... 1 LIQUID (ORAL) ..... 2 DROP ..... 3 TOPICAL OINTMENT, CREME, LOTION ..... 4 SUPPOSITORIES ..... 5 INHALANT, AEROSOL/SPRAY USED ORALLY ..... 6 SHAMPOO, SOAP ..... 7 INJECTION (BODY) ..... 8 INJECTION (IV) ..... 9 PATCHES ..... 10 TOPICAL GEL/JELLY ..... 11 POWDER ..... 12 OTHER (SPECIFY)..... 91 _____
C4.	What is the strength of the medicine? RECORD AMOUNT AND UNIT OF MEASURE. (E.G., 100 MILLIGRAMS, 10 GRAMS, ETC.) **FMEDUNIT**	AMOUNT: **FMEDAMT** UNIT OF MEASURE: (CIRCLE ONE) NO STRENGTH LISTED..... 0 MICROGRAMS (mcg)..... 1 MILLIGRAMS (mg) ..... 2 GRAMS (gm)..... 3 MILLEQUIVALENTS (meq)..... 4 GRAINS (gr)..... 5 OUNCES..... 6 MILLILITERS (ml) ..... 7 CUBIC CENTIMETER (CC)..... 8 OTHER (SPECIFY) ..... 91 _____ DON'T KNOW ..... -8
C5a.	How much of this medicine was to be taken at one time? What is the dosage?	NUMBER: **FMEDTNUM** NO DOSAGE LISTED..... 0 DON'T KNOW ..... -8
C5b.	How many times <u>per day</u> was this dosage taken? **FMEDDNUM** [PROBE FOR TIMES PER WEEK OR PER MONTH IF PER DAY IS NOT KNOWN.] **FMEDPER** [IF TAKEN ONE TIME ONLY, CODE 95.] [IF PRESCRIBED AS NEEDED (PRN), CODE 96.] **C5PRNFLG** [IF DOSAGE WAS SELF ADMINISTERED AND NUMBER OF TIMES ARE NOT KNOWN, CODE 94.] **FMEDDAOS**	NUMBER: _____ PER DAY ..... 1 WEEK ..... 2 MONTH ..... 3 EVERY OTHER DAY ..... 4 OTHER (SPECIFY) ..... 91 _____ ONE TIME ONLY ..... 95 PRN ..... 96 DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8
C6.	How many days or weeks was this dosage administered for (SP) since (REFERENCE DATE)? **FMEDDWNO** **FMEDPNUM** [PROBE FOR MONTHS IF DAYS OR WEEKS ARE NOT KNOWN.] [IF C5 = PRN, THEN PROBE FOR TOTAL TIMES SINCE REFERENCE DATE.] **FMEDPNOS**	NUMBER: _____ OF DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 OTHER (SPECIFY) ..... 91 _____ DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8

MEDICINE NAME: _____	MEDICINE NAME: _____	MEDICINE NAME: _____
PILLS/CAPSULES/TABLETS ..... 1 LIQUID (ORAL) ..... 2 DROP ..... 3 TOPICAL OINTMENT, CREME, LOTION ..... 4 SUPPOSITORIES ..... 5 INHALANT, AEROSOL/SPRAY USED ORALLY ..... 6 SHAMPOO, SOAP ..... 7 INJECTION (BODY) ..... 8 INJECTION (IV) ..... 9 PATCHES ..... 10 TOPICAL GEL/JELLY ..... 11 POWDER ..... 12 OTHER (SPECIFY)..... 91 _____	PILLS/CAPSULES/TABLETS ..... 1 LIQUID (ORAL) ..... 2 DROP ..... 3 TOPICAL OINTMENT, CREME, LOTION ..... 4 SUPPOSITORIES ..... 5 INHALANT, AEROSOL/SPRAY USED ORALLY ..... 6 SHAMPOO, SOAP ..... 7 INJECTION (BODY) ..... 8 INJECTION (IV) ..... 9 PATCHES ..... 10 TOPICAL GEL/JELLY ..... 11 POWDER ..... 12 OTHER (SPECIFY) ..... 91 _____	PILLS/CAPSULES/TABLETS ..... 1 LIQUID (ORAL) ..... 2 DROP ..... 3 TOPICAL OINTMENT, CREME, LOTION ..... 4 SUPPOSITORIES ..... 5 INHALANT, AEROSOL/SPRAY USED ORALLY ..... 6 SHAMPOO, SOAP ..... 7 INJECTION (BODY) ..... 8 INJECTION (IV) ..... 9 PATCHES ..... 10 TOPICAL GEL/JELLY ..... 11 POWDER ..... 12 OTHER (SPECIFY)..... 91 _____
AMOUNT: _____ UNIT OF MEASURE: (CIRCLE ONE) NO STRENGTH LISTED..... 0 MICROGRAMS (mcg)..... 1 MILLIGRAMS (mg) ..... 2 GRAMS (gm)..... 3 MILLEQUIVALENTS (meq)..... 4 GRAINS (gr)..... 5 OUNCES..... 6 MILLILITERS (ml) ..... 7 CUBIC CENTIMETER (CC) ..... 8 OTHER (SPECIFY) ..... 91 _____ DON'T KNOW ..... -8	AMOUNT: _____ UNIT OF MEASURE: (CIRCLE ONE) NO STRENGTH LISTED..... 0 MICROGRAMS (mcg) ..... 1 MILLIGRAMS (mg) ..... 2 GRAMS (gm)..... 3 MILLEQUIVALENTS (meq) ..... 4 GRAINS (gr) ..... 5 OUNCES ..... 6 MILLILITERS (ml)..... 7 CUBIC CENTIMETER (CC)..... 8 OTHER (SPECIFY) ..... 91 _____ DON'T KNOW ..... -8	AMOUNT: _____ UNIT OF MEASURE: (CIRCLE ONE) NO STRENGTH LISTED ..... 0 MICROGRAMS (mcg)..... 1 MILLIGRAMS (mg) ..... 2 GRAMS (gm) ..... 3 MILLEQUIVALENTS (meq)..... 4 GRAINS (gr)..... 5 OUNCES..... 6 MILLILITERS (ml) ..... 7 CUBIC CENTIMETER (CC) ..... 8 OTHER (SPECIFY) ..... 91 _____ DON'T KNOW ..... -8
NUMBER: _____ NO DOSAGE LISTED..... 0 DON'T KNOW ..... -8	NUMBER: _____ NO DOSAGE LISTED ..... 0 DON'T KNOW ..... -8	NUMBER: _____ NO DOSAGE LISTED..... 0 DON'T KNOW ..... -8
NUMBER: _____ PER DAY ..... 1 WEEK ..... 2 MONTH ..... 3 EVERY OTHER DAY..... 4 OTHER (SPECIFY) ..... 91 _____ ONE TIME ONLY ..... 95 PRN ..... 96 DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8	NUMBER: _____ PER DAY ..... 1 WEEK ..... 2 MONTH ..... 3 EVERY OTHER DAY..... 4 OTHER (SPECIFY)..... 91 _____ ONE TIME ONLY ..... 95 PRN ..... 96 DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8	NUMBER: _____ PER DAY ..... 1 WEEK ..... 2 MONTH ..... 3 EVERY OTHER DAY ..... 4 OTHER (SPECIFY) ..... 91 _____ ONE TIME ONLY ..... 95 PRN ..... 96 DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8
NUMBER: _____ OF DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 OTHER (SPECIFY) ..... 91 _____ DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8	NUMBER: _____ OF DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 OTHER (SPECIFY)..... 91 _____ DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8	NUMBER: _____ OF DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 OTHER (SPECIFY) ..... 91 _____ DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8

C2.	What is the name of the medicine? PROBE FOR CORRECT SPELLING OF MEDICINE. PROBE: Was (SP) given any other prescribed medicines? RECORD NAME OF MEDICINE IN MEDICINE COLUMN. IF MORE THAN 12, USE SUPPLEMENTAL GRID.	MEDICINE NAME: _____
C3.	In what form is the medicine? CIRCLE ONE ONLY. SHOW CARD C1	PILLS/CAPSULES/TABLETS ..... 1 LIQUID (ORAL) ..... 2 DROP ..... 3 TOPICAL OINTMENT, CREME, LOTION ..... 4 SUPPOSITORIES ..... 5 INHALANT, AEROSOL/SPRAY USED ORALLY ..... 6 SHAMPOO, SOAP ..... 7 INJECTION (BODY) ..... 8 INJECTION (IV) ..... 9 PATCHES ..... 10 TOPICAL GEL/JELLY ..... 11 POWDER ..... 12 OTHER (SPECIFY)..... 91 _____
C4.	What is the strength of the medicine? RECORD AMOUNT AND UNIT OF MEASURE. (E.G., 100 MILLIGRAMS, 10 GRAMS, ETC.)	AMOUNT: _____ UNIT OF MEASURE: (CIRCLE ONE) NO STRENGTH LISTED..... 0 MICROGRAMS (mcg)..... 1 MILLIGRAMS (mg) ..... 2 GRAMS (gm)..... 3 MILLEQUIVALENTS (meq)..... 4 GRAINS (gr)..... 5 OUNCES..... 6 MILLILITERS (ml) ..... 7 CUBIC CENTIMETER (CC)..... 8 OTHER (SPECIFY) ..... 91 _____ DON'T KNOW ..... -8
C5a.	How much of this medicine was to be taken at one time? What is the dosage?	NUMBER: _____ NO DOSAGE LISTED..... 0 DON'T KNOW ..... -8
C5b.	How many times <u>per day</u> was this dosage taken? [PROBE FOR TIMES PER WEEK OR PER MONTH IF PER DAY IS NOT KNOWN.] [IF TAKEN ONE TIME ONLY, CODE 95.] [IF PRESCRIBED AS NEEDED (PRN), CODE 96.] [IF DOSAGE WAS SELF ADMINISTERED AND NUMBER OF TIMES ARE NOT KNOWN, CODE 94.]	NUMBER: _____ PER DAY ..... 1 WEEK ..... 2 MONTH ..... 3 EVERY OTHER DAY ..... 4 OTHER (SPECIFY) ..... 91 _____ ONE TIME ONLY ..... 95 PRN ..... 96 DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8
C6.	How many days or weeks was this dosage administered for (SP) since (REFERENCE DATE)? [PROBE FOR MONTHS IF DAYS OR WEEKS ARE NOT KNOWN.] [IF C5 = PRN, THEN PROBE FOR TOTAL TIMES SINCE REFERENCE DATE.]	NUMBER: _____ OF DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 OTHER (SPECIFY) ..... 91 _____ DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8

MEDICINE NAME: _____	MEDICINE NAME: _____	MEDICINE NAME: _____
PILLS/CAPSULES/TABLETS ..... 1 LIQUID (ORAL) ..... 2 DROP ..... 3 TOPICAL OINTMENT, CREME, LOTION ..... 4 SUPPOSITORIES ..... 5 INHALANT, AEROSOL/SPRAY USED ORALLY ..... 6 SHAMPOO, SOAP ..... 7 INJECTION (BODY) ..... 8 INJECTION (IV) ..... 9 PATCHES ..... 10 TOPICAL GEL/JELLY ..... 11 POWDER ..... 12 OTHER (SPECIFY)..... 91 _____	PILLS/CAPSULES/TABLETS ..... 1 LIQUID (ORAL) ..... 2 DROP ..... 3 TOPICAL OINTMENT, CREME, LOTION ..... 4 SUPPOSITORIES ..... 5 INHALANT, AEROSOL/SPRAY USED ORALLY ..... 6 SHAMPOO, SOAP ..... 7 INJECTION (BODY) ..... 8 INJECTION (IV) ..... 9 PATCHES ..... 10 TOPICAL GEL/JELLY ..... 11 POWDER ..... 12 OTHER (SPECIFY) ..... 91 _____	PILLS/CAPSULES/TABLETS ..... 1 LIQUID (ORAL) ..... 2 DROP ..... 3 TOPICAL OINTMENT, CREME, LOTION ..... 4 SUPPOSITORIES ..... 5 INHALANT, AEROSOL/SPRAY USED ORALLY ..... 6 SHAMPOO, SOAP ..... 7 INJECTION (BODY) ..... 8 INJECTION (IV) ..... 9 PATCHES ..... 10 TOPICAL GEL/JELLY ..... 11 POWDER ..... 12 OTHER (SPECIFY)..... 91 _____
AMOUNT: _____ UNIT OF MEASURE: (CIRCLE ONE) NO STRENGTH LISTED..... 0 MICROGRAMS (mcg)..... 1 MILLIGRAMS (mg) ..... 2 GRAMS (gm)..... 3 MILLEQUIVALENTS (meq)..... 4 GRAINS (gr)..... 5 OUNCES..... 6 MILLILITERS (ml) ..... 7 CUBIC CENTIMETER (CC) ..... 8 OTHER (SPECIFY) ..... 91 _____ DON'T KNOW ..... -8	AMOUNT: _____ UNIT OF MEASURE: (CIRCLE ONE) NO STRENGTH LISTED..... 0 MICROGRAMS (mcg) ..... 1 MILLIGRAMS (mg) ..... 2 GRAMS (gm)..... 3 MILLEQUIVALENTS (meq) ..... 4 GRAINS (gr) ..... 5 OUNCES..... 6 MILLILITERS (ml)..... 7 CUBIC CENTIMETER (CC)..... 8 OTHER (SPECIFY) ..... 91 _____ DON'T KNOW ..... -8	AMOUNT: _____ UNIT OF MEASURE: (CIRCLE ONE) NO STRENGTH LISTED ..... 0 MICROGRAMS (mcg)..... 1 MILLIGRAMS (mg) ..... 2 GRAMS (gm) ..... 3 MILLEQUIVALENTS (meq)..... 4 GRAINS (gr)..... 5 OUNCES..... 6 MILLILITERS (ml) ..... 7 CUBIC CENTIMETER (CC) ..... 8 OTHER (SPECIFY) ..... 91 _____ DON'T KNOW ..... -8
NUMBER: _____ NO DOSAGE LISTED..... 0 DON'T KNOW ..... -8	NUMBER: _____ NO DOSAGE LISTED ..... 0 DON'T KNOW ..... -8	NUMBER: _____ NO DOSAGE LISTED..... 0 DON'T KNOW ..... -8
NUMBER: _____ PER DAY ..... 1 WEEK ..... 2 MONTH ..... 3 EVERY OTHER DAY..... 4 OTHER (SPECIFY) ..... 91 _____ ONE TIME ONLY ..... 95 PRN ..... 96 DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8	NUMBER: _____ PER DAY ..... 1 WEEK ..... 2 MONTH ..... 3 EVERY OTHER DAY..... 4 OTHER (SPECIFY)..... 91 _____ ONE TIME ONLY ..... 95 PRN ..... 96 DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8	NUMBER: _____ PER DAY ..... 1 WEEK ..... 2 MONTH ..... 3 EVERY OTHER DAY ..... 4 OTHER (SPECIFY) ..... 91 _____ ONE TIME ONLY ..... 95 PRN ..... 96 DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8
NUMBER: _____ OF DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 OTHER (SPECIFY) ..... 91 _____ DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8	NUMBER: _____ OF DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 OTHER (SPECIFY)..... 91 _____ DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8	NUMBER: _____ OF DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 OTHER (SPECIFY) ..... 91 _____ DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8

C2.	What is the name of the medicine? PROBE FOR CORRECT SPELLING OF MEDICINE. PROBE: Was (SP) given any other prescribed medicines? RECORD NAME OF MEDICINE IN MEDICINE COLUMN. IF MORE THAN 12, USE SUPPLEMENTAL GRID.	MEDICINE NAME: _____
C3.	In what form is the medicine? CIRCLE ONE ONLY. SHOW CARD C1	PILLS/CAPSULES/TABLETS ..... 1 LIQUID (ORAL) ..... 2 DROP ..... 3 TOPICAL OINTMENT, CREME, LOTION ..... 4 SUPPOSITORIES ..... 5 INHALANT, AEROSOL/SPRAY USED ORALLY ..... 6 SHAMPOO, SOAP ..... 7 INJECTION (BODY) ..... 8 INJECTION (IV) ..... 9 PATCHES ..... 10 TOPICAL GEL/JELLY ..... 11 POWDER ..... 12 OTHER (SPECIFY)..... 91 _____
C4.	What is the strength of the medicine? RECORD AMOUNT AND UNIT OF MEASURE. (E.G., 100 MILLIGRAMS, 10 GRAMS, ETC.)	AMOUNT: _____ UNIT OF MEASURE: (CIRCLE ONE) NO STRENGTH LISTED..... 0 MICROGRAMS (mcg)..... 1 MILLIGRAMS (mg) ..... 2 GRAMS (gm)..... 3 MILLEQUIVALENTS (meq)..... 4 GRAINS (gr)..... 5 OUNCES..... 6 MILLILITERS (ml) ..... 7 CUBIC CENTIMETER (CC)..... 8 OTHER (SPECIFY) ..... 91 _____ DON'T KNOW ..... -8
C5a.	How much of this medicine was to be taken at one time? What is the dosage?	NUMBER: _____ NO DOSAGE LISTED..... 0 DON'T KNOW ..... -8
C5b.	How many times <u>per day</u> was this dosage taken? [PROBE FOR TIMES PER WEEK OR PER MONTH IF PER DAY IS NOT KNOWN.] [IF TAKEN ONE TIME ONLY, CODE 95.] [IF PRESCRIBED AS NEEDED (PRN), CODE 96.] [IF DOSAGE WAS SELF ADMINISTERED AND NUMBER OF TIMES ARE NOT KNOWN, CODE 94.]	NUMBER: _____ PER DAY ..... 1 WEEK ..... 2 MONTH ..... 3 EVERY OTHER DAY ..... 4 OTHER (SPECIFY) ..... 91 _____ ONE TIME ONLY ..... 95 PRN ..... 96 DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8
C6.	How many days or weeks was this dosage administered for (SP) since (REFERENCE DATE)? [PROBE FOR MONTHS IF DAYS OR WEEKS ARE NOT KNOWN.] [IF C5 = PRN, THEN PROBE FOR TOTAL TIMES SINCE REFERENCE DATE.]	NUMBER: _____ OF DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 OTHER (SPECIFY) ..... 91 _____ DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8

MEDICINE NAME: _____	MEDICINE NAME: _____	MEDICINE NAME: _____
PILLS/CAPSULES/TABLETS ..... 1 LIQUID (ORAL) ..... 2 DROP ..... 3 TOPICAL OINTMENT, CREME, LOTION ..... 4 SUPPOSITORIES ..... 5 INHALANT, AEROSOL/SPRAY USED ORALLY ..... 6 SHAMPOO, SOAP ..... 7 INJECTION (BODY) ..... 8 INJECTION (IV) ..... 9 PATCHES ..... 10 TOPICAL GEL/JELLY ..... 11 POWDER ..... 12 OTHER (SPECIFY)..... 91 _____	PILLS/CAPSULES/TABLETS ..... 1 LIQUID (ORAL) ..... 2 DROP ..... 3 TOPICAL OINTMENT, CREME, LOTION ..... 4 SUPPOSITORIES ..... 5 INHALANT, AEROSOL/SPRAY USED ORALLY ..... 6 SHAMPOO, SOAP ..... 7 INJECTION (BODY) ..... 8 INJECTION (IV) ..... 9 PATCHES ..... 10 TOPICAL GEL/JELLY ..... 11 POWDER ..... 12 OTHER (SPECIFY) ..... 91 _____	PILLS/CAPSULES/TABLETS ..... 1 LIQUID (ORAL) ..... 2 DROP ..... 3 TOPICAL OINTMENT, CREME, LOTION ..... 4 SUPPOSITORIES ..... 5 INHALANT, AEROSOL/SPRAY USED ORALLY ..... 6 SHAMPOO, SOAP ..... 7 INJECTION (BODY) ..... 8 INJECTION (IV) ..... 9 PATCHES ..... 10 TOPICAL GEL/JELLY ..... 11 POWDER ..... 12 OTHER (SPECIFY)..... 91 _____
AMOUNT: _____ UNIT OF MEASURE: (CIRCLE ONE) NO STRENGTH LISTED..... 0 MICROGRAMS (mcg)..... 1 MILLIGRAMS (mg) ..... 2 GRAMS (gm)..... 3 MILLEQUIVALENTS (meq)..... 4 GRAINS (gr)..... 5 OUNCES..... 6 MILLILITERS (ml) ..... 7 CUBIC CENTIMETER (CC) ..... 8 OTHER (SPECIFY) ..... 91 _____ DON'T KNOW ..... -8	AMOUNT: _____ UNIT OF MEASURE: (CIRCLE ONE) NO STRENGTH LISTED..... 0 MICROGRAMS (mcg) ..... 1 MILLIGRAMS (mg) ..... 2 GRAMS (gm)..... 3 MILLEQUIVALENTS (meq) ..... 4 GRAINS (gr) ..... 5 OUNCES..... 6 MILLILITERS (ml)..... 7 CUBIC CENTIMETER (CC)..... 8 OTHER (SPECIFY) ..... 91 _____ DON'T KNOW ..... -8	AMOUNT: _____ UNIT OF MEASURE: (CIRCLE ONE) NO STRENGTH LISTED ..... 0 MICROGRAMS (mcg)..... 1 MILLIGRAMS (mg) ..... 2 GRAMS (gm) ..... 3 MILLEQUIVALENTS (meq)..... 4 GRAINS (gr)..... 5 OUNCES..... 6 MILLILITERS (ml) ..... 7 CUBIC CENTIMETER (CC) ..... 8 OTHER (SPECIFY) ..... 91 _____ DON'T KNOW ..... -8
NUMBER: _____ NO DOSAGE LISTED..... 0 DON'T KNOW ..... -8	NUMBER: _____ NO DOSAGE LISTED ..... 0 DON'T KNOW ..... -8	NUMBER: _____ NO DOSAGE LISTED..... 0 DON'T KNOW ..... -8
NUMBER: _____ PER DAY ..... 1 WEEK ..... 2 MONTH ..... 3 EVERY OTHER DAY..... 4 OTHER (SPECIFY) ..... 91 _____ ONE TIME ONLY ..... 95 PRN ..... 96 DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8	NUMBER: _____ PER DAY ..... 1 WEEK ..... 2 MONTH ..... 3 EVERY OTHER DAY..... 4 OTHER (SPECIFY)..... 91 _____ ONE TIME ONLY ..... 95 PRN ..... 96 DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8	NUMBER: _____ PER DAY ..... 1 WEEK ..... 2 MONTH ..... 3 EVERY OTHER DAY ..... 4 OTHER (SPECIFY) ..... 91 _____ ONE TIME ONLY ..... 95 PRN ..... 96 DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8
NUMBER: _____ OF DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 OTHER (SPECIFY) ..... 91 _____ DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8	NUMBER: _____ OF DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 OTHER (SPECIFY)..... 91 _____ DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8	NUMBER: _____ OF DAYS ..... 1 WEEKS ..... 2 MONTHS ..... 3 OTHER (SPECIFY) ..... 91 _____ DK-SELF ADMINISTERED ..... 94 DON'T KNOW ..... -8

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D. INPATIENT HOSPITAL STAYS

D1. Between (REFERENCE DATE) and (END DATE), was (SP) admitted to or temporarily residing in a hospital or inpatient hospital unit? [We are interested in all admissions, whether (SP) was admitted and discharged the same day or remained overnight or longer. If (SP) was in the hospital on (REFERENCE DATE), please include that stay here.]

FINSTAYS

YES	1	(D2)
NO	2	(GO TO SECTION E)
DON'T KNOW	-8	(GO TO SECTION E)

D2. How many times was (SP) admitted to hospital?

FSTAYSNO _____

TIMES

(ASK D3 - D11 FOR EACH HOSPITAL STAY AS APPLICABLE. IF MORE THAN 3 STAYS USE SUPPLEMENTAL GRID.)

		HOSPITAL STAY #1
D3.	On what date was (SP) admitted to the hospital the (first/next) time? **FINPAMM FINPADD FINPAYY**	DATE ADMITTED _____/_____/_____
D4.	On what date was (SP) discharged from the hospital (that time)? **FINPDMM FINPDDD FINPDYY**	DATE DISCHARGED _____/_____/_____ ***BOX D1*** STILL IN 1 (D6)

BOX D1	REVIEW D3 AND D4. IF MONTH OR DAY IS DK IN D3 OR D4, GO TO D5. OTHERWISE, GO TO D6.

D5.	How many nights was (SP) in the hospital? **FINPNITE**	_____ NIGHTS
D6.	Is this hospital a facility of the Veterans Administration? **FINPVA**	YES ..... 1 NO 2
D7.	What was the main reason (SP) entered the hospital? **FINPREAS** **FINPREOS**	MEDICAL TREATMENT OF CONDITION ..... 1 (D8) OPERATION OR SURGICAL PROCEDURE ..... 2 (D10) SPECIAL DIAGNOSTIC TESTS .... 3(D8) OTHER (SPECIFY) _____ 91 (D8)
D8.	What was the condition? **FINPCON1** PROBE: Any other condition? **FINPCON2** **FINPCON3**	CONDITION 1: _____ CONDITION 2: _____ CONDITION 3: _____
D9.	Were any operations or surgical procedures performed on (SP) during that stay? **FINPSURG**	YES ..... 1 (D10) NO ..... 2 (D11) DON'T KNOW ..... -8 (D11)
D10.	What was the name of the operation or surgical procedure? PROBE: Any other operation or surgical procedure? ENTER NAME(S) OF OPERATION OR SURGICAL PROCEDURE. IF NOT KNOWN, DESCRIBE WHAT WAS DONE. **FINPSUR1** **FINPSUR2** **FINPSUR3**	CONDITION 1: _____ CONDITION 2: _____ CONDITION 3: _____
D11.	What is the name and address of that hospital? (GO TO NEXT HOSPITAL STAY. IF LAST HOSPITAL STAY, GO TO SECTION E.)	**FINPNAM** NAME **FINPADDR** ADDRESS **FINPCITY** **FINPST** **FINPZIP** CITY STATE ZIP

HOSPITAL STAY #2	HOSPITAL STAY #3
DATE ADMITTED _____/_____/_____	DATE ADMITTED _____/_____/_____
DATE DISCHARGED _____/_____/_____ ***BOX D1*** STILL IN 1 (D6)	DATE DISCHARGED _____/_____/_____ ***BOX D1*** STILL IN 1 (D6)

_____ NIGHTS	_____ NIGHTS
YES ..... 1 NO 2	YES ..... 1 NO 2
TREATMENT OF MEDICAL CONDITION ..... 1 (D8) OPERATION OR SURGICAL PROCEDURE ..... 2 (D10) SPECIAL DIAGNOSTIC TESTS .... 3 (D8) Other (SPECIFY) _____ 91 (D8)	TREATMENT OF MEDICAL CONDITION ..... 1 (D8) OPERATION OR SURGICAL PROCEDURE ..... 2 (D10) SPECIAL DIAGNOSTIC TESTS .... 3 (D8) OTHER (SPECIFY) _____ 91 (D8)
CONDITION 1: _____ _____ CONDITION 2: _____ _____ CONDITION 3: _____ _____	CONDITION 1: _____ _____ CONDITION 2: _____ _____ CONDITION 3: _____ _____
YES ..... 1 (D10) NO ..... 2 (D11) DON'T KNOW ..... -8 (D11)	YES ..... 1 (D10) NO ..... 2 (D11) DON'T KNOW ..... -8 (D11)
OPERATION 1: _____ _____ OPERATION 2: _____ _____ OPERATION 3: _____ _____	OPERATION 1: _____ _____ OPERATION 2: _____ _____ OPERATION 3: _____ _____
_____ NAME _____ _____ ADDRESS _____ CITY STATE ZIP	_____ NAME _____ _____ ADDRESS _____ CITY STATE ZIP

E. FACILITY CHARGES

[E1-E10 NOT ASKED THIS VERSION.]

E11. Now, I would like to know about all facility charges for (SP) since [PREVIOUS ROUND END BILL DATE/ ADMISSION DATE]. Through what date up to (END DATE) do you have records for all facility charges?

FCHGENDM / **FCHGENDD** / **FCHGENDY** (ENTER ON FLAP AS END BILL DATE)
MONTH DAY YEAR

FACILITY CHARGE INFORMATION NOT AVAILABLE ..... 2 (SECTION F) **FCHG.FCHGAVAI**

BOX E1	ASK RESPONDENT FOR BEGINNING AND ENDING DATES FOR EACH BILLING PERIOD OCCURRING BETWEEN PREVIOUS ROUND END BILL DATE/ADMISSION DATE AND THE CURRENT END BILL DATE LISTED IN E11. BEGINNING WITH THE EARLIEST PERIOD, RECORD BEGINNING AND ENDING DATES FOR <u>EACH</u> PERIOD IN THE PERIOD COLUMN HEADINGS IN THE GRID BELOW. ASK E12, E13, and E13a FOR EACH PERIOD LISTED; THEN PROCEED WITH BOX E2. IF MORE THAN 4 PERIODS ATTACH SUPPLEMENTAL BILLING PERIOD PAGES.	PERIOD #5
		FBILBEGM, **FBILBEGD**, **FBILBEGY** FROM: _____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR **FBILENDM**, **FBILENDD**, **FBILENDY**
E12.	What would have been the total basic charges for a private-pay resident for the period from (DATE) to (DATE)? [The total basic charge will typically include room and board and some nursing care.] **NOPRIVPY**	E12. $ **FTOTBASE** ._____ FACILITY HAS NO PRIVATE PAY..... 1
E13.	Including <u>all</u> sources of payment, what was the <u>total</u> payment for (SP's) basic charge for the period from (DATE) to (DATE).	E13. $ **FTOTSRCE** TOTAL PAYMENT
	a. Please look at this card and tell me all the sources of payment for (SP's) basic charge for the period from (DATE) to (DATE). (CIRCLE ALL THAT APPLY)	E13b. (ASK FOR EACH SOURCE:) How much did or will (INSERT SOURCE) pay for the charge period from (DATE) to (DATE)?
SHOW CARD E3	1. OWN INCOME OR FAMILY SUPPORT (INCLUDE SOCIAL SECURITY) **PAYBOWN**	1 $ **FOWNAMT** ._____
	2. MEDICARE (TITLE XVIII) **PAYBMCR**	2 $ **FMCARAMT** ._____
	3. MEDICAID (TITLE XIX) **PAYBMCD**	3 $ **FMCADAMT** ._____
	4. VA (VETERANS ADMINISTRATION) **PAYBVA**	4 $ **FVAAMT** ._____
	5. PRIVATE HEALTH INSURANCE OR LONG TERM CARE INSURANCE **PAYBPRI**	5 $ **FPINSAMT** ._____
	6. SSI (SUPPLEMENTAL SECURITY INCOME) **PAYBSSI**	6 $ **FSUPPAMT** ._____
	7. PAYMENT FOR CONTINUING OR LIFE CARE COMMUNITY **PAYBLIF**	7 $ **FLIFEAMT** ._____
	91. OTHER SOURCE SPECIFY SOURCE **PAYBOTH** **PAYBOS** →	91 $ **FOTHRAMT** ._____ _____

BOX E2	a. E13 = E12 (E18) E13 < E12 (b) E13 > E12 (E18)	
	b. SUBTRACT E13 FROM E12 AND RECORD AMOUNT IN EACH COLUMN; THEN GO TO E14.	b. $ **FTOTMORE** ._____

☐ CHECK IF MEDICAID IS REPORTED AS A SOURCE OF PAYMENT AND WAS NOT REPORTED IN THE PREVIOUS ROUND.

PERIOD #6	PERIOD #7	PERIOD #8
FROM: _____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	FROM: _____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	FROM: _____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR
E12. $_____.____ FACILITY HAS NO PRIVATE PAY ... 1	E12. $_____.____ FACILITY HAS NO PRIVATE PAY 1	E12. $_____.____ FACILITY HAS NO PRIVATE PAY 1
E13. $ _____ TOTAL PAYMENT E13b. (ASK FOR EACH SOURCE:) How much did or will (INSERT SOURCE) pay for the charge period from (DATE) to (DATE)? 1 $_____.____ 2 $_____.____ 3 $_____.____ 4 $_____.____ 5 $_____.____ 6 $_____.____ 7 $_____.____ 91 $_____.____ _____	E13. $ _____ TOTAL PAYMENT E13b. (ASK FOR EACH SOURCE:) How much did or will (INSERT SOURCE) pay for the charge period from (DATE) to (DATE)? 1 $_____.____ 2 $_____.____ 3 $_____.____ 4 $_____.____ 5 $_____.____ 6 $_____.____ 7 $_____.____ 91 $_____.____ _____	E13. $ _____ TOTAL PAYMENT E13b. (ASK FOR EACH SOURCE:) How much did or will (INSERT SOURCE) pay for the charge period from (DATE) to (DATE)? 1 $_____.____ 2 $_____.____ 3 $_____.____ 4 $_____.____ 5 $_____.____ 6 $_____.____ 7 $_____.____ 91 $_____.____ _____
b. $_____.____	b. $_____.____	b. $_____.____

		PERIOD #5
E14.	For the period from (DATE) to (DATE) the total basic charge for a private-pay resident was more than the total payments for (SP's) basic charge. Do you expect to receive all of the outstanding amount?	YES..... 1 (E18) NO..... 2 (E15) DON'T KNOW ..... -8 (E18) **BPAYALL**
E15.	How much of the (AMOUNT IN BOX E2b) do you expect that you will not receive?	**BNOPDAMT** $_____._____
E16.	What is the reason you will not receive that amount? (RECORD VERBATIM; THEN CODE ALL THAT APPLY.)	**BNOPDVB** _____ _____ _____ FACILITY ABSORBS COST ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 DON'T KNOW ..... -8

BOX E3	CHECK E16: IS OPTION 2 CIRCLED, THIRD PARTY DOES NOT REIMBURSE IN FULL?	YES..... 1 (E17) NO..... 2 (E18)

E17.	Which of the payment sources does not reimburse in full? (CIRCLE ALL THAT APPLY)	
SHOW CARD E3	1. OWN INCOME OR FAMILY SUPPORT (INCLUDE SOCIAL SECURITY)	**FNFULOWN** 1
	2. MEDICARE (TITLE XVIII)	**FNFULMCR** 2
	3. MEDICAID (TITLE XIX)	**FNFULMCD** 3
	4. VA (VETERANS ADMINISTRATION)	**FNFULVA** 4
	5. PRIVATE HEALTH INSURANCE OR LONG TERM CARE INSURANCE	**FNFULPRI** 5
	6. SSI (SUPPLEMENTAL SECURITY INCOME)	**FNFULSSI** 6
	7. PAYMENT FOR CONTINUING OR LIFE CARE COMMUNITY	**FNFULLIF** 7
	91. OTHER SOURCE	**FNFULOTH** .....91 (SPECIFY) **FNFULLOS** _____

PERIOD #6	PERIOD #7	PERIOD #8
YES ..... 1 (E18) NO ..... 2 (E15) DON'T KNOW ..... -8 (E18)	YES ..... 1 (E18) NO ..... 2 (E15) DON'T KNOW ..... -8 (E18)	YES ..... 1 (E18) NO ..... 2 (E15) DON'T KNOW ..... -8 (E18)
$_____._____	$_____._____	$_____._____
_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
FACILITY ABSORBS COST ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 DON'T KNOW ..... -8	FACILITY ABSORBS COST ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 DON'T KNOW ..... -8	FACILITY ABSORBS COST ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 DON'T KNOW ..... -8

YES ..... 1 (E17) NO 2 (E18)	YES ..... 1 (E17) NO 2 (E18)	YES ..... 1 (E17) NO 2 (E18)

..... 1	 1	 1
..... 2	 2	 2
..... 3	 3	 3
..... 4	 4	 4
..... 5	 5	 5
..... 6	 6	 6
..... 7	 7	 7
..... 91 (SPECIFY) _____	.....91 (SPECIFY) _____	.....91 (SPECIFY) _____

The next questions are about medical charges that may have been billed by the facility between (PREVIOUS ROUND END BILL DATE) and (CURRENT END BILL DATE).

E18. Between (PREVIOUS ROUND END BILL DATE) and (CURRENT END BILL DATE) was there a separate charge billed by the facility for (INSERT CATEGORY)?	E19. What was the total charge billed by the facility for (INSERT CATEGORY) from (PREVIOUS ROUND END BILL DATE) to (CURRENT END BILL DATE)?
a. Dental Services? **FSCHDENT** YES ..... 1 → NO ..... 2 (b) DON'T KNOW ..... -8 (b)	**FDENTAMT** $_____.____ DON'T KNOW ..... -8 (E18b)
b. Private duty nursing? **FSCHNURS** YES ..... 1 → NO ..... 2 (c) DON'T KNOW ..... -8 (c)	**FNURSAMT** $_____.____ DON'T KNOW ..... -8 (E18c)
c. Turning and positioning? **FSCHTURN** YES ..... 1 → NO ..... 2 (d) DON'T KNOW ..... -8 (d)	**FTURNAMT** $_____.____ DON'T KNOW ..... -8 (E18d)
d. Physician services? **FSCHPHY** YES ..... 1 → NO ..... 2 (e) DON'T KNOW ..... -8 (e)	**FPHYSAMT** $_____.____ DON'T KNOW ..... -8 (E18e)
e. Services from a medical practitioner such as audiologist, optometrist, etc.? **FSCHMEDP** YES ..... 1 → NO ..... 2 (f) DON'T KNOW ..... -8 (f)	**FMEDPAMT** $_____.____ DON'T KNOW ..... -8 (E18f)
f. A doctor's office or clinic visit? **FSCHCLIN** YES ..... 1 → NO ..... 2 (g) DON'T KNOW ..... -8 (g)	**FCLINAMT** $_____.____ DON'T KNOW ..... -8 (E18g)
g. Mental Health Professional Services? **FSCHMENT** YES ..... 1 → NO ..... 2 (h) DON'T KNOW ..... -8 (h)	**FMENTAMT** $_____.____ DON'T KNOW ..... -8 (E18h)
h. Therapist Services such as physical, speech, etc.? **FSCHTHER** YES ..... 1 → NO ..... 2 (i) DON'T KNOW ..... -8 (i)	**FTHERAMT** $_____.____ DON'T KNOW ..... -8 (E18i)

E18. Between (PREVIOUS ROUND END BILL DATE) and (CURRENT END BILL DATE) was there a separate charge billed by the facility for (INSERT CATEGORY)?	E19. What was the total charge billed by the facility for (INSERT CATEGORY) from (PREVIOUS ROUND END BILL DATE) to (CURRENT END BILL DATE)?
i. Services from other medical persons such as a paramedic, etc.? **FSCHOMDP** YES ..... 1 → NO ..... 2 (j) DON'T KNOW ..... -8 (j)	**FOMDPAMT** $_____.____ DON'T KNOW ..... -8 } (E18j)
j. Prescription drugs? **FSCHPMED** YES ..... 1 → NO ..... 2 (k) DON'T KNOW ..... -8 (k)	**FPMEDAMT** $_____.____ DON'T KNOW ..... -8 } (E18k)
k. Diabetic equipment or supplies? **FSCHDIAB** YES ..... 1 → NO ..... 2 (l) DON'T KNOW ..... -8 (l)	**FDIABAMT** $_____.____ DON'T KNOW ..... -8 } (E18l)
l Eyeglasses or contact lenses? **FSCHEYE** YES ..... 1 → NO ..... 2 (m) DON'T KNOW ..... -8 (m)	**FEYECAMT** $_____.____ DON'T KNOW ..... -8 } (E18m)
m. Hearing aid or other communication device? **FSCHHAID** YES ..... 1 → NO ..... 2 (n) DON'T KNOW ..... -8 (n)	**FHAIDAMT** $_____.____ DON'T KNOW ..... -8 } (E18n)
n. Ambulance service? **FSCHAMBU** YES ..... 1 → NO ..... 2 (o) DON'T KNOW ..... -8 (o)	**FAMBSAMT** $_____.____ DON'T KNOW ..... -8 } (E18o)
o. Prosthesis? **FSCHPROS** YES ..... 1 → NO ..... 2 (p) DON'T KNOW ..... -8 (p)	**FPROSAMT** $_____.____ DON'T KNOW ..... -8 } (E18p)
p. Other medical devices or equipment? **FSCHOTHR** YES ..... 1 → NO ..... 2 (q) DON'T KNOW ..... -8 (q)	**FODEVAMT** $_____.____ DON'T KNOW ..... -8 } (E18q)

E18. Between (PREVIOUS ROUND END BILL DATE) and (CURRENT END BILL DATE) was there a separate charge billed by the facility for (INSERT CATEGORY)?	E19. What was the total charge billed by the facility for (INSERT CATEGORY) from (PREVIOUS ROUND END BILL DATE) to (CURRENT END BILL DATE)?
q. Any other medically necessary items or provider services that we haven't talked about already? **FSCHGPRO** YES (SPECIFY)..... 1 a. _____ **FSCHGOS1** b. _____ **FSCHGOS2** c._____ **FSCHGOS3** d. _____ **FSCHGOS4** e. _____ **FSCHGOS5** f. _____ **FSCHGOS6** NO ..... 2 ***BOX E4*** DON'T KNOW ..... -8 ***BOX E4***	a. $_____._____ **FOS1AMT** b. $_____._____ **FOS2AMT** c. $_____._____ **FOS3AMT** d. $_____._____ **FOS4AMT** e. $_____._____ **FOS5AMT** f. $_____._____ **FOS6AMT** ***BOX E4***

BOX E4	IS ANY ITEM CODED "YES" IN E18?		
	YES	1	(E20a)
	NO	2	(SECTION F)

E20a. Altogether, how much was separately billed by the facility for medical services for (SP) from (PREVIOUS ROUND END BILL DATE) to (CURRENT END BILL DATE)? **FSCHGTOT**

$ _____.____

TOTAL AMOUNT BILLED

E20b. Have you received payment or do you expect to receive any payment for these services? **FSCHGPAY**

YES 1 (E21)
NO 2 (E23)
DON'T KNOW ..... -8 (E21)

E21. Please look at this card and tell me all the sources of payment or expected sources of payment for these special services from (PREVIOUS ROUND END BILL DATE) TO (CURRENT END BILL DATE). (CIRCLE ALL CODES THAT APPLY; THEN ASK E21a FOR EACH SOURCE.) (PROBE FOR ALL SOURCES.)

SHOW CARD E3

		(ASK FOR EACH SOURCE:) E21a. How much did or will (SOURCE) pay for special services for (SP) for that period?
1.	OWN INCOME OR FAMILY SUPPORT (INCLUDE SOCIAL SECURITY) **FSPAYOWN**	**FSOWNAMT** 1 $_____.____
2.	MEDICARE (TITLE XVIII) **FSPAYMCR**	**FSMCRAMT** 2 $_____.____
3.	MEDICAID (TITLE XIX) **FSPAYMCD**	**FSMCDAMT** 3 $_____.____
4.	VA (VETERAN'S ADMINISTRATION **FSPAYVA**	**FSVAAMT** 4 $_____.____
5.	PRIVATE HEALTH INSURANCE OR LONG TERM CARE INSURANCE **FSPAYPRI**	**FSPRIAMT** 5 $_____.____
6.	SSI (SUPPLEMENTAL SECURITY INCOME) **FSPAYSSI**	**FSSSIAMT** 6 $_____.____
7.	PREPAYMENT FOR CONTINUING OR LIFE CARE COMMUNITY **FSPAYLIF**	**FSLIFAMT** 7 $_____.____
91.	OTHER SOURCE **FSPAYOTH**	**FSOTHAMT** 91 $_____.____
	SPECIFY **FSPAYOS**	_____

BOX E5

a. TOTAL ALL PAYMENT SOURCES LISTED IN E21a. — a. $ **FSPYSRCE** .____

b. a = E20a (SECTION F)

a < E20a (c)

a > E20a (SECTION F)

c. SUBTRACT a FROM E20a AND RECORD AMOUNT IN EACH COLUMN; THEN PROCEED WITH E22. — c. $ **FSPYMORE** .____

E22.	For the period from (PREVIOUS ROUND END BILL DATE) to (CURRENT END BILL DATE) the total ancillary charges were more than the total payment sources. Do you expect to receive any or all of that amount? **APAYALL**	YES..... 1 (GO TO SECTION F) NO..... 2 (E23) DON'T KNOW ..... -8 (GO TO SECTION F)
E23.	How much of the (AMOUNT IN E20a/AMOUNT IN BOX E5c.) do you expect that you will not receive? **ANOPDAMT**	$_____._____
E24.	What is the reason? (RECORD VERBATIM; THEN CODE ALL THAT APPLY.) **ANOPDVB** **ANOPDDET** **ANOPDFUL** **ANOPDOTH**	_____ _____ _____ _____ FACILITY ABSORBS COST ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 DON'T KNOW ..... -8

BOX E6	CHECK E24: IS OPTION 2 CIRCLED, THIRD PARTY DOES NOT REIMBURSE IN FULL?	YES..... 1 (E25) NO..... 2 (GO TO SECTION F)

E25.	Which of the payment sources does not reimburse in full? (CIRCLE ALL THAT APPLY)	
	1. OWN INCOME OR FAMILY SUPPORT (INCLUDE SOCIAL SECURITY)	..... 1 **FSNOOWNF**
	2. MEDICARE (TITLE XVIII)	..... 2 **FSNOMCAR**
	3. MEDICAID (TITLE XIX)	..... 3 **FSNOMCAD**
	4. VA (VETERANS ADMINISTRATION)	..... 4 **FSNOVA**
	5. PRIVATE HEALTH INSURANCE OR LONG TERM CARE INSURANCE	..... 5 **FSNOPRIV**
	6. SSI (SUPPLEMENTAL SECURITY INCOME)	..... 6 **FSNOSSI**
	7. PAYMENT FOR CONTINUING OR LIFE CARE COMMUNITY	..... 7 **FSNOLIFC**
	91. OTHER SOURCE (SPECIFY)	.....91 (SPECIFY) _____ **FSNOOTHR** **FSNOOS**

GO TO SECTION F, TRACING AND CLOSING

F. TRACING AND CLOSING

BOX F1	REFER TO FLAP REVIEW DISCHARGE DATE AND VITAL STATUS OF SP: a. IS SP IN THIS FACILITY? YES ..... 1 ***BOX F2*** NO ..... 2 (b) b. WAS SP DISCHARGED ALIVE? YES ..... 1 (F1) NO ..... 2 ***BOX F2*** DON'T KNOW ..... -8 (F1)

F1. You told me that (SP) has been discharged from this facility. Where was (SP) discharged to?

SPGODCHG

HOME 1 (F2)
HOSPITAL 2 (F3)
OTHER LONG TERM CARE FACILITY 3 (F3)

SPGODCOS

SOME OTHER PLACE (SPECIFY) 91 (F3)
_____

F2. What is (SP's) home address?

NFACADDR _____
ADDRESS

NFACCITY _____ / _____
NFACST CITY STATE

NFACZIP _____
ZIP

SKIP TO F4

F3. What is the name and address of that place?

NEWFNONE PLACE HAS NO NAME 1
PRIVATE RESIDENCE 2

NFACNAME _____
HOSPITAL/FACILITY NAME

NFACADDR _____
ADDRESS

NFACCITY _____ / _____
NFACST CITY STATE

NFACZIP _____
ZIP

DON'T KNOW ..... -8

F4. Do you have a phone number for that place? IF YES, RECORD NUMBER BELOW.

NFACAREA PHONE # (_____)_____
NFACEXCH DOES NOT HAVE PHONE # 2
NFACLOCL

F5. Please give me the name of a contact at the (facility/home), such as the name of (the administrator/a relative or someone) at the (facility/home).

NFACFNAM _____
NFACMINT CONTACT NAME
NFACLNAM
NFACPREL _____
POSITION/RELATIONSHIP

NO CONTACT NAME KNOWN ..... -8

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BOX F2	a.	REFER TO A8, (PAGE 3): A8 CODED "YES" ..... 1 (c) A8 CODED "NO" ..... 2 (F11) A8 IS BLANK ..... 3 (b)
	b.	REFER TO BASELINE QUESTIONNAIRE - B15 (PAGE 9): B15 CODED "YES" ..... 1 (c) B15 CODED "N0" 2 (F11)
	c.	RECORD DISCHARGE DATE(S) FROM A9/B16 BELOW, AND, FOR EACH PERIOD OF DISCHARGE AND READMISSION ENTERED IN A9/B16, ASK F6-F10.

You told me (SP) was discharged and readmitted from this (facility/home) (# PERIODS IN A9/B16) times between (REF. DATE) and [(DATE IN A2/B2)/today].

		PERIOD 1 DISCHARGE DATE: _____/_____/_____	PERIOD 2 DISCHARGE DATE: _____/_____/_____
F6.	For the time that (SP) was discharged on (A9/B16 DISCHARGE DATE), where was (SP) discharged to? **DCHGPLAC** SPECIFY **DCHGOS**	HOME ..... 1 (F7) HOSPITAL ..... 2 (F8) OTHER LONG TERM CARE FACILITY ..... 3 (F8) SOME OTHER PLACE ..... 91 (F8) _____	HOME ..... 1 (F7) HOSPITAL ..... 2 (F8) OTHER LONG TERM CARE FACILITY ..... 3 (F8) SOME OTHER PLACE ..... 91 (F8) _____
F7.	VERIFY HOME ADDRESS IF RECORDED IN F2. OTHERWISE, ASK: What is (SP's) home address? **DCHGHOME** **DCHGADDR** **DCHGCITY** **DCHGST** **DCHGZIP**	SAME AS F2 1 _____ ADDRESS _____ CITY _____ _____ STATE ZIP GO TO F9	SAME AS F2 1 _____ ADDRESS _____ CITY _____ _____ STATE ZIP GO TO F9

		PERIOD 1 DISCHARGE DATE: _____/_____/_____	PERIOD 2 DISCHARGE DATE: _____/_____/_____
F8.	What is the name and address of that place? **DCHGPRIV** **DCHGPNAM** **DCHGPADR** **DCHGPCTY** **DCHGPST** **DCHGZIP**	PLACE HAS NO NAME ..... 1 PRIVATE RESIDENCE ..... 2 _____ HOSPITAL/FACILITY NAME _____ ADDRESS _____ CITY _____ _____ STATE ZIP DON'T KNOW ..... -8	PLACE HAS NO NAME ..... 1 PRIVATE RESIDENCE ..... 2 _____ HOSPITAL/FACILITY NAME _____ ADDRESS _____ CITY _____ _____ STATE ZIP DON'T KNOW ..... -8
F9.	Do you have a phone number for that place? IF YES, RECORD NUMBER BELOW. **DCHGAREA** **DCHGEXCH, DCHGLOCL** **DCHGNOPH**	(_____ PHONE NUMBER NO PHONE # 2	(_____ PHONE NUMBER NO PHONE # 2
F10.	Please give me the name of a contact at the (facility/home), such as the name of (the administrator/a relative or someone) at the (facility/home). **DCHGFNAM** **DCHGMINT** **DCHGLNAM** **DCHGPREL**	_____ CONTACT NAME _____ POSITION/RELATIONSHIP NO CONTACT NAME KNOWN ..... -8	_____ CONTACT NAME _____ POSITION/RELATIONSHIP NO CONTACT NAME KNOWN ..... -8

BOX F3	COMPLETE F6-F10 FOR EACH DISCHARGE DATE FROM A9/B16, THEN GO TO F11.

COMPLETE F11 - F14 FOR EACH RESPONDENT.			RESPONDENT 1
F11.	Thank you. (ENTER RESPONDENT NAME).	**FRESFNAM** **FRESMINT** **FRESLNAM**	NAME: _____
F12.	What is your job title?	**FRESTITL**	JOB TITLE: _____
F13.	INTERVIEWER: WERE PATIENT RECORDS USED?	**FRESREC**	YES ..... 1 NO..... 2
F14.	INTERVIEWER: WHICH SECTIONS DID RESPONDENT ANSWER? (CIRCLE ALL THAT APPLY)	**FRESSECA, FRESSECB,** **FRESSECD, FRESSECE, FRESSEB4**	A B C D E F B4 - B6

RESPONDENT 2	RESPONDENT 3	RESPONDENT 41
NAME: _____	NAME: _____	NAME: _____
JOB TITLE: _____	JOB TITLE: _____	JOB TITLE: _____
YES ..... 1 NO..... 2	YES ..... 1 NO..... 2	YES ..... 1 NO 2
A B C D E F B4 - B6	A B C D E F B4 - B6	A B C D E F B4 - B6

TIME INTERVIEW ENDED: _____ AM/PM

MRES.FCORETIM

FOLDOUT FLAP

1.	REFERENCE DATE	_____/_____/_____ (MONTH) (DAY) (YEAR)	**MRES.MREFDATE**
2.	ADMISSION DATE	_____/_____/_____ (MONTH) (DAY) (YEAR)	**FRND.ADMINMM, ADMINDD, ADMINYY**
3.	DISCHARGE DATE	_____/_____/_____ (MONTH) (DAY) (YEAR)	**DISCHMM, DISCHDD, DISCHYY**
4.	VITAL STATUS:	ALIVE ..... 1 DECEASED ..... 2 UNKNOWN 3	**VITALS**
5.	END DATE	_____/_____/_____ (MONTH) (DAY) (YEAR)	**FENDDATE**
6.	END BILL DATE	_____/_____/_____ (MONTH) (DAY) (YEAR)	**ENDBILMM, ENDBILDD, ENDBILYY**