

| Variable Name    | MR Screen Name | Question Type | Question Text/Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Code List                                                                                                                                                                                                                                                                                                | Routing                                                                                                                                                                                                                                                                 |
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|                  |                |               | <p><b>HOME HEALTH UTILIZATION QUESTIONNAIRE SPECIFICATIONS</b></p> <p><u>CRITERIA</u><br/>                     INTTYPE=C001, C002, C004, C005, C006, C007, C010<br/>                     SPALIVE=ALL<br/>                     SEASON=ALL<br/>                     SPPROXY=SP or PROXY<br/>                     Other: N/A</p> <p><u>PLACEMENT</u><br/>                     If INTTYPE in (C001, C002, C004, C005, C006, C007, C010) administer after IUQ.</p>                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                         |
| HHPRPROF         | HH1            | yes/no        | <p>SHOW CARD HH1</p> <p>(At the time of the last interview, [you/(SP)] indicated that [you/(she/he)] had been helped at home by a health or medical professional.)</p> <p>[(Since/since) (REFERENCE DATE/UTILDATE)/(Between/between) (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)], [have you been/has (SP) been/was (SP)] helped at home by any (other) health or medical professionals, such as those listed on this card? (This may include health or medical professionals reported in prior interviews.)</p> <p>[Health professionals include nurse (visiting nurse, private duty nurse, etc.), doctor, social worker, therapist, hospice worker, home health aides, and those who provide homemaker services.]</p> | (01) YES<br>(02) NO<br>(03) INDICATED YES BY DATAPREP. DO NOT DISPLAY. DATA EDITING ONLY.<br>(-8) DON'T KNOW<br>(-9) REFUSED                                                                                                                                                                             | (01) HH4-PROFWORK<br>(02) HH18 - HHPRFRND<br>(03) DO NOT DISPLAY. DATA EDITING ONLY.<br>(-8) HH18 - HHPRFRND<br>(-9) HH18 - HHPRFRND                                                                                                                                    |
| PROFWORK         | HH4            | code one      | <p>Does this health or medical professional work for a place or organization?</p> <p>[PROBE: Or does this health or medical professional work for himself/herself?]</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (01) WORKS FOR ORGANIZATION<br>(02) WORKS FOR SELF<br>(-8) DON'T KNOW<br>(-9) REFUSED                                                                                                                                                                                                                    | (01) HH5-PROVIDER_HHPORG<br>(02) HH2-PROVIDER_HHP<br>(-8) HH2-PROVIDER_HHP<br>(-9) HH2-PROVIDER_HHP                                                                                                                                                                     |
| PROVIDER_HHP ORG | HH5            | roster        | <p>What is the name of the home health place or organization who helped [you/(SP)] at home [since (REFERENCE DATE/UTILDATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)]?</p> <p>[PROBE: Who would (you/SP) call if the home health provider did not show up?]</p> <p>ADD OR SELECT ONLY ONE PROVIDER.</p> <p>ENTER THE NAME OF THE PLACE OR ORGANIZATION RATHER THAN AN INDIVIDUAL PROVIDER.</p> <p>ONLY SELECT "NEED TO EDIT SPELLING OF EXISTING PROVIDER" IF YOU ARE CURRENTLY ENTERING AN EVENT WITH THAT PROVIDER.</p> <p>[DO NOT ADD A NEW ROSTER ENTRY IF A DIFFERENT PERSON CAME FROM AN ORGANIZATION ALREADY LISTED ON THE ROSTER.]</p>                                                | (01) CONTINUOUS ANSWER<br><br>[DISPLAY PROVIDER ROSTER AS RESPONSE OPTIONS:<br>1. [PROVIDER 1]<br>2. [PROVIDER 2]<br>...<br>N. [PROVIDER N]<br>N+1. ADD ANOTHER<br>N+2. NEED TO EDIT SPELLING OF EXISTING PROVIDER<br>DISPLAY PROVIDER NAME, SPECIALITY, GROUP NAME FOR ALL PROVIDERS WHERE PROVNUM>02.] | (01-N) BOX HH1AAA<br>(N+1) PROVNAME-HH5<br>(N+2) CHNGSPL-CHNGSPL<br><br>IF EXISTING PROVIDER SELECTED, GO TO BOX HH1AAA.<br>ELSE IF "ADD ANOTHER" SELECTED, GO TO PROVNAME-HH5<br>ELSE IF "NEED TO EDIT SPELLING OF EXISTING PROVIDER" SELECTED, GO TO CHNGSPL-CHNGSPL. |
| PROVNAME         | HH5            | verbatim      | <p>[PROVIDER LOOKUP CALLED FROM THIS SCREEN]</p> <p>ENTER THE NAME OF THE PLACE OR ORGANIZATION RATHER THAN AN INDIVIDUAL PROVIDER.</p> <p>[DO NOT ADD A NEW ROSTER ENTRY IF A DIFFERENT PERSON CAME FROM AN ORGANIZATION ALREADY LISTED ON THE ROSTER.]</p> <p>YOU CAN CONSULT THE RESPONDENT'S STATEMENTS AND APPOINTMENT CARDS TO ENSURE THE PROVIDER NAME IS ENTERED CORRECTLY.</p> <p>NAME:</p>                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                          | BOX HH1AAA                                                                                                                                                                                                                                                              |

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| CHNGSPL       | CHNGSPL        | roster        | <p>WHICH PROVIDER IS MISPELLED?</p> <p>THIS SCREEN IS ONLY FOR CORRECTING MISPELLINGS. TO ADD A NEW PROVIDER, BACK UP AND SELECT "ADD ANOTHER."</p> <p>ONLY SELECT A PROVIDER IF YOU ARE CURRENTLY ENTERING AN EVENT WITH THAT PROVIDER. IF YOU ARE NOT CURRENTLY ENTERING AN EVENT WITH A MISPELLED PROVIDER, BACK UP TO SELECT OR ADD THE PROVIDER THE RESPONDENT SAW DURING THIS EVENT.</p>                                          | <p>[DISPLAY PROVIDER ROSTER AS RESPONSE OPTIONS:<br/>1. [PROVIDER 1]<br/>2. [PROVIDER 2]<br/>...<br/>N. [PROVIDER N]</p> <p>DISPLAY PROVIDER NAME, SPECIALITY, GROUP NAME FOR ALL PROVIDERS WHERE PROVNUM&gt;02.</p>                               | CRCTSPL-CRCTSPL                                                                                                                                                                                                                                                                   |
| CRCTSPL       | CRCTSPL        | verbatim      | <p>WHAT IS THE CORRECT SPELLING OF THIS PROVIDER'S NAME?</p> <p>THIS SCREEN IS ONLY FOR CORRECTING MISPELLINGS. TO ADD A NEW PROVIDER, BACK UP AND SELECT "ADD ANOTHER."<br/>[DISPLAY PROVIDER SELECTED AT CHNGSPL-CHNGSPL]</p> <p>NAME:</p>                                                                                                                                                                                            | (01) [Continuous Answer]                                                                                                                                                                                                                           | BOX HH1AAA                                                                                                                                                                                                                                                                        |
| PROVIDER_HHP  | HH2            | roster        | <p>What is the name of the health professional who helped [you/(SP)] at home [since (REFERENCE DATE/UTLDATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)]?</p> <p>ENTER NAME OF PERSON WHO HELPED. DO NOT ENTER THE NAME OF PLACE OR ORGANIZATION.</p> <p>ONLY SELECT "NEED TO EDIT SPELLING OF EXISTING PROVIDER" IF YOU ARE CURRENTLY ENTERING AN EVENT WITH THAT PROVIDER.</p> | <p>(01) CONTINUOUS ANSWER</p> <p>[DISPLAY PROVIDER ROSTER AS RESPONSE OPTIONS:<br/>1. [PROVIDER 1]<br/>2. [PROVIDER 2]<br/>...<br/>N. [PROVIDER N]</p> <p>DISPLAY PROVIDER NAME, SPECIALITY, GROUP NAME FOR ALL PROVIDERS WHERE PROVNUM&gt;02.</p> | <p>(01-N) BOX HH1AAA<br/>(N+1) PROVNAME-HH2<br/>(N+2) CHNGSPL-CHNGSPL</p> <p>IF EXISTING PROVIDER SELECTED, GO TO BOX HH1AAA<br/>ELSE IF "ADD ANOTHER" SELECTED, GO TO PROVNAME-HH2<br/>ELSE IF "NEED TO EDIT SPELLING OF EXISTING PROVIDER" SELECTED, GO TO CHNGSPL-CHNGSPL.</p> |
| PROVNAME      | HH2            | verbatim      | <p>[PROVIDER LOOKUP CALLED FROM THIS SCREEN]</p> <p>ENTER NAME OF PERSON WHO HELPED. DO NOT ENTER THE NAME OF PLACE OR ORGANIZATION.</p> <p>YOU CAN CONSULT THE RESPONDENT'S STATEMENTS AND APPOINTMENT CARDS TO ENSURE THE PROVIDER NAME IS ENTERED CORRECTLY.</p> <p>NAME:</p>                                                                                                                                                        |                                                                                                                                                                                                                                                    | BOX HH1AAA                                                                                                                                                                                                                                                                        |
| CHNGSPL       | CHNGSPL        | roster        | <p>WHICH PROVIDER IS MISPELLED?</p> <p>THIS SCREEN IS ONLY FOR CORRECTING MISPELLINGS. TO ADD A NEW PROVIDER, BACK UP AND SELECT "ADD ANOTHER."</p> <p>ONLY SELECT A PROVIDER IF YOU ARE CURRENTLY ENTERING AN EVENT WITH THAT PROVIDER. IF YOU ARE NOT CURRENTLY ENTERING AN EVENT WITH A MISPELLED PROVIDER, BACK UP TO SELECT OR ADD THE PROVIDER THE RESPONDENT SAW DURING THIS EVENT.</p>                                          | <p>[DISPLAY PROVIDER ROSTER AS RESPONSE OPTIONS:<br/>1. [PROVIDER 1]<br/>2. [PROVIDER 2]<br/>...<br/>N. [PROVIDER N]</p> <p>DISPLAY PROVIDER NAME, SPECIALITY, GROUP NAME FOR ALL PROVIDERS WHERE PROVNUM&gt;02.</p>                               | CRCTSPL-CRCTSPL                                                                                                                                                                                                                                                                   |
| CRCTSPL       | CRCTSPL        | verbatim      | <p>WHAT IS THE CORRECT SPELLING OF THIS PROVIDER'S NAME?</p> <p>THIS SCREEN IS ONLY FOR CORRECTING MISPELLINGS. TO ADD A NEW PROVIDER, BACK UP AND SELECT "ADD ANOTHER."<br/>[DISPLAY PROVIDER SELECTED AT CHNGSPL-CHNGSPL]</p> <p>NAME:</p>                                                                                                                                                                                            | (01) [Continuous Answer]                                                                                                                                                                                                                           | BOX HH1AAA                                                                                                                                                                                                                                                                        |
|               | BOX HH1AAA     | routing       | IF (HOME HEALTH PROVIDER WAS ADDED AT HH2 OR HH5) OR (AN EXISTING PROVIDER WAS SELECTED AT HH2 OR HH5 THAT WAS NOT ASSOCIATED WITH A HOME HEALTH EVENT), GO TO HH3 - PROVSPEC. ELSE GO TO BOX HH1BBB.                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                   |

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|---------------|----------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PROVSPEC      | HH3            | code one      | <p>What kind of health professional [is (PROVIDER NAME)/did [you/(SP)] see from (PROVIDER NAME)]?</p> <p>[SELECT THE RESPONSE CATEGORY FOR A GIVEN SPECIALTY ONLY IF THE RESPONDENT SPECIFICALLY NAMES THE LISTED SPECIALTY OR MENTIONS THE WORDS OR INITIALS IN PARENTHESES FOLLOWING THAT PROVIDER SPECIALTY. IF THE RESPONDENT NAMES A MEDICAL SPECIALTY NOT LISTED BELOW, BUT LISTED ON MPQ JOB AID 1, SUCH AS 'CARDIOLOGY,' SELECT 'MEDICAL DOCTOR.']</p> | (01) DENTIST/DENTAL PROVIDER<br>(02) MEDICAL DOCTOR<br>(03) AUDIOLOGIST<br>(04) CHIROPRACTOR<br>(05) CLINICAL SOCIAL WORKER<br>(06) DIETITIAN-NUTRITIONIST<br>(07) HEARING THERAPIST<br>(08) HOME HEALTH/HEALTH AIDE<br>(09) HOMEMAKER<br>(10) HOSPICE WORKER<br>(11) I.V. THERAPIST<br>(12) NURSE (RN)<br>(13) NURSE PRACTITIONER<br>(14) NURSE'S AIDE<br>(15) OCCUPATIONAL THERAPIST (OT)<br>(16) OPTOMETRIST (OD)<br>(17) OSTEOPATH (DO)<br>(18) PARAMEDIC<br>(19) PHYSICAL THERAPIST (PT)<br>(20) PHYSICIAN'S ASSISTANT<br>(21) PODIATRIST (FOOT DOCTOR)<br>(22) PSYCHOLOGIST<br>(23) RESPIRATORY THERAPIST<br>(24) SOCIAL/CASE WORKER<br>(25) SPEECH THERAPIST<br>(26) THERAPIST (MENTAL HEALTH)<br>(27) X-RAY TECHNICIAN<br>(28) LICENSED PRACTICAL NURSE (LPN)<br>(29) ACUPUNCTURIST<br>(30) HOMEOPATH<br>(31) MASSAGE THERAPIST<br>(32) NATUROPATH<br>(33) LICENSED PROFESSIONAL COUNSELOR [LPC]<br>(34) LAB TECHNICIAN<br>(91) OTHER MEDICAL PROVIDER SPECIALTY<br>(-8) DON'T KNOW<br>(-9) REFUSED | (01)-(34), (-8), (-9) BOX HH1AA<br>(91) HH3 - PROVSPoS                                                                                                                                                                                                         |
| PROVSPOS      | HH3            | text          | OTHER MEDICAL PROVIDER (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | BOX HH1AA                                                                                                                                                                                                                                                      |
|               | BOX HH1AA      | routing       | IF HH4 -PROFWORK = 1/Works for Organization, SET HOME HEALTH PROVIDER FOR THIS VISIT TO THE HOME HEALTH ORGANIZATION SELECTED AT HH5, AND GO TO HH6 - HHPLACE. ELSE SET HOME HEALTH PROVIDER FOR THIS VISIT TO THE PROVIDER SELECTED AT HH2, HH19, ST27 OR NS27, AND GO TO BOX HH1BB.                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                |
| HHPLACE       | HH6            | code one      | <p>PROVIDER NAME: (PROVIDER NAME)</p> <p>What kind of place or organization is (PROVIDER NAME)?</p>                                                                                                                                                                                                                                                                                                                                                            | (01) MANAGED CARE PLAN (SUCH AS HMO)<br>(02) MEAL PROGRAM (SUCH AS MEALS ON WHEELS)<br>(03) VISITING NURSE ASSOCIATION<br>(04) HOME HEALTH AGENCY<br>(05) HOSPITAL<br>(06) PRIVATE PHYSICIAN/GROUP PRACTICE<br>(07) HOSPICE<br>(08) REHABILITATION OR SPORTS MEDICINE THERAPY<br>(09) LOCAL GOVERNMENT ORGANIZATION<br>(10) CHURCH OR COMMUNITY ORGANIZATION<br>(11) ASSISTED LIVING/RETIREMENT HOME<br>(91) OTHER (SPECIFY)<br>(-8) DON'T KNOW<br>(-9) REFUSED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (01) BOX HH1BB<br>(02) BOX HH1BBB<br>(03) BOX HH1BB<br>(04) BOX HH1BB<br>(05) BOX HH1BB<br>(06) BOX HH1BB<br>(07) BOX HH1BB<br>(08) BOX HH1BB<br>(09) BOX HH1BB<br>(10) BOX HH1BB<br>(11) BOX HH1BB<br>(91) HH6 - HHPLACOS<br>(-8) BOX HH1BB<br>(-9) BOX HH1BB |
| HHPLACOS      | HH6            | text          | OTHER (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                                                | (01) CONTINUOUS ANSWER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                |
|               | BOX HH1BBB     | routing       | SET HOME HEALTH PROVIDER FOR THIS VISIT TO THE PROVIDER SELECTED AT HH2, HH5, OR HH19. IF TYPE OF HOME HEALTH PROVIDER ORGANIZATION IS A MEAL PROGRAM, GO TO HH7 - OTHMEALS. ELSE GO TO BOX HH1BB.                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                |
| OTHMEALS      | HH7            | yes/no        | [Between (REFERENCE DATE/UTILDATE) and (today/DATE OF DEATH/ DATE OF INSTITUTIONALIZATION/ENDUTILD)], did (PROVIDER NAME) provide any services to [you/(SP)] other than delivering meals?                                                                                                                                                                                                                                                                      | (01) YES<br>(02) NO<br>(-8) DON'T KNOW<br>(-9) REFUSED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | BOX HH1BB                                                                                                                                                                                                                                                      |

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|               | BOX HH1BB      | routing       | IF TYPE OF HOME HEALTH PROVIDER IS A MEAL PROGRAM THAT DID NOT PROVIDE ANY OTHER SERVICES BESIDES MEALS, GO TO BOX HH3.<br>ELSE IF (HOME HEALTH PROVIDER IS A FRIEND OR RELATIVE) OR (TYPE OF HOME HEALTH PROVIDER IS A LOCAL GOVERNMENT, CHURCH OR COMMUNITY ORGANIZATION), GO TO HH11-EVENT.<br>ELSE GO TO BOX HH1.                                                                                                                                                                                                   |                                                                      |                                                                                             |
|               | BOX HH1        | routing       | IF (SP REPORTED RECEIVING HEALTH CARE SERVICES THROUGH V.A. IN THE CURRENT ROUND OR ANY PREVIOUS ROUND) AND (IF THIS PROVIDER IS ASSOCIATED WITH V.A. IS UNKNOWN), GO TO HH8 - VAPLACE.<br>ELSE GO TO BOX HH1A.                                                                                                                                                                                                                                                                                                         |                                                                      |                                                                                             |
| VAPLACE       | HH8            | yes/no        | Is [(PROVIDER NAME) associated with/(PROVIDER NAME)] a Department of Veterans Affairs, or V.A., facility?                                                                                                                                                                                                                                                                                                                                                                                                               | (01) YES<br>(02) NO<br>(-8) DON'T KNOW<br>(-9) REFUSED               | BOX HH1A                                                                                    |
|               | BOX HH1A       | routing       | IF (SP COVERED BY A MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND) AND (IF THIS PROVIDER IS ASSOCIATED WITH A MANAGED CARE PLAN IS UNKNOWN), GO TO HH10A - HMOASSOC.<br>ELSE IF (SP COVERED BY A MANAGED CARE PLAN ANYTIME DURING THE CURRENT ROUND) AND (THIS PROVIDER IS NOT ASSOCIATED WITH A MANAGED CARE PLAN), GO TO HH10B - HMOREFER.<br>ELSE GO TO HH11-EVENT.                                                                                                                                             |                                                                      |                                                                                             |
| HMOASSOC      | HH10A          | yes/no        | Is (PROVIDER NAME) associated with [your/(SP's)] [READ MANAGED CARE PLAN NAME(S) BELOW] plan?                                                                                                                                                                                                                                                                                                                                                                                                                           | (01) YES<br>(02) NO<br>(-8) DON'T KNOW<br>(-9) REFUSED               | (01) HH11- EVENT<br>(02) HH10B - HMOREFER<br>(-8) HH10B - HMOREFER<br>(-9) HH10B - HMOREFER |
| HMOREFER      | HH10B          | yes/no        | [Were you/Was (SP)] referred to (PROVIDER NAME) by [READ MANAGED CARE PLAN NAME(S) BELOW]?<br>[INCLUDE REFERRALS BY THE RESPONDENT'S PRIMARY CARE PHYSICIAN (PCP).]                                                                                                                                                                                                                                                                                                                                                     | (01) YES<br>(02) NO<br>(-8) DON'T KNOW<br>(-9) REFUSED               | HH11 -EVENT                                                                                 |
| EVENT         | HH11           | roster        | When did [you/(SP)] see [(PROVIDER NAME)/(someone from (PROVIDER NAME))]? Please tell me all the dates [since (REFERENCE DATE/UTILDATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)].<br>ENTER ALL DATES.<br><br>[IF THE RESPONDENT SAW THE SAME PROVIDER TWICE ON THE SAME DAY, ENTER THE DATE ONLY ONCE.]<br><br>IF R HAD 5 OR MORE VISITS FROM THIS PROVIDER DURING THIS REFERENCE PERIOD, SELECT "REPEAT VISITS" AND LEAVE THE DAY FIELD BLANK. ENTER EACH MONTH SEPARATELY. | (01) [Continuous answer.]                                            | HH12-HPADD                                                                                  |
| HPADD         | HH12           | choose one    | HAVE ALL DATES BEEN ENTERED?<br><br>[DISPLAY ALL EVENTS ASSOCIATED WITH THIS PROVIDER]                                                                                                                                                                                                                                                                                                                                                                                                                                  | (01) ADD ANOTHER<br>(02) ALL DONE                                    | (01) HH11 -EVENT<br>(02) HH13-NEEDNURS                                                      |
| NEEDNURS      | HH13           | yes/no        | SHOW CARD HH2<br><br>(Generally speaking, did/Generally speaking, does)[(PROVIDER NAME)/someone from (PROVIDER NAME)] help [you/(SP)] by giving any medical or nursing treatment, such as the things shown on this card? ["MEDICAL OR NURSING TREATMENT" MEANS SUCH THINGS AS APPLYING STERILE BANDAGES OR DRESSINGS, GIVING MEDICATIONS, TAKING BLOOD PRESSURE, GIVING SHOTS OR INJECTIONS.]<br><br>[PROBE: We just need to know in general.]                                                                          | (01) YES, AT LEAST ONE<br>(02) NO<br>(-8) DON'T KNOW<br>(-9) REFUSED | HH14 - NEEDMEAL                                                                             |
| NEEDMEAL      | HH14           | yes/no        | SHOW CARD HH3<br><br>(Generally speaking, did/Generally speaking, does) [(PROVIDER NAME)/someone from (PROVIDER NAME)] help with [your/(SP's)] daily needs by doing things, such as the ones shown on this card? [HELP WITH DAILY NEEDS MEANS HELP IN USING THE TELEPHONE, DOING HOUSEWORK, PREPARING MEALS.]<br><br>[PROBE: We just need to know in general.]                                                                                                                                                          | (01) YES, AT LEAST ONE<br>(02) NO<br>(-8) DON'T KNOW<br>(-9) REFUSED | HH15 - NEEDCARE                                                                             |
| NEEDCARE      | HH15           | yes/no        | SHOW CARD HH4<br><br>(Generally speaking, did/Generally speaking, does) [(PROVIDER NAME)/someone from (PROVIDER NAME)] help with [your/(SP's)] personal care by doing things such as those shown on this card? [HELP WITH PERSONAL CARE MEANS HELP WITH BATHING, SHOWERING, DRESSING, EATING, WALKING, USING THE TOILET.]<br><br>[PROBE: We just need to know in general.]                                                                                                                                              | (01) YES, AT LEAST ONE<br>(02) NO<br>(-8) DON'T KNOW<br>(-9) REFUSED | BOX HH2                                                                                     |

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|               | BOX HH2        | routing       | IF EXISTING PROVIDER SELECTED at HH2-PROVIDER_HHP, HH5-PROVIDER_HHPORG, HH19-PROVIDER_HHF, or ST13-PROVIDER_STDATE, GO TO BOX HH3.<br>ELSE IF "ADD ANOTHER" SELECTED at HH2-PROVIDER_HHP, HH5-PROVIDER_HHPORG, HH19-PROVIDER_HHF, or ST13-PROVIDER_STDATE, GO TO HH15A-ATNDPHYS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                        |
| ATNDPHYS      | HH15A          | text          | To be eligible for Medicare home health services, a beneficiary must be under the care of a physician who decides home health services are necessary.<br><br>What is the complete name of the physician who determined that [you/SP] should receive home health services?<br><br>[IF NEEDED: This physician can also be referred to as the attending physician.]<br><br>[IF THE RESPONDENT DOES NOT RECEIVE HOME HEALTH SERVICES THROUGH MEDICARE, SELECT NOT APPLICABLE. IF THE RESPONDENT DOES NOT KNOW THE NAME OF THE PHYSICIAN, SELECT DON'T KNOW.]<br><br>[ENCOURAGE THE RESPONDENT TO REFER TO A BILL, TELEPHONE DIRECTORY, APPOINTMENT CARD, ETC., FOR COMPLETE INFORMATION.]                                                                                       | [DISPLAY PROVIDER ROSTER AS RESPONSE OPTIONS:<br>1. [PROVIDER 1]<br>2. [PROVIDER 2]<br><br>(01) continuous answer<br>(996) NOT APPLICABLE/RESPONDENT DOES NOT RECEIVE HOME HEALTH SERVICES THROUGH MEDICARE<br>(-8) Don't Know<br>(-9) Refused<br><br>DISPLAY PROVIDER NAME, SPECIALITY, GROUP NAME FOR ALL PROVIDERS WHERE PROVNUM>02. | BOX HH3                                                                                                                                                                                                                                                                |
|               | BOX HH3        | routing       | IF CURRENTLY ADMINISTERING ST, GO TO BOX ST23B.<br>ELSE IF CURRENTLY ADMINISTERING NS, GO TO BOX NS33.<br>ELSE IF CURRENTLY ASKING ABOUT HOME HEALTH FRIENDS OR FAMILY, GO TO HH28-HHFMORE.<br>ELSE IF HOME HEALTH PROVIDER WORKED FOR SELF, GO TO HH16 - HHPMORE.<br>ELSE GO TO HH17 - HHPOMORE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                        |
| HHPMORE       | HH16           | yes/no        | [Since (REFERENCE DATE/UTILDATE)/Between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)], [have you been/has (SP) been/was (SP)] helped at home by any other health professionals?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (01) YES<br>(02) NO<br>(-8) DON'T KNOW<br>(-9) REFUSED                                                                                                                                                                                                                                                                                  | (01)HH4 -PROFWORK<br>(02) HH18 - HHPFRND<br>(-8) HH18 - HHPFRND<br>(-9) HH18 - HHPFRND                                                                                                                                                                                 |
| HHPOMORE      | HH17           | yes/no        | Other than the persons who (have) visited [you/(SP)] from (PROVIDER NAME) [or from the other(s) we've talked about], [have you been/has (SP) been/was (SP)] helped at home by any other health professionals [since (REFERENCE DATE/UTILDATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)]?<br><br>[DON'T INCLUDE ANY OTHER PERSONS COMING FROM THE SAME ORG/ AGENCY LISTED BELOW]                                                                                                                                                                                                                                                                                                                                                   | (01) YES<br>(02) NO<br>(-8) DON'T KNOW<br>(-9) REFUSED                                                                                                                                                                                                                                                                                  | (01) HH4-PROFWORK<br>(02) HH18 - HHPFRND<br>(-8) HH18 - HHPFRND<br>(-9) HH18 - HHPFRND                                                                                                                                                                                 |
| HHPFRND       | HH18           | yes/no        | SHOW CARD HH5<br><br>(At the time of the last interview, [you/(SP)] indicated that, because of health problems, [you/(she/he)] had received personal care or help at home with daily needs from a person who did not live with [you/(her/him)].)<br><br>(Besides what you have already talked about, [(Since/since) (REFERENCE DATE/UTILDATE)/(Between/between) (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)], because of health problems [have you/has (SP)/did (SP)] (received/receive) any personal care or help at home with daily needs from (any other) persons who (do/did) not live with (you/him/her), including friends, neighbors, or relatives? (This may include friends, neighbors, or relatives reported in prior interviews.) | (01) YES<br>(02) NO<br>(03) INDICATED YES BY DATAPREP DO NOT DISPLAY. DATA EDITING ONLY.<br>(-8) DON'T KNOW<br>(-9) REFUSED                                                                                                                                                                                                             | (01) HH19 - PROVIDER_HHF<br>(02) BOX HH7<br>(03) DO NOT DISPLAY. DATA EDITING ONLY.<br>(-8) BOX HH7<br>(-9) BOX HH7                                                                                                                                                    |
| PROVIDER_HHF  | HH19           | roster        | Who helped [you/(SP)]? What is the name of the person who helped (you/him/her)?<br>ENTER NAME OF PERSON WHO HELPED.<br><br>[SELECT OR ADD ONLY ONE PERSON. DO NOT ENTER A PERSON WHO LIVES WITH THE SP.]<br><br>ONLY SELECT "NEED TO EDIT SPELLING OF EXISTING PROVIDER" IF YOU ARE CURRENTLY ENTERING AN EVENT WITH THAT PROVIDER.                                                                                                                                                                                                                                                                                                                                                                                                                                         | (01) CONTINUOUS ANSWER<br><br>[DISPLAY PROVIDER ROSTER AS RESPONSE OPTIONS:<br>1. [PROVIDER 1]<br>2. [PROVIDER 2]<br>...<br>N. [PROVIDER N]<br><br>DISPLAY PROVIDER NAME, SPECIALITY, GROUP NAME FOR ALL PROVIDERS WHERE PROVNUM>02                                                                                                     | (01-N) BOX HH3AA<br>(N+1) PROVNAME-HH19<br>(N+2) CHNGSPL-CHNGSPL<br><br>IF EXISTING PROVIDER SELECTED, GO TO BOX HH3AA<br>ELSE IF "ADD ANOTHER" SELECTED, GO TO PROVNAME-HH19<br>ELSE IF "NEED TO EDIT SPELLING OF EXISTING PROVIDER" SELECTED, GO TO CHNGSPL-CHNGSPL. |
| PROVNAME      | HH19           | verbatim      | [PROVIDER LOOKUP CALLED FROM THIS SCREEN]<br><br>ENTER NAME OF PERSON WHO HELPED. DO NOT ENTER THE NAME OF THE PLACE OR ORGANIZATION.<br><br>NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                         | BOX HH3AA                                                                                                                                                                                                                                                              |

| Variable Name | MR Screen Name | Question Type | Question Text/Description                                                                                                                                                                                                                                                                                                                                                               | Code List                                                                                                                                                                                                                                                                                                                                                                                                                  | Routing                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------|----------------|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CHNGSPL       | CHNGSPL        | roster        | WHICH PROVIDER IS MISPELLED?<br><br>THIS SCREEN IS ONLY FOR CORRECTING MISPELLINGS. TO ADD A NEW PROVIDER, BACK UP AND SELECT "ADD ANOTHER."<br><br>ONLY SELECT A PROVIDER IF YOU ARE CURRENTLY ENTERING AN EVENT WITH THAT PROVIDER. IF YOU ARE NOT CURRENTLY ENTERING AN EVENT WITH A MISPELLED PROVIDER, BACK UP TO SELECT OR ADD THE PROVIDER THE RESPONDENT SAW DURING THIS EVENT. | [DISPLAY PROVIDER ROSTER AS RESPONSE OPTIONS:<br>1. [PROVIDER 1]<br>2. [PROVIDER 2]<br>...<br>N. [PROVIDER N]<br><br>DISPLAY PROVIDER NAME, SPECIALITY, GROUP NAME FOR ALL PROVIDERS WHERE PROVNUM>02.                                                                                                                                                                                                                     | CRCTSPL-CRCTSPL                                                                                                                                                                                                                                                                                                                                                                                                                  |
| CRCTSPL       | CRCTSPL        | verbatim      | WHAT IS THE CORRECT SPELLING OF THIS PROVIDER'S NAME?<br><br>THIS SCREEN IS ONLY FOR CORRECTING MISPELLINGS. TO ADD A NEW PROVIDER, BACK UP AND SELECT "ADD ANOTHER."<br>[DISPLAY PROVIDER SELECTED AT CHNGSPL-CHNGSPL]<br><br>NAME:                                                                                                                                                    | (01) [Continuous Answer]                                                                                                                                                                                                                                                                                                                                                                                                   | BOX HH3AA                                                                                                                                                                                                                                                                                                                                                                                                                        |
|               | BOX HH3AA      | routing       | IF (HOME HEALTH PROVIDER WAS ADDED AT HH19) OR (AN EXISTING PROVIDER WAS SELECTED AT HH19 THAT WAS NOT ASSOCIATED WITH A HOME HEALTH EVENT), GO TO HH20 - HHFTYPE. ELSE GO TO BOX HH1BBB.                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| HHFTYPE       | HH20           | code one      | Is (PROVIDER NAME) a friend, neighbor, or a relative?                                                                                                                                                                                                                                                                                                                                   | (01) FRIEND OR NEIGHBOR<br>(02) RELATIVE<br>(-8) DON'T KNOW<br>(-9) REFUSED                                                                                                                                                                                                                                                                                                                                                | (01) BOX HH1AA<br>(02) HH21 - HHFRELAT<br>(-8) BOX HH1AA<br>(-9) BOX HH1AA                                                                                                                                                                                                                                                                                                                                                       |
| HHFRELAT      | HH21           | code one      | How is (PROVIDER NAME) related to [you/(SP)]?<br>[CLASSIFY ANY "STEP" RELATIONSHIP WITH THE RELATED "NON-STEP" RELATIONSHIP (E.G., STEP-DAUGHTER = DAUGHTER).]                                                                                                                                                                                                                          | (02) SPOUSE<br>(03) SON<br>(04) DAUGHTER<br>(05) BROTHER<br>(06) SISTER<br>(07) FATHER<br>(08) MOTHER<br>(09) SON-IN-LAW<br>(10) DAUGHTER-IN-LAW<br>(11) GRANDSON<br>(12) GRANDDAUGHTER<br>(13) NEPHEW<br>(14) NIECE<br>(51) FRIEND/NEIGHBOR<br>(52) BOARDER<br>(53) NURSE/NURSE'S AIDE<br>(54) LEGAL/FINANCIAL OFFICER<br>(55) GUARDIAN<br>(56) PARTNER<br>(57) ROOMMATE<br>(91) OTHER<br>(-8) DON'T KNOW<br>(-9) REFUSED | (02) BOX HH1AA<br>(03) BOX HH1AA<br>(04) BOX HH1AA<br>(05) BOX HH1AA<br>(06) BOX HH1AA<br>(07) BOX HH1AA<br>(08) BOX HH1AA<br>(09) BOX HH1AA<br>(10) BOX HH1AA<br>(11) BOX HH1AA<br>(12) BOX HH1AA<br>(13) BOX HH1AA<br>(14) BOX HH1AA<br>(51) BOX HH1AA<br>(52) BOX HH1AA<br>(53) BOX HH1AA<br>(54) BOX HH1AA<br>(55) BOX HH1AA<br>(56) BOX HH1AA<br>(57) BOX HH1AA<br>(91) HH21 - HHFRELOS<br>(-8) BOX HH1AA<br>(-9) BOX HH1AA |
| HHFRELOS      | HH21           | text          | OTHER (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                         | (01) CONTINUOUS ANSWER                                                                                                                                                                                                                                                                                                                                                                                                     | BOX HH1AA                                                                                                                                                                                                                                                                                                                                                                                                                        |
| HHFMORE       | HH28           | yes/no        | [Since (REFERENCE DATE/UTLDATE)/Between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/ENDUTILD)], [have you/has (SP)/did (SP)] (received/receive) personal care or help at home with daily needs from any other persons who (do/did) not live with (you/him/her)?                                                                                                    | (01) YES<br>(02) NO<br>(-8) DON'T KNOW<br>(-9) REFUSED                                                                                                                                                                                                                                                                                                                                                                     | (01) HH19 - PROVIDER_HHF<br>(02) BOX HH7<br>(-8) BOX HH7<br>(-9) BOX HH7                                                                                                                                                                                                                                                                                                                                                         |
|               | BOX HH7        | routing       | GO TO MPQ.                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                  |