

HOME CARE PAGE

Some people are limited in what they can do because of a physical or mental condition; that is, they cannot do some of the daily activities that other people do.

Person number	Activity	Doesn't do	If "doesn't do," go to next line. Does -- use any SPECIAL EQUIPMENT in (activity)?	Does -- receive or need the help of ANOTHER PERSON in (activity)?	Does -- need help from another person in (activity) most of the time, some of the time, or once in a while?
(a)	(b)	(c)	(d)	(e)	(f)
	(1) Walking, except for using stairs?	<input type="checkbox"/> Doesn't do (Mark H box, THEN 1c)	1 Y 2 N	1 Y 2 N (Next line)	1 <input type="checkbox"/> All/most 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Once 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Other - Specify
	(2) Going outside?	<input type="checkbox"/> Doesn't do (Mark H box, THEN 1c)	1 Y 2 N	1 Y 2 N (Next line)	1 <input type="checkbox"/> All/most 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Once 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Other - Specify
	(3) Using the toilet in the bathroom, including getting to the bathroom?	<input type="checkbox"/> Doesn't do (Mark H box, THEN 1c)	1 Y 2 N	1 Y 2 N (Next line)	1 <input type="checkbox"/> All/most 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Once 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Other - Specify
	(4) Bathing, including sponge baths?	<input type="checkbox"/> Doesn't do (Mark H box, THEN 1c)	1 Y 2 N	1 Y 2 N (Next line)	1 <input type="checkbox"/> All/most 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Once 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Other - Specify
	(5) Dressing?	<input type="checkbox"/> Doesn't do (Mark H box, THEN 1c)	1 Y 2 N	1 Y 2 N (Next line)	1 <input type="checkbox"/> All/most 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Once 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Other - Specify
	(6) Eating?	<input type="checkbox"/> Doesn't do (Mark H box, THEN 1c)	1 Y 2 N	1 Y 2 N (Next line)	1 <input type="checkbox"/> All/most 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Once 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Other - Specify
	(7) Getting in and out of bed or chairs?	<input type="checkbox"/> Doesn't do (Mark H box, THEN 1c)	1 Y 2 N	1 Y 2 N (Next line)	1 <input type="checkbox"/> All/most 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Once 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Other - Specify

If "Yes," ask 1b and c "doesn't do" Y or N

1a. Because of a disability or health problem, does anyone in the family, (that is you, your --, etc.), receive or need help from another person, or use special equipment in --

b. Who is this?

c. Does anyone else receive or need help or use special equipment in -- ?

2a. BECAUSE OF A DISABILITY OR HEALTH PROBLEM, does anyone in the family receive or need help from another person in --

If "Yes," ask 2b and c.

b. Who is this?

c. Does anyone else receive or need help in -- ?

(1) Preparing their own meals?	<input type="checkbox"/> Y <input type="checkbox"/> N
(2) Shopping for personal items, such as magazines, toilet items, or medicines?	<input type="checkbox"/> Y <input type="checkbox"/> N
(3) Doing routine household chores, not including yard work?	<input type="checkbox"/> Y <input type="checkbox"/> N
(4) Handling their own money?	<input type="checkbox"/> Y <input type="checkbox"/> N

2b. 1 Meals
2 Shopping
3 Chores
4 Handling money

3a. Because of a disability or health problem does anyone in the family usually stay in bed all or most of the time? Y N (4)

b. Who is this? Mark box in person's column.

c. Anyone else? Y (Reask 3b and c) N

3b. 1 Stays in bed (H box THEN 3c)

Mark box or ask:

4a. What (other) condition causes -- to (need help in activities in 1 and 2/(or) stay in bed)?

b. Does any other condition cause -- to (need help in activities in 1 and 2/(or) stay in bed)?

Mark box or ask:

c. Which of these conditions would you say is the MAIN condition that causes -- to (need help in activities in 1 and 2/(or) stay in bed)?

No H box (NP)

1 Y (Reask 4a and b) 2 N

Old age only (NP)
 Only one condition

Main condition

HC1 Refer to item C2 to determine if a condition page was completed for the main condition in 4.
Enter condition number, or mark box.

HC1 Cond. number (NP)
 No condition page

5. When did -- first notice his (main condition in 4)?

5. 1 Last week
2 Week before
3 Past 2 weeks, DK which
4 2 weeks - 3 months
5 Over 3-12 months
6 More than 12 months ago

HOME CARE PAGE – Continued

Person number (a)	Activity (b)	Doesn't do (c) <input type="checkbox"/> Doesn't do (Mark H box, THEN 1c)	If "doesn't do," go to next line. Does -- use any SPECIAL EQUIPMENT in (activity)? (d) 1 Y 2 N	Does -- receive or need the help of ANOTHER PERSON in (activity)? (e) 1 Y 2 N (Next line)	Does -- need help from another person in (activity) most of the time, some of the time, or once in a while? (f) 1 <input type="checkbox"/> All/most 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Once 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Other – Specify
		<input type="checkbox"/> Doesn't do (Mark H box, THEN 1c)	1 Y 2 N	1 Y 2 N (Next line)	1 <input type="checkbox"/> All/most 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Once 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Other – Specify
		<input type="checkbox"/> Doesn't do (Mark H box, THEN 1c)	1 Y 2 N	1 Y 2 N (Next line)	1 <input type="checkbox"/> All/most 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Once 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Other – Specify
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		<input type="checkbox"/> Doesn't do (Mark H box, THEN 1c)	1 Y 2 N	1 Y 2 N (Next line)	1 <input type="checkbox"/> All/most 2 <input type="checkbox"/> Some 3 <input type="checkbox"/> Once 4 <input type="checkbox"/> Never 5 <input type="checkbox"/> Other – Specify

2		3		4		5		6	
1 <input type="checkbox"/> Meals 2 <input type="checkbox"/> Shopping 3 <input type="checkbox"/> Chores 4 <input type="checkbox"/> Handling money	2b. <input type="checkbox"/> Meals <input type="checkbox"/> Shopping <input type="checkbox"/> Chores <input type="checkbox"/> Handling money	1 <input type="checkbox"/> Meals 2 <input type="checkbox"/> Shopping 3 <input type="checkbox"/> Chores 4 <input type="checkbox"/> Handling money	2b. <input type="checkbox"/> Meals <input type="checkbox"/> Shopping <input type="checkbox"/> Chores <input type="checkbox"/> Handling money	1 <input type="checkbox"/> Meals 2 <input type="checkbox"/> Shopping 3 <input type="checkbox"/> Chores 4 <input type="checkbox"/> Handling money	2b. <input type="checkbox"/> Meals <input type="checkbox"/> Shopping <input type="checkbox"/> Chores <input type="checkbox"/> Handling money	1 <input type="checkbox"/> Meals 2 <input type="checkbox"/> Shopping 3 <input type="checkbox"/> Chores 4 <input type="checkbox"/> Handling money	2b. <input type="checkbox"/> Meals <input type="checkbox"/> Shopping <input type="checkbox"/> Chores <input type="checkbox"/> Handling money	1 <input type="checkbox"/> Meals 2 <input type="checkbox"/> Shopping 3 <input type="checkbox"/> Chores 4 <input type="checkbox"/> Handling money	2b. <input type="checkbox"/> Meals <input type="checkbox"/> Shopping <input type="checkbox"/> Chores <input type="checkbox"/> Handling money
<input type="checkbox"/> Stays in bed (H box THEN 3c)		<input type="checkbox"/> Stays in bed (H box THEN 3c)		<input type="checkbox"/> Stays in bed (H box THEN 3c)		<input type="checkbox"/> Stays in bed (H box THEN 3c)		<input type="checkbox"/> Stays in bed (H box THEN 3c)	
<input type="checkbox"/> No H box (NP)		<input type="checkbox"/> No H box (NP)		<input type="checkbox"/> No H box (NP)		<input type="checkbox"/> No H box (NP)		<input type="checkbox"/> No H box (NP)	
1 Y (Reask 4a and b) 2 N		b. 1 Y (Reask 4a and b) 2 N		1 Y (Reask 4a and b) 2 N		b. 1 Y (Reask 4a and b) 2 N		1 Y (Reask 4a and b) 2 N	
<input type="checkbox"/> Old age only (NP) <input type="checkbox"/> Only one condition		<input type="checkbox"/> Old age only (NP) <input type="checkbox"/> Only one condition		<input type="checkbox"/> Old age only (NP) <input type="checkbox"/> Only one condition		<input type="checkbox"/> Old age only (NP) <input type="checkbox"/> Only one condition		<input type="checkbox"/> Old age only (NP) <input type="checkbox"/> Only one condition	
Main condition		Main condition		Main condition		Main condition		Main condition	
Cond. number (NP) <input type="checkbox"/> No condition page		HCl Cond. number (NP) <input type="checkbox"/> No condition page		Cond. number (NP) <input type="checkbox"/> No condition page		HCl Cond. number (NP) <input type="checkbox"/> No condition page		Cond. number (NP) <input type="checkbox"/> No condition page	
1 <input type="checkbox"/> Last week 2 <input type="checkbox"/> Week before 3 <input type="checkbox"/> Past 2 weeks, DK which 4 <input type="checkbox"/> 2 weeks – 3 months 5 <input type="checkbox"/> Over 3–12 months 6 <input type="checkbox"/> More than 12 months ago		5. 1 <input type="checkbox"/> Last week 2 <input type="checkbox"/> Week before 3 <input type="checkbox"/> Past 2 weeks, DK which 4 <input type="checkbox"/> 2 weeks – 3 months 5 <input type="checkbox"/> Over 3–12 months 6 <input type="checkbox"/> More than 12 months ago		1 <input type="checkbox"/> Last week 2 <input type="checkbox"/> Week before 3 <input type="checkbox"/> Past 2 weeks, DK which 4 <input type="checkbox"/> 2 weeks – 3 months 5 <input type="checkbox"/> Over 3–12 months 6 <input type="checkbox"/> More than 12 months ago		5. 1 <input type="checkbox"/> Last week 2 <input type="checkbox"/> Week before 3 <input type="checkbox"/> Past 2 weeks, DK which 4 <input type="checkbox"/> 2 weeks – 3 months 5 <input type="checkbox"/> Over 3–12 months 6 <input type="checkbox"/> More than 12 months ago		1 <input type="checkbox"/> Last week 2 <input type="checkbox"/> Week before 3 <input type="checkbox"/> Past 2 weeks, DK which 4 <input type="checkbox"/> 2 weeks – 3 months 5 <input type="checkbox"/> Over 3–12 months 6 <input type="checkbox"/> More than 12 months ago	

HOME CARE PAGE – Continued

<p>6a. Does anyone in the family have a colostomy, a urinary catheter, or any other device to help control bowel movements or urination? Y N (7)</p>																																			
<p>b. Who is this? Mark "Device" box in person's column.</p>		6b. 1 <input type="checkbox"/> Device																																	
<p>c. Anyone else? Y (Reask 6b and c) N</p> <p>If "Device," ask 6d and e</p>																																			
<p>d. Which does -- have -- a colostomy, a catheter, or another type of device?</p>		d. 1 <input type="checkbox"/> Colostomy 2 <input type="checkbox"/> Catheter 3 <input type="checkbox"/> Other -- Specify <i>P</i>																																	
<p>e. Does -- receive or need help from another person in taking care of his (device in 6d)?</p>		e. 1 Y (Mark H box THEN NP) 2 N																																	
<p>7a. (Besides --) Does anyone (else) in the family have any accidents or any trouble controlling their bowel movements or urination? Y N (8)</p>																																			
<p>b. Who is this? Mark "Trouble controlling" box in person's column.</p>		7b. 1 <input type="checkbox"/> Trouble controlling																																	
<p>c. Anyone else? Y (Reask 7b and c) N</p>																																			
<p>8a. Does anyone in the family (that is you, your, -- etc.) now use (any of the following special aids) --</p> <p>If "Yes," ask 8b and c</p> <table border="0" style="width:100%"> <tr> <td></td> <td style="text-align:center">Y</td> <td style="text-align:center">N</td> </tr> <tr> <td>(1) An artificial arm? (1)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(2) An artificial leg? (2)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(3) A brace of any kind? (if "Yes," ask: On what part of the body is the brace worn?) (3)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(4) Crutches? (4)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(5) A cane or walking stick? (5)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(6) Special shoes? (6)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(7) A wheel chair? (7)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(8) A walker? (8)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(9) A guide dog? (9)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(10) Any other kind of aid for getting around? (10)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> </table>			Y	N	(1) An artificial arm? (1)	<input type="checkbox"/>	<input type="checkbox"/>	(2) An artificial leg? (2)	<input type="checkbox"/>	<input type="checkbox"/>	(3) A brace of any kind? (if "Yes," ask: On what part of the body is the brace worn?) (3)	<input type="checkbox"/>	<input type="checkbox"/>	(4) Crutches? (4)	<input type="checkbox"/>	<input type="checkbox"/>	(5) A cane or walking stick? (5)	<input type="checkbox"/>	<input type="checkbox"/>	(6) Special shoes? (6)	<input type="checkbox"/>	<input type="checkbox"/>	(7) A wheel chair? (7)	<input type="checkbox"/>	<input type="checkbox"/>	(8) A walker? (8)	<input type="checkbox"/>	<input type="checkbox"/>	(9) A guide dog? (9)	<input type="checkbox"/>	<input type="checkbox"/>	(10) Any other kind of aid for getting around? (10)	<input type="checkbox"/>	<input type="checkbox"/>	8b. 1 <input type="checkbox"/> Artificial arm 2 <input type="checkbox"/> Artificial leg 3 <input type="checkbox"/> Brace -- Part of body <i>P</i> 4 <input type="checkbox"/> Crutches 5 <input type="checkbox"/> Cane or walking stick 6 <input type="checkbox"/> Special shoes 7 <input type="checkbox"/> Wheel chair 8 <input type="checkbox"/> Walker 9 <input type="checkbox"/> Guide dog 10 <input type="checkbox"/> Other -- Specify <i>P</i>
	Y	N																																	
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<p>b. Who is this? Mark box in person's column.</p>																																			
<p>c. Anyone else?</p>																																			
<p>9a. Does anyone in the family use --</p> <p>If "Yes," ask 9b and c</p> <table border="0" style="width:100%"> <tr> <td></td> <td style="text-align:center">Y</td> <td style="text-align:center">N</td> </tr> <tr> <td>(1) Eyeglasses? (1)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(2) Contact lenses? (2)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(3) A hearing aid? (3)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> </table>			Y	N	(1) Eyeglasses? (1)	<input type="checkbox"/>	<input type="checkbox"/>	(2) Contact lenses? (2)	<input type="checkbox"/>	<input type="checkbox"/>	(3) A hearing aid? (3)	<input type="checkbox"/>	<input type="checkbox"/>	9b. 1 <input type="checkbox"/> Eyeglasses 2 <input type="checkbox"/> Contact lenses 3 <input type="checkbox"/> Hearing aid																					
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(3) A hearing aid? (3)	<input type="checkbox"/>	<input type="checkbox"/>																																	
<p>b. Who is this? Mark box in person's column</p>																																			
<p>c. Anyone else?</p>																																			
<p>10a. Does anyone in the family receive help here at home with --</p> <p>If "Yes," ask 10b and c</p> <table border="0" style="width:100%"> <tr> <td></td> <td style="text-align:center">Y</td> <td style="text-align:center">N</td> </tr> <tr> <td>(1) Receiving injections or shots? (1)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(2) Physical therapy? (2)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(3) Changing bandages? (3)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>(8) Any other nursing or medical treatments? (8)</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> </table>			Y	N	(1) Receiving injections or shots? (1)	<input type="checkbox"/>	<input type="checkbox"/>	(2) Physical therapy? (2)	<input type="checkbox"/>	<input type="checkbox"/>	(3) Changing bandages? (3)	<input type="checkbox"/>	<input type="checkbox"/>	(8) Any other nursing or medical treatments? (8)	<input type="checkbox"/>	<input type="checkbox"/>	10b. 1 <input type="checkbox"/> Injections 2 <input type="checkbox"/> Physical therapy 3 <input type="checkbox"/> Bandages 4 <input type="checkbox"/> Other -- Specify <i>P</i>																		
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<p>b. Who is this? Mark box in person's column</p>																																			
<p>c. Anyone else?</p>																																			

<input type="checkbox"/> Device	6b.	<input type="checkbox"/> Device	<input type="checkbox"/> Device	6b.	<input type="checkbox"/> Device	<input type="checkbox"/> Device
<input type="checkbox"/> Colostomy <input type="checkbox"/> Catheter <input type="checkbox"/> Other - Specify <i>z</i>	d.	<input type="checkbox"/> Colostomy <input type="checkbox"/> Catheter <input type="checkbox"/> Other - Specify <i>z</i>	<input type="checkbox"/> Colostomy <input type="checkbox"/> Catheter <input type="checkbox"/> Other - Specify <i>z</i>	d.	<input type="checkbox"/> Colostomy <input type="checkbox"/> Catheter <input type="checkbox"/> Other - Specify <i>z</i>	<input type="checkbox"/> Colostomy <input type="checkbox"/> Catheter <input type="checkbox"/> Other - Specify <i>z</i>
1 Y (Mark H box THEN NP) 2 N	e.	1 Y (Mark H box THEN NP) 2 N	1 Y (Mark H box THEN NP) 2 N	e.	1 Y (Mark H box THEN NP) 2 N	1 Y (Mark H box THEN NP) 2 N
<input type="checkbox"/> Trouble controlling	7b.	<input type="checkbox"/> Trouble controlling	<input type="checkbox"/> Trouble controlling	7b.	<input type="checkbox"/> Trouble controlling	<input type="checkbox"/> Trouble controlling
<input type="checkbox"/> Artificial arm <input type="checkbox"/> Artificial leg <input type="checkbox"/> Brace - Part of body <i>z</i> <input type="checkbox"/> Crutches <input type="checkbox"/> Cane or walking stick <input type="checkbox"/> Special shoes <input type="checkbox"/> Wheel chair <input type="checkbox"/> Walker <input type="checkbox"/> Guide dog <input type="checkbox"/> Other - Specify <i>z</i>	8b.	<input type="checkbox"/> Artificial arm <input type="checkbox"/> Artificial leg <input type="checkbox"/> Brace - Part of body <i>z</i> <input type="checkbox"/> Crutches <input type="checkbox"/> Cane or walking stick <input type="checkbox"/> Special shoes <input type="checkbox"/> Wheel chair <input type="checkbox"/> Walker <input type="checkbox"/> Guide dog <input type="checkbox"/> Other - Specify <i>z</i>	<input type="checkbox"/> Artificial arm <input type="checkbox"/> Artificial leg <input type="checkbox"/> Brace - Part of body <i>z</i> <input type="checkbox"/> Crutches <input type="checkbox"/> Cane or walking stick <input type="checkbox"/> Special shoes <input type="checkbox"/> Wheel chair <input type="checkbox"/> Walker <input type="checkbox"/> Guide dog <input type="checkbox"/> Other - Specify <i>z</i>	8b.	<input type="checkbox"/> Artificial arm <input type="checkbox"/> Artificial leg <input type="checkbox"/> Brace - Part of body <i>z</i> <input type="checkbox"/> Crutches <input type="checkbox"/> Cane or walking stick <input type="checkbox"/> Special shoes <input type="checkbox"/> Wheel chair <input type="checkbox"/> Walker <input type="checkbox"/> Guide dog <input type="checkbox"/> Other - Specify <i>z</i>	<input type="checkbox"/> Artificial arm <input type="checkbox"/> Artificial leg <input type="checkbox"/> Brace - Part of body <i>z</i> <input type="checkbox"/> Crutches <input type="checkbox"/> Cane or walking stick <input type="checkbox"/> Special shoes <input type="checkbox"/> Wheel chair <input type="checkbox"/> Walker <input type="checkbox"/> Guide dog <input type="checkbox"/> Other - Specify <i>z</i>
<input type="checkbox"/> Eyeglasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Hearing aid	9b.	<input type="checkbox"/> Eyeglasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Hearing aid	<input type="checkbox"/> Eyeglasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Hearing aid	9b.	<input type="checkbox"/> Eyeglasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Hearing aid	<input type="checkbox"/> Eyeglasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Hearing aid
<input type="checkbox"/> Injections <input type="checkbox"/> Physical therapy <input type="checkbox"/> Bandages <input type="checkbox"/> Other - Specify <i>z</i>	10b.	<input type="checkbox"/> Injections <input type="checkbox"/> Physical therapy <input type="checkbox"/> Bandages <input type="checkbox"/> Other - Specify <i>z</i>	<input type="checkbox"/> Injections <input type="checkbox"/> Physical therapy <input type="checkbox"/> Bandages <input type="checkbox"/> Other - Specify <i>z</i>	10b.	<input type="checkbox"/> Injections <input type="checkbox"/> Physical therapy <input type="checkbox"/> Bandages <input type="checkbox"/> Other - Specify <i>z</i>	<input type="checkbox"/> Injections <input type="checkbox"/> Physical therapy <input type="checkbox"/> Bandages <input type="checkbox"/> Other - Specify <i>z</i>

<input type="checkbox"/> Meals	11b. <input type="checkbox"/> Meals	<input type="checkbox"/> Meals	11b. <input type="checkbox"/> Meals	<input type="checkbox"/> Meals
1 Y 2 N (NP)	d. 1 Y 2 N (NP)	1 Y 2 N (NP)	d. 1 Y 2 N (NP)	1 Y 2 N (NP)
_____	e. _____	_____	e. _____	_____
<input type="checkbox"/> Nurse	12b. <input type="checkbox"/> Nurse	<input type="checkbox"/> Nurse	12b. <input type="checkbox"/> Nurse	<input type="checkbox"/> Nurse

FOOTNOTES

Complete for each person with H box INDIVIDUAL HOME CARE PAGE		1. Person number _____
2a. Earlier you said that --- receives or needs the help of another person. Who helps ---? (Is --- helped by anyone who lives here, by any other friends or relatives, a nurse, or any other health care professionals who come into the home, or is --- helped by someone else?)	2a.	1 <input type="checkbox"/> Related HH members 2 <input type="checkbox"/> Nurse 3 <input type="checkbox"/> Other health worker - Specify _____ 4 <input type="checkbox"/> Other relatives or friends 5 <input type="checkbox"/> Other - Specify _____
b. Does anyone else help ---?	b.	Y (Reask 2a and b) N
If "Nurse" in 2a, ask:		
3a. On the average, how many days per week does the nurse visit ---?	3a.	_____ Days per week
b. When the nurse visits, how many hours per day does he or she usually spend helping ---?	b.	00 <input type="checkbox"/> Less than 1 hour _____ Hours
c. Does anyone in the family, that is you, your ---, etc. pay any part of the cost for the nurse?	c.	1 Y 2 N
d. Does any government agency or program help pay for the nurse?	d.	1 Y 2 N (3f)
e. What agency or program helps pay?	e.	1 <input type="checkbox"/> Medicaid <input type="checkbox"/> Other - Specify _____ 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Health insurance
f. During the past 2 weeks, how many times was --- visited by the nurse?	f.	_____ Number of times
If "Other health worker" in 2a, ask:		
4a. On the average, how many days per week does the (other health worker) visit ---?	4a.	_____ Days per week
b. When the (other health worker) visits, how many hours per day does he or she usually spend helping ---?	b.	00 <input type="checkbox"/> Less than 1 hour _____ Hours
c. Does anyone in the family, that is you, your ---, etc. pay any part of the cost for the (other health worker)?	c.	1 Y 2 N
d. Does any government agency or program help pay for the (other health worker)?	d.	1 Y 2 N (4f)
e. What agency or program helps pay?	e.	1 <input type="checkbox"/> Medicaid <input type="checkbox"/> Other - Specify _____ 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Health insurance
f. During the past 2 weeks, how many times was --- visited by the (other health worker)?	f.	_____ Number of times
HC2	HC2	1 <input type="checkbox"/> Under 17 (NP) 2 <input type="checkbox"/> 17 +
5a. Does --- receive or need help from others in using public transportation, such as buses, trains, subways, or planes?	5a.	1 Y (6) 2 N 4 <input type="checkbox"/> Doesn't use (5c)
b. Does --- use public transportation?	b.	1 Y (6) 2 N
c. If --- had to use public transportation, would --- need the help of other persons?	c.	1 Y 2 N
6a. Does --- drive a car?	6a.	1 Y (7) 2 N
b. Does --- not drive a car because of a disability or health problem or because of some other reason?	b.	1 <input type="checkbox"/> Age 2 <input type="checkbox"/> Disability 3 <input type="checkbox"/> Other
7a. Does --- use the telephone without the help of another person?	7a.	1 Y (8) 2 N
b. Would --- be able to use the telephone in an emergency?	b.	1 Y 2 N
8a. During the 2 weeks outlined in red on the calendar, did --- have any visits from a friend, relative or neighbor?	8a.	1 Y 2 N (8c)
b. How many times during that period was --- visited by friends, relatives or neighbors? (Was it 3 or more times or less than 3 times?) (Was it 12 or more times or less than 12 times?)	b.	1 <input type="checkbox"/> 1-3 times 3 <input type="checkbox"/> 13+ times 2 <input type="checkbox"/> 4-12 times
c. During these 2 weeks, did --- go out to visit a friend, relative or neighbor?	c.	1 Y 2 N (9)
d. How many times during that period did --- go out to visit friends, relatives or neighbors? (Was it 3 or more times or less than 3 times?) (Was it 12 or more times or less than 12 times?)	d.	1 <input type="checkbox"/> 1-3 times 3 <input type="checkbox"/> 13+ times 2 <input type="checkbox"/> 4-12 times
9. During the past 12 months, did --- go on a vacation?	9.	1 Y 2 N
10. Because of a disability or health problem, how often must someone be here with ---, most of the time, some of the time, once in a while or never?	10.	1 <input type="checkbox"/> Most/All 4 <input type="checkbox"/> Never 2 <input type="checkbox"/> Some 5 <input type="checkbox"/> Other - Specify _____ 3 <input type="checkbox"/> Once

1. Person number _____	1. Person number _____	1. Person number _____
2a. 1 <input type="checkbox"/> Related HH members 2 <input type="checkbox"/> Nurse 3 <input type="checkbox"/> Other health worker - Specify _____ 4 <input type="checkbox"/> Other relatives or friends 5 <input type="checkbox"/> Other - Specify _____	2a. 1 <input type="checkbox"/> Related HH members 2 <input type="checkbox"/> Nurse 3 <input type="checkbox"/> Other health worker - Specify _____ 4 <input type="checkbox"/> Other relatives or friends 5 <input type="checkbox"/> Other - Specify _____	2a. 1 <input type="checkbox"/> Related HH members 2 <input type="checkbox"/> Nurse 3 <input type="checkbox"/> Other health worker - Specify _____ 4 <input type="checkbox"/> Other relatives or friends 5 <input type="checkbox"/> Other - Specify _____
b. Y (Reask 2a and b) N	b. Y (Reask 2a and b) N	b. Y (Reask 2a and b) N
3a. _____ Days per week	3a. _____ Days per week	3a. _____ Days per week
b. 00 <input type="checkbox"/> Less than 1 hour _____ Hours	b. 00 <input type="checkbox"/> Less than 1 hour _____ Hours	b. 00 <input type="checkbox"/> Less than 1 hour _____ Hours
c. 1 Y 2 N	c. 1 Y 2 N	c. 1 Y 2 N
d. 1 Y 2 N (3f)	d. 1 Y 2 N (3f)	d. 1 Y 2 N (3f)
e. 1 <input type="checkbox"/> Medicaid <input type="checkbox"/> Other - Specify _____ 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Health insurance	e. 1 <input type="checkbox"/> Medicaid <input type="checkbox"/> Other - Specify _____ 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Health insurance	e. 1 <input type="checkbox"/> Medicaid <input type="checkbox"/> Other - Specify _____ 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Health insurance
f. _____ Number of times	f. _____ Number of times	f. _____ Number of times
4a. _____ Days per week	4a. _____ Days per week	4a. _____ Days per week
b. 00 <input type="checkbox"/> Less than 1 hour _____ Hours	b. 00 <input type="checkbox"/> Less than 1 hour _____ Hours	b. 00 <input type="checkbox"/> Less than 1 hour _____ Hours
c. 1 Y 2 N	c. 1 Y 2 N	c. 1 Y 2 N
d. 1 Y 2 N (4f)	d. 1 Y 2 N (4f)	d. 1 Y 2 N (4f)
e. 1 <input type="checkbox"/> Medicaid <input type="checkbox"/> Other - Specify _____ 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Health insurance	e. 1 <input type="checkbox"/> Medicaid <input type="checkbox"/> Other - Specify _____ 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Health insurance	e. 1 <input type="checkbox"/> Medicaid <input type="checkbox"/> Other - Specify _____ 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Health insurance
f. _____ Number of times	f. _____ Number of times	f. _____ Number of times
HC2 1 <input type="checkbox"/> Under 17 (NP) 2 <input type="checkbox"/> 17+	HC2 1 <input type="checkbox"/> Under 17 (NP) 2 <input type="checkbox"/> 17+	HC2 1 <input type="checkbox"/> Under 17 (NP) 2 <input type="checkbox"/> 17+
5a. 1 Y (6) 2 N 4 <input type="checkbox"/> Doesn't use (5c)	5a. 1 Y (6) 2 N 4 <input type="checkbox"/> Doesn't use (5c)	5a. 1 Y (6) 2 N 4 <input type="checkbox"/> Doesn't use (5c)
b. 1 Y (6) 2 N	b. 1 Y (6) 2 N	b. 1 Y (6) 2 N
c. 1 Y 2 N	c. 1 Y 2 N	c. 1 Y 2 N
6a. 1 Y (7) 2 N	6a. 1 Y (7) 2 N	6a. 1 Y (7) 2 N
b. 1 <input type="checkbox"/> Age 2 <input type="checkbox"/> Disability 3 <input type="checkbox"/> Other	b. 1 <input type="checkbox"/> Age 2 <input type="checkbox"/> Disability 3 <input type="checkbox"/> Other	b. 1 <input type="checkbox"/> Age 2 <input type="checkbox"/> Disability 3 <input type="checkbox"/> Other
7a. 1 Y (8) 2 N	7a. 1 Y (8) 2 N	7a. 1 Y (8) 2 N
b. 1 Y 2 N	b. 1 Y 2 N	b. 1 Y 2 N
8a. 1 Y 2 N (8c)	8a. 1 Y 2 N (8c)	8a. 1 Y 2 N (8c)
b. 1 <input type="checkbox"/> 1-3 times 3 <input type="checkbox"/> 13+ times 2 <input type="checkbox"/> 4-12 times	b. 1 <input type="checkbox"/> 1-3 times 3 <input type="checkbox"/> 13+ times 2 <input type="checkbox"/> 4-12 times	b. 1 <input type="checkbox"/> 1-3 times 3 <input type="checkbox"/> 13+ times 2 <input type="checkbox"/> 4-12 times
c. 1 Y 2 N (9)	c. 1 Y 2 N (9)	c. 1 Y 2 N (9)
d. 1 <input type="checkbox"/> 1-3 times 3 <input type="checkbox"/> 13+ times 2 <input type="checkbox"/> 4-12 times	d. 1 <input type="checkbox"/> 1-3 times 3 <input type="checkbox"/> 13+ times 2 <input type="checkbox"/> 4-12 times	d. 1 <input type="checkbox"/> 1-3 times 3 <input type="checkbox"/> 13+ times 2 <input type="checkbox"/> 4-12 times
9. 1 Y 2 N	9. 1 Y 2 N	9. 1 Y 2 N
10. 1 <input type="checkbox"/> Most/All 4 <input type="checkbox"/> Never 2 <input type="checkbox"/> Some 5 <input type="checkbox"/> Other - Specify _____ 3 <input type="checkbox"/> Once	10. 1 <input type="checkbox"/> Most/All 4 <input type="checkbox"/> Never 2 <input type="checkbox"/> Some 5 <input type="checkbox"/> Other - Specify _____ 3 <input type="checkbox"/> Once	10. 1 <input type="checkbox"/> Most/All 4 <input type="checkbox"/> Never 2 <input type="checkbox"/> Some 5 <input type="checkbox"/> Other - Specify _____ 3 <input type="checkbox"/> Once