PROVIDER LABEL

OMB #: 0935-0108

MEDICAL PROVIDER COMPONENT FOR REFERENCE YEAR 2005

CONTACT GUIDE FOR HOME CARE ORGANIZATIONS

IF PROVIDER IS A HOSPITAL, ASK: May I please speak to someone in the home health care department? [GO TO INTRODUCTION ON NEXT PAGE]

OTHERWISE ASK:
May I please speak to the Business Manager or someone who is in charge of billing for the organization? [IF ON SECOND CALL PERSON IS UNAVAILABLE, ASK TO SPEAK TO SUPERVISOR IN THAT DEPARTMENT]

___ NOT AN ORGANIZATION. (GO TO INTRODUCTION ON NEXT PAGE.)

___ ORGANIZATION AND: (CHECK APPROPRIATE CATEGORY BELOW)

- ___ HAS BILLING STAFF. GO TO INTRODUCTION ON NEXT PAGE.
- ___ BILLING IS PERFORMED BY OUTSIDE BILLING SERVICE. ASK TO SPEAK TO PERSON WHO DEALS WITH THE BILLING SERVICE.
- ___ DOES NOT BILL -- ALL SERVICES PROVIDED ON PREPAID OR A CAPITATED BASIS. ASK TO SPEAK TO SOMEONE WHO DEALS WITH PATIENT RECORDS. THEN START WITH INTRODUCTION ON NEXT PAGE.
- ___ NO BILLING STAFF AND IT IS NOT CLEAR WHO TO SPEAK TO. RECORD INFORMATION BELOW, TERMINATE CALL, AND CONSULT WITH TASK COORDINATOR.

____

____

INTRODUCTION

Hello, my name is (YOUR NAME) and I am calling on behalf of the U.S. Public Health Service. This is a nationwide study about how people in the United States use and pay for health care.

[NUMBER FROM PATIENT LIST: _____] person(s) in our survey identified (this organization/you) as having provided home care services during 2005 and signed an authorization form allowing you to release information to us about the services they received. Right now, I just need to ask you a few brief questions about (the organization/the services you provide). Then I can send a package of materials that explains more about what we need.

(IF PROVIDER IS A HOSPITAL, BEGIN WITH H1a.)

H1. First, let me verify that this is a home health care agency.

YES, HOME HEALTH CARE AGENCY .... 1 (BOX 2)
YES, HOME HEALTH CARE DEPT. IN HOSPITAL .... 2 (BOX 2)
NO -- SOME OTHER KIND OF ORGANIZATION 3
NO -- NOT AN ORGANIZATION .... 4 (BOX 1)

H1a. Does your organization include a home health care unit or department?

YES .... 1 (BOX 2)
NO 2

H1b. Does your organization ever make arrangements for other organizations or individuals to provide some kind of assistance to people in their homes?

YES 1 (H4)
NO 2 (H2)

BOX 1

FOR INDIVIDUAL PROVIDERS:

H1c. During 2005, did you provide any kind of assistance to people in their homes?

YES 1
NO .... 2 [TERMINATE AND CONSULT TASK COORDINATOR]

H1d. Were the services you provided exclusively to persons who needed in-home assistance for health reasons?

EXPLAIN, IF NECESSARY: Health reasons can include either physical or mental health conditions.

YES 1 (H4)
NO .... 2 (BOX 3)

H2. Does your organization provide any kind of assistance to people in their homes?

YES.. 1
NO .... 2 [THANK RESPONDENT AND END]

H2a. Are your services provided exclusively to persons who need in-home assistance for health reasons?

EXPLAIN, IF NECESSARY: Health reasons can include either physical or mental health conditions.

YES .... 1 (BOX 2)
NO 2

H2b. What kind of services does your organization provide to people in their homes?

CLEANING OR YARD WORK	1	(BOX 3)
TRANSPORTATION	2	(BOX 3)
SHOPPING........	3	(BOX 3)
EMOTIONAL SUPPORT PERSON OR ONE-ON-ONE BUDDY...	4	(BOX 3)
SUPPORT GROUPS........	5	(BOX 3)
CHILD CARE........	6	(BOX 3)
Other. (RECORD VERBATIM) ____________________ ____________________............	7	[TERMINATE AND CONSULT TASK COORDINATOR]

BOX 2

H3. INTERVIEWER: IS THIS A RUBBER-BAND CASE?

YES........	1	
NO	2	(H4)

H3a. I need to verify that the following organizations were associated with this organization during 2005. [REVIEW EACH PROVIDER WITH THE CONTACT PERSON AND COMPLETE A SAMPLE PROBLEM FORM AS APPROPRIATE]

H4. We need information about the in-home services provided to the persons in our study and about the charges and payments for those services. Would you (or someone in your office) be able to provide this information?

YES, RESPONDENT (OR SOMEONE ELSE IN OFFICE) CAN PROVIDE INFORMATION 1 (H5)
NO, NEED TO CONTACT BILLING SERVICE 2 (H12)
NO, NEED TO CONTACT DIFFERENT DEPARTMENT 3 (H14)
NO, ORGANIZATION ARRANGES FOR HOME HEALTH CARE -- NEED TO CONTACT H.H. CARE ORGANIZATION DIRECTLY .... 4 (BOX 4, PAGE 10)
NO, THIS TYPE OF INFORMATION IS NOT AVAILABLE (RECORD VERBATIM) ______________________________ [TERMINATE AND CONSULT TASK COORDINATOR]

BOX 3

FOR ORGANIZATIONS OR INDIVIDUALS THAT DO NOT EXCLUSIVELY PROVIDE SERVICES FOR HEALTH REASONS (SEE H2a):

H4a We need information about the services provided to the persons in our study and about the charges and payments for those services. Would you or someone in your office be able to provide this information?

YES, OFFICE CAN PROVIDE INFORMATION 1 (NCH1)
NO, NEED TO CONTACT BILLING SERVICE 2 (H12)
NO, THIS TYPE OF INFORMATION IS NOT AVAILABLE (RECORD VERBATIM) ______________________________ TERMINATE AND CONSULT TASK COORDINATOR

H5. We would like to send you a copy of the authorization form(s) and then call back to collect the information. May I FAX the form(s) to you? (IF NOT: May I mail the form(s) to you?)

CAN PROVIDE INFORMATION BEFORE RECEIVING AUTHORIZATION FORM(S).. 1
FAX AUTHORIZATION FORM(S) BEFORE COLLECTING INFORMATION 2
MAIL AUTHOHRIZATION FORM(S) BEFORE COLLECTING INFORMATION 3
PREFERS MAILING RECORDS – FAX AUTHORIZATION FORM(S) 4
PREFERS MAILING RECORDS – MAIL AUTHORIZATION FORM(S) 5

H6. OMITTED.

H7. CODE ONE:

HOME CARE FORM(S) COMPLETE 1
FAX AUTHORIZATION FORM(S) BEFORE COLLECTING
DATA 2 (H8)
MAIL AUTHORIZATION FORM(S) BEFORE COLLECTING
DATA 3 (H9)
RESPONDENT WILL MAIL RECORDS 4 (H9)

H7a. Thank you very much for your time and help with this study. We will send you (the envelope and) a copy of the authorization form(s) for your files. (H9)

H8. We will FAX you a copy of the authorization form(s) today. What is your FAX number?

FAX NUMBER: (_______)______________________________

H8a. And what name and title should I put on the FAX cover page?

NAME: _______________________________________
TITLE: _______________________________________
DEPARTMENT: _______________________________________

H8b. RESPONDENT NAME:

SAME AS NAME ON FAX COVER PAGE.................................... 1
DIFFERENT FROM NAME ON FAX COVER PAGE
(RECORD)____...... 2

GO TO H10.

H9. Would you be the best person to receive the authorization form(s)?

YES .... 1 (VERIFY NAME, TITLE, AND DEPARTMENT)
NO .... 2 (OBTAIN NAME, TITLE, AND DEPARTMENT)

H9a. Let me also verify that I have the correct mailing address:

NAME: ________________________________
TITLE: ________________________________
DEPARTMENT: ________________________________
PROVIDER NAME: ________________________________
ADDRESS: ________________________________
____
CITY: __________ STATE: ______ ZIP: ______
TELEPHONE: (______)______________ EXT: _______

H9b. RESPONDENT NAME:

SAME AS NAME WHO WILL RECEIVE FORM(S) 1
DIFFERENT FROM NAME WHO WILL RECEIVE FORM(S)
(RECORD)________________________________ 2

IF HOME CARE BOOKLETS COMPLETED,THANK RESPONDENT AND END CONTACT. OTHERWISE, CONTINUE.

H10. We will call you back shortly to collect the information.

What would be the best day and time to call?

DAY:___________ DATE:_________ R's TIME: __________ AM/PM

Thank you very much for your help. [END CONTACT AND RECORD FAX/MAIL DATE AND APPOINTMENT ON CONTACT PERSON CALL RECORD.]

H11. After you receive the authorization form(s), we hope you can mail the records to our office within two weeks. Thank you very much for your time and your help with this study. [END CONTACT].

H12. We will need to get in touch with the billing service to obtain some of the information we need. What is the name of the billing service, their telephone number, and the name of a contact person?

PERSON'S NAME: ______________________________

TITLE: ______________________________

NAME OF SERVICE: ______________________________

TELEPHONE: (_____)_______________ EXT:______

H13. I think we can probably get all the additional information we need from (BILLING SERVICE). We will send you a copy of the authorization form(s) for your files. Let me verify that I have your correct mailing address.

NAME: ______________________________

TITLE: ______________________________

DEPARTMENT: ______________________________

PROVIDER NAME: ______________________________

ADDRESS: ______________________________

____

CITY: __________ STATE: ______ ZIP: ______

Thank you very much for your help. [END CONTACT AND CALL BILLING SERVICE NAMED IN H12]

NEED TO CONTACT DIFFERENT DEPARTMENT: (HOSPITAL, CHAIN, ETC.)

H14. Who could we contact to obtain this information?

NAME: ______________________________
TITLE: ______________________________
DEPARTMENT: ______________________________
ORGANIZATION NAME: ______________________________
ADDRESS: ______________________________
____
CITY: __________ STATE: ______ ZIP: ________
TELEPHONE: (______)______________ EXT: ________

H14a. Thank you very much for your time and help with this study. [END CONTACT.]

CONTACT GUIDE FOR BILLING SERVICE

H15. Hello, my name is (YOUR NAME). We are conducting the Medical Expenditure Panel Survey for the US Public Health Service. The survey is about how people in the United States use and pay for health care.

We were referred to you by (PROVIDER) for information about (NUMBER) of their clients. [**READ IF NECESSARY**: We are collecting information about the home care services (this/these) person(s) received from (PROVIDER) during 2005. We would like to send you copies of the authorization form(s) we have from (this/these) person(s) and then call back to collect the information we need. May I FAX the form(s) to you? (IF NOT: May I mail the form(s) to you?)]

IF ASKED FOR WHAT TYPE OF INFORMATION WE NEED: For each month of service, we need information about diagnoses, services provided, charges and payments.

CAN PROVIDE INFORMATION BEFORE RECEIVING AUTHORIZATION FORM(S) 1
FAX AUTHORIZATION FORM(S) BEFORE COLLECTING INFORMATION 2 (H18)
MAIL AUTHORIZATION FORM(S) BEFORE COLLECTING INFORMATION 3 (H18)

H16. [COMPLETE HOME CARE BOOKLET(S) NOW. WHEN ALL FORM(S) HAVE BEEN COMPLETED, GO TO H18.]

H17. OMITTED

H18. CODE ONE:

HOME CARE BOOKLET(S) COMPLETE 1

FAX AUTHORIZATION FORM(S) BEFORE COLLECTING DATA 3 (H19)

MAIL AUTHORIZATION FORM(S) BEFORE COLLECTING DATA 3 (H20)

H18a. Thank you very much for your time and help with this study. We will be sending you the authorization form(s) (and envelope) today. (H20)

H19. We will be faxing you the authorization form(s) today. What is your FAX number?

FAX NUMBER: (_______)______________________________

H19a. And what name and title should I put on the fax cover page?

NAME: ______________________________

TITLE: ______________________________

DEPARTMENT: ______________________________

H19b. RESPONDENT NAME:

SAME AS NAME ON FAX COVER PAGE 1
DIFFERENT FROM NAME ON FAX COVER PAGE (RECORD)______________________________ 2

H20. Would you be the best person to receive the (authorization form(s)/envelope)?

YES.. 1 (VERIFY NAME, TITLE, AND DEPARTMENT)
NO .... 2 (OBTAIN NAME, TITLE, AND DEPARTMENT)

H20a. Let me also verify that I have the correct mailing address.

NAME: ____________________________________
TITLE: ____________________________________
DEPARTMENT: ____________________________________
PROVIDER NAME: ____________________________________
ADDRESS: ____________________________________
____
CITY: ___________ STATE: ______ ZIP: ______
TELEPHONE: (______)________________ EXT: _______

H20b. RESPONDENT NAME:

SAME AS NAME WHO WILL RECEIVE FORM(S) 1
DIFFERENT FROM NAME WHO WILL RECEIVE FORM(S)
(RECORD)____....... 2

IF HOME CARE BOOKLETS COMPLETED, THANK RESPONDENT AND END CONTACT. IF RESPONDENT WILL MAIL RECORDS, GO TO H22. OTHERWISE, CONTINUE.

H21. We will call you back shortly to collect the information.

What would be the best day and time to call?

DAY:____________ DATE:__________ R's TIME: ___________ AM/PM

Thanks again. [END CONTACT]

H22. After you receive the authorization form(s), we hope you can mail the records to our office within two weeks. Thank you very much for your time and your help with this study. [END CONTACT]

FOR ORGANIZATIONS PROVIDING NON-HEALTH-CARE HOME CARE SERVICES:

NHC1. We would like to send you a copy of the authorization form(s) and then call back to collect the information. May I FAX the form(s) to you? (IF NOT: May I mail the form(s) to you?)

CAN PROVIDE INFORMATION BEFORE RECEIVING AUTHORIZATION FORM(S) 1
FAX AUTHORIZATION FORM(S) BEFORE COLLECTING INFORMATION 2 (NHC4)
MAIL AUTHORIZATION FORM(S) BEFORE COLLECTING INFORMATION 3 (NHC4)
PREFERS MAILING RECORDS – FAX AUTHORIZATION FORM(S) 4 (NHC4)
PREFERS MAILING RECORDS – MAIL AUTHORIZATION FORM(S) 5 (NHC4)

NHC2. COMPLETE NON-HEALTH-CARE HOME CARE FORM(S) NOW. WHEN ALL FORM(S) HAVE BEEN COMPLETED, GO TO NHC4.

NHC3. OMITTED

NHC4. CODE ONE:

NON-HEALTH-CARE HOME CARE FORM(S) COMPLETE 1
FAX AUTHORIZATION FORM(S) BEFORE COLLECTING DATA 2 (NHC5)
MAIL AUTHORIZATION FORM(S) BEFORE COLLECTING DATA 3 (NHC6)
RESPONDENT WILL MAIL RECORDS 4 (NHC6)

NHC4a. Thank you very much for your time and help with this study. We will send you (the envelope and) a copy of the authorization form(s) for your files. (NHC6)

NHC5. We will fax you a copy of the authorization form(s) today. What is your FAX number?

FAX NUMBER: (_______)______________________________

NHC5a. What name and title should I put on the FAX cover page?

NAME: ______________________________
TITLE: ______________________________
DEPARTMENT: ______________________________

NHC5b. RESPONDENT NAME:

SAME AS NAME ON FAX COVER PAGE 1
DIFFERENT FROM NAME ON FAX COVER PAGE (RECORD)______________________________ 2

IF RESPONDENT NEEDS AN ENVELOPE FOR THE PRICE LIST, CONTINUE. OTHERWISE, GO TO NHC7

NHC6. Would you be the best person to receive the (authorization form(s)/envelope)?

YES .... 1 (VERIFY NAME, TITLE, AND DEPARTMENT)
NO .... 2 (OBTAIN NAME, TITLE, AND DEPARTMENT)

NHC6a. Let me also verify that I have the correct mailing address:

NAME: ________________________________
TITLE: ________________________________
DEPARTMENT: ________________________________
PROVIDER NAME: ________________________________
ADDRESS: ________________________________
____

CITY: __________ STATE: ______ ZIP: ______

TELEPHONE: (______)______________ EXT: _______

NHC6b. RESPONDENT NAME:

SAME AS NAME WHO WILL RECEIVE FORM(S) 1
DIFFERENT FROM NAME WHO WILL RECEIVE FORM(S)
(RECORD)____________________________________....... 2

IF NON-HEALTH-CARE, HOME CARE FORM(S) COMPLETED, THANK CORRESPONDENT AND END CONTACT. IF RESPONDENT WILL MAIL RECORDS, GO TO NHC8. OTHERWISE, CONTINUE.

NHC7. We will call you back shortly to collect the information.

What would be the best day and time to call?

DAY:__________ DATE:_________ R's TIME: __________ AM/PM

Thank you very much for your help. [END CONTACT AND RECORD FAX/MAIL DATE AND APPOINTMENT ON CONTACT PERSON CALL RECORD.]

NHC8. After you receive the authorization form(s), we hope you can mail the records to our office within two weeks. Thank you very much for your time and your help with this study. [END CONTACT]

BOX 4
ORGANIZATIONS WHO ARRANGE FOR HOME CARE

COMPLETE TABLE BELOW FOR EACH PATIENT ON LIST. IF SAME ORGANIZATION PROVIDED CARE TO MORE THAN ONE PATIENT, ENTER ORGANIZATION NAME AND THEN "SEE ABOVE".

H22. Could you give me the name of each organization that provided home care to (PATIENT NAME). I also need the name, title, and telephone number of a contact person at the organization.

PATIENT NAME:	
______________________	ORGANIZATION NAME: ______________________
______________________	CONTACT NAME: ______________________
______________________	TITLE: ______________________
	TELEPHONE: (____) ______________ EXT: ______________

PATIENT NAME:	
______________________	ORGANIZATION NAME: ______________________
______________________	CONTACT NAME: ______________________
______________________	TITLE: ______________________
	TELEPHONE: (____) ______________ EXT: ______________

PATIENT NAME:	
______________________	ORGANIZATION NAME: ______________________
______________________	CONTACT NAME: ______________________
______________________	TITLE: ______________________
	TELEPHONE: (____) ______________ EXT: ______________

PATIENT NAME:	
______________________	ORGANIZATION NAME: ______________________
______________________	CONTACT NAME: ______________________
______________________	TITLE: ______________________
	TELEPHONE: (____) ______________ EXT: ______________

PATIENT NAME:	
______________________	ORGANIZATION NAME: ______________________
______________________	CONTACT NAME: ______________________
______________________	TITLE: ______________________
	TELEPHONE: (____) ______________ EXT: ______________

TERMINATE INTERVIEW

FOLLOW-UP INTRODUCTION

HF1. May I please speak to (RESPONDENT)?

Hello, my name is (YOUR NAME) and I am calling about the Medical Expenditure Panel Survey, which we are conducting for the U.S. Public Health Service. Did you receive the authorization form(s) we (Faxed/sent)?

YES 1 (HF6)
NO AND WAS FAXED 2
NO AND WAS MAILED 3

HF2. Let me (FAX/send) the authorization form(s) to you (again).

HAS FAX 1
DOES NOT HAVE FAX OR PREFERS MAIL 2 (HF4)

HF3. I would like to verify your name and FAX number. I have (NAME AND FAX NUMBER FROM H8a). Is that correct?

FAX NUMBER: (_______)______________________________
NAME: ______________________________________
TITLE: ______________________________________
DEPARTMENT: ______________________________________

We will FAX the materials to you and call back shortly to collect the information. What would be the best day and time to call you back?

DAY:___________ DATE:_________ R's TIME: __________ AM/PM

Thank you very much for your help. [END CONTACT AND RECORD FAX DATE AND APPOINTMENT ON CONTACT PERSON CALL RECORD.]

HF4. I would like to verify your name and address. I have (NAME AND ADDRESS FROM H9a). Is that correct? [MAKE CORRECTIONS AS NECESSARY]

NAME: ___________________________________
TITLE: ___________________________________
DEPARTMENT: ___________________________________
PROVIDER NAME: ___________________________________
ADDRESS: ___________________________________
____
CITY: __________ STATE: ______ ZIP: ______
TELEPHONE: (______)_______________ EXT: _______

HF5. What would be the best day and time to call you back?

DAY:___________ DATE:_________ R's TIME: __________ AM/PM

Thank you very much for your help. [END CONTACT AND RECORD MAIL DATE AND APPOINTMENT ON CONTACT PERSON CALL RECORD.]

HF6. If it is convenient for you, we can just go ahead and complete the data form(s) together over the phone right now. I'd be happy to hold on while you get the information you need from your records.

WILL COMPLETE BY PHONE NOW 1
WILL COMPLETE BY PHONE IN THE FUTURE 2 (HF8)
PREFERS MAILING RECORDS... 3 (HF9)

HF7. COMPLETE FORM(S) NOW. (USE REGULAR HOME CARE FORM(S) OR NON-HEALTH-CARE HOME CARE FORM(S) DEPENDING ON RESPONSE TO H2a.)

WHEN ALL FORM(S) HAVE BEEN COMPLETED, SAY: Thank you very much for your time and your help with this study. [END CONTACT]

HF8. What would be the best day and time to call you back?

DAY:___________ DATE:_________ R's TIME: __________ AM/PM

Thank you very much for your help. [END CONTACT AND RECORD APPOINTMENT ON CONTACT PERSON CALL RECORD.]

HF9. OMITTED

HF10. We hope you can mail the records to our office within two weeks. Thank you very much for your time and your help with this study. [END CONTACT]