

**MEMORANDUM**

**To:** Angela Scarborough  
OCIO

**From:** Katrina Baum  
BJS

**Date:** December 7, 2006

**Re:** 83-c for the NCVS-2  
OMB Approval Number 1121-0111

This memo explains adjustments reflected in the 83-c form for the above data collection. The current instrument has several questions about disabilities. The existing questions are being replaced with the questions below that are currently used in the American Community Survey (ACS). There is no expected change in overall burden.

Current questions	New questions
<p>167. Does a mental health condition currently keep you from participating fully in work, school, or other activities?</p> <p>168. Do you have any of the following:</p> <ul style="list-style-type: none"> <li>a. An intellectual disability such as mental retardation or Down Syndrome?</li> <li>b. Autism?</li> <li>c. Cerebral Palsy?</li> </ul> <p>169. Have you ever suffered a stroke, brain tumor, or any type of brain injury that causes you to have difficulty thinking, concentrating, or making decisions?</p> <p>170. Other than anything you've already mentioned, do you have any SERIOUS disabling conditions? Anything else?</p> <p>171. I'm going to read you a list of activities. As I read each activity, please tell me if you have difficulty or need help none of the time, most of the time, or all of the time:</p> <ul style="list-style-type: none"> <li>a. Taking care of yourself, such as bathing, dressing, or eating?</li> <li>b. Communicating, such as talking with or listening to other people?</li> <li>c. Learning any new skills or activities?</li> <li>d. With mobility such as bending, walking, or climbing stairs?</li> <li>e. Making important decisions for yourself about your health care, education, or career?</li> <li>f. Living independently, such as preparing meals, doing housework, or shopping for groceries and personal items?</li> <li>g. Managing your finances, such as keeping track of your money and paying bills?</li> </ul>	<p>Q1. Do you have any of the following long-lasting conditions:</p> <ul style="list-style-type: none"> <li>a. Blindness, deafness, or a severe vision or hearing impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>b. A condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <p>Q2. Because of a physical, mental, or emotional condition lasting 6 months or more, do you have any difficulty in doing any of the following activities:</p> <ul style="list-style-type: none"> <li>a. Learning, remembering, or concentrating? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>b. Dressing, bathing, or getting around inside the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <p>Q3. Because of a physical, mental, or emotional condition lasting 6 months or more, do you have any difficulty in doing any of the following activities:</p> <ul style="list-style-type: none"> <li>a. Going outside the home alone to shop or visit a doctor's office? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>b. Working at a job or business? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul>