IN. HEALTH INSURANCE QUESTIONNAIRE

(BASELINE ONLY)

IN1PRE1 omitted.

IN1PRE2

The following questions are about {SP's} health insurance.

PRESS ENTER TO CONTINUE.

BOX IN3	If Baseline: If HA47=-7,-8,-5, or -1 or if EX23A=-7,-8,-5, or -1, go to IN1. Else, go to IN5A. Else: The last time IN was administered: If IN1 or IN1A = 0, 2, or -8 and EX23A or HA47 = -8, -5, or -1; or If IN1 = 1 and IN6 not = 1; Go to IN1A. If Round 20, go to IN5A. Else, go to IN18.

IN1

Has {SP} ever been covered by {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)}?

YES	1	(IN2)
NO	0	(BOX IN7)
PENDING	2	(BOX IN7)
DK	-8	(BOX IN7)
RF	-7	(BOX IN7)

IN1A

{The last time we asked about {SP's} health insurance, {he/she} was not covered by {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)}}. Is {SP} now covered by {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)}?

YES	1	
NO	0	(BOX IN5)
PENDING	2	(BOX IN5)
DK	-8	(BOX IN5)
RF	-7	(BOX IN5)

IN2

Do you have a document that shows {SP's} most current {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number?

YES 1
NO..... 0
DK ..... -8
RF ..... -7

IN3

{Please read me {SP's} {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number from the document/Please tell me {SP's} {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number.}

_____
MEDICAID ID NUMBER

DK..... -8 (IN5A)
RF..... -7 (IN5A)

IN4

I'd like to verify the {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number that I have recorded. I have entered {MEDICAID ID NUMBER}. Is this correct?

YES..... 1 (IN5A)
NO 0

IN5

Let me enter it again. (What {is/was} {SP's} {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number?)

_____ (IN4)
MEDICAID ID NUMBER

DK..... -8
RF..... -7

IN5A

Some states now use HMOs (health maintenance organizations) to provide some or all health care for Medicaid beneficiaries. {Is/Was} {SP} enrolled in a {"PREFERRED" NAME FOR MEDICAID} {or "ALLOWED FOR" NAME FOR MEDICAID} HMO?

YES 1
NO 0
DK..... -8
RF..... -7

BOX IN3A	If baseline, continue. If coming from IN1A, go to IN9. Else, go to BOX IN5.

IN6

Was {SP} covered by {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} {on September 1, {YEAR}/when {she/he} was admitted to {FACILITY/{FAD/RAD UNIT} on {FAD/RAD}}?

YES	1	
NO	0	(BOX IN7)
DK	-8	(BOX IN7)
RF	-7	(BOX IN7)

IN7

In what year was {she/he} first covered by {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)}?

YEAR ( )

BOX IN4	If IN7=-7 or -8, go to IN10. If IN7YR>92, go to IN9. Else, go to Box IN5.

IN9

In what month did {her/his} {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} begin?

SELECT ONLY ONE.

USE ARROW KEYS. TO SELECT/DESELECT, PRESS ENTER. TO EXIT, PRESS ESC.

BOX IN5	If baseline: If (IN7YR) ≤ FAD/RAD, go to BOX IN7; else, go to IN10. Else: If Round 20 and SP is CFR, go to INEND. Else, go to IN18.

IN10

Please look at this card and tell me where {SP} was living {in {DATE FROM IN7/IN9.}/{when {her/his} {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} coverage first began.}

SHOW CARD IN1

IN THIS FACILITY	1	
OTHER NURSING HOME/REHAB CENTER	2	(BOX IN7)
PERSONAL CARE HOME/RESIDENTIAL CARE FACILITY	3	(BOX IN7)
CCRC/RETIREMENT HOME/CENTER	4	(BOX IN7)
HOSPITAL	5	(BOX IN7)
PRIVATE HOME OR APARTMENT	6	(BOX IN7)
OTHER LTC FACILITY	7	(BOX IN7)
OTHER (SPECIFY)_____	91	(BOX IN7)

BOX IN6	If FACILITY has more than one part, continue; else, go to BOX IN7.

IN11

In which part of {LARGER FACILITY} did {he/she} live {when {her/his} {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} coverage first began.}?

PROBE: Is it [READ NAMES FROM PLACE ROSTER]?

USE ARROW KEYS. TO SELECT, PRESS ENTER.
TO EXIT, PRESS ESC.

BOX IN7	If HA44A = 0 and HA44B (Medicare number) □ -7 or -8, or HA44A = 1, go to IN13; Else, continue.

IN12A

Our records show that {SP} is covered by Medicare. I'd like to ask some questions about {his/her} Medicare coverage.

IN12-13

Was {SP} covered by {VARIABLE TEXT} of Medicare on {September 1, {YEAR}/{FAD/RAD}}?

IN12 YES = 1, NO = 0

Part A? ( )

IN13

Part B? ( )

IN13A

Part D? ( )

PRESS F1 FOR PART A, PART B, AND PART D DEFINITIONS.

BOX IN8	If coming from IN12A, continue. Else, go to IN18.

IN14

I'd like to verify the Medicare ID number we have in our records.

Do you have a document that shows {SP's} Medicare ID number?

YES	1	
NO	0	(IN18)
DK	-8	(IN18)
RF	-7	(IN18)

IN14A

The Medicare ID number for {SP} that we show in our records is {MEDICARE #/RRB#}. Is this the same ID number that you have in your records?

YES	1	(IN18)
NO	0	
DK	-8	(IN18)
RF	-7	(IN18)

IN14B

Does {SP}'s Medicare ID number begin with a letter or number?

NUMBER	1
LETTER	2

IN15

{Please read me {SP's} Medicare ID number from your records/Please tell me {SP's} Medicare ID number.}

MEDICARE: ( ) - ( ) - ( ) - ( )
AREA GROUP END BIC

RRB: ( )
RRB#

DK ..... -8 (IN18)
RF ..... -7 (IN18)

IN16

I'd like to verify the Medicare ID number that I have recorded. I have entered {MEDICARE#/RRB#}. Is this correct?

YES 1 (IN18)
NO 0
DK ..... -8 (IN18)
RF ..... -7 (IN18)

IN17

Let me enter it again. (What {is/was} {SP's} Medicare ID number?)

{MEDICARE: ( ) - ( ) - ( ) - ( )} (IN16)
AREA GROUP END BIC

{RRB: ( )} (IN16)
RRB#

DK ..... -8
RF ..... -7

IN18

On {September 1, {YEAR}/{FAD/RAD}}, was {SP} covered by private health insurance that pays for some or all charges for inpatient and outpatient hospital and physician services {and/or supplements Medicare (Medigap policy)}?

YES 1 (IN19)
NO 0 (IN20)
DK ..... -8 (IN20)
RF ..... -7 (IN20)

IN19

What is the name of the insurance company?
PROBE: Any others?

IN20

On {September 1, {YEAR}/{FAD/RAD}}, was {SP} covered by private health insurance that pays for some or all charges for more than 100 days of nursing home care, that is, a long-term care policy?

YES 1 (IN21)
NO 0 (IN22)
DK ..... -8 (IN22)
RF ..... -7 (IN22)

IN21

What is the name of the insurance company?
PROBE: Any others?

IN22

Was {SP} covered by either TRICARE or CHAMPVA for hospital or physician care on {September 1, {YEAR}/{FAD/RAD}}?

YES 1
NO 0

PRESS F1 FOR EXPLANATION OF TRICARE AND CHAMPVA.

IN23

Was {SP} covered by any other Department of Veterans Affairs (VA) program or contract on {September 1, {YEAR}/{FAD/RAD}}?

YES	1
NO	0

IN24

{Besides {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)}, was/Was} {SP} covered by any <u>other</u> public assistance health insurance program on {September 1, {YEAR}/{FAD/RAD}}?

YES	1	
NO	0	(BOX IN9)
DK	-8	(BOX IN9)
RF	-7	(BOX IN9)

IN25

What {is/was} the name of the public assistance health insurance program?

_____

NAME OF PUBLIC ASSISTANCE HEALTH INSURANCE PROGRAM

Box IN8 omitted.

IN26 omitted.

BOX IN9	If SP alive, and a CFR, FFC, or FCF, and round = any fall round, continue. Else, go to INEND.

BQ13A

Is {SP} currently married, widowed, divorced, separated, or never married?

MARRIED	1
WIDOWED	2
DIVORCED	3
SEPARATED	4
NEVER MARRIED	5

INEND

YOU HAVE COMPLETED THE HEALTH INSURANCE SECTION FOR THIS SP.

PRESS ENTER TO RETURN TO NAVIGATION SCREEN.

Medicare beneficiaries who are entitled to Medicare Part A **or** enrolled in Part B are eligible to enroll in subsidized prescription drug coverages offered in their areas through Medicare Part D.