APPENDIX C

DATA COLLECTION PROTOCOLS

LSP COST STUDY WORKSHEET #1: FACILITY LABOR COSTS

(Include staff working at the specific meal preparation or meal service facility.)

A. NAME OF FACILITY

B. NUMBER OF MEALS PREPARED OR SERVED PER WEEK	**CONGREGATE**	**HOME-DELIVERED**
Meals served to Title III participants		
Meals served in other programs to other persons		

C. LABOR USED

	PERSON OR CATEGORY 1	**PERSON OR CATEGORY 2**	**PERSON OR CATEGORY 3**	**PERSON OR CATEGORY 4**	**PERSON OR CATEGORY 5**	**PERSON OR CATEGORY 6**
NAME OF PERSON OR CATEGORY →						
Actual salary or average salary for position (*enter 0 if volunteer*)						
Salary is per (year, week, hour)						
Average percent fringe benefits						
If volunteer, equivalent salary						
Total hours worked per week						
Breakdown of work time[a]						
Hours on activities related only to congregate meals						
Hours on activities related only to home-delivered meals						
Hours on activities related to both congregate and home-delivered meals						
Hours on nonmeal-related activities						

[a]Entries should add to total hours worked from previous line.

LSP COST STUDY WORKSHEET #2: MEAL DELIVERY LABOR COSTS

(Record labor costs associated with delivering meals to sites or to particpants' homes.)

A. NAME OR DESCRIPTION OF ROUTE

B. NUMBER OF MEALS DELIVERED PER WEEK	**CONGREGATE**	**HOME-DELIVERED**
Meals served to Title III participants		
Meals served to other persons		

C. LABOR USED

	PERSON OR CATEGORY 1	**PERSON OR CATEGORY 2**	**PERSON OR CATEGORY 3**	**PERSON OR CATEGORY 4**	**PERSON OR CATEGORY 5**	**PERSON OR CATEGORY 6**
NAME OF PERSON OR CATEGORY →						
Actual salary or average salary for position (*enter 0 if volunteer*)						
Salary is per (year, week, hour)						
Average percent fringe benefits						
If volunteer, equivalent salary						
Total hours worked per week						
Total hours spent on this delivery route per week						

LSP COST STUDY WORKSHEET #3: ENTIRE NUTRITION PROJECT FOOD OPERATIONS: NON-LABOR COSTS

(Note: If any item (such as a space) can't be separated out between meal-related and nonmeal-related, report the aggregate.)

COST COMPONENT		COST PER WEEK	MEALS PER WEEK
A.	Payments to Vendors for Already-Prepared Food		
	Congregate		
	Home Delivered		
	Total[a]		
B.	Food Ingredients for Meals Prepared at Affiliated Central Kitchen or On-Site		
	Congregate		
	Home Delivered		
	Total[a]		
C.	Purchase of Frozen Meals		
	Congregate		
	Home Delivered		
	Total[a]		
D.	Value of USDA Commodities Used		
E.	Value of Other Donated Food		
F.	Non-Food Supplies		
G.	Rent or Space Costs		
	Sites		
	Central Kitchen		
	Central Administration		
	Additional Commodity Storage Costs		
H.	Utility Costs		
I.	Value of Donated Space and Utilities		
J.	Insurance		
K.	Gasoline		
L.	Other (SPECIFY)		

[a]If the same food is used for congregate and home-delivered meals, a total is acceptable.

NON-LABOR COSTS *(continued)*

EQUIPMENT VALUE	**ESTIMATED REPLACEMENT COST OF COMPARABLE EQUIPMENT, BOUGHT NEW**
Vehicles	
Food Preparation and Service Equipment	
Production Equipment	
Packaging Equipment	
Transport Equipment Other Than Vehicles[a]	
Serving Equipment	
Building and Improvements (Enter "0" if No Buildings are Owned)	
Office Equipment	
Other (SPECIFY)	

[a]Such as insulated containers for food transport.

VEHICLE USAGE	**PERCENTAGE OF TOTAL VEHICLE USE TIME**
Transporting Food to Congregate Sites	
Transporting Participants to Congregate Sites	
Other Participant Transportation	
Home Delivery of Meals	
General and Administrative	
Other (SPECIFY)	

LSP COST STUDY WORKSHEET #4: CENTRAL ADMINISTRATIVE LABOR COSTS

(Include staff with central administrative responsibilities.)

A. NAME OF NUTRITION PROJECT

B. NUMBER OF MEALS PREPARED OR SERVED PER WEEK	**CONGREGATE**	**HOME-DELIVERED**
Meals served to Title III participants		
Meals served to other persons		

C. LABOR USED

	PERSON OR CATEGORY 1	**PERSON OR CATEGORY 2**	**PERSON OR CATEGORY 3**	**PERSON OR CATEGORY 4**	**PERSON OR CATEGORY 5**	**PERSON OR CATEGORY 6**
NAME OF PERSON OR CATEGORY ⟶						
Actual salary or average salary for position (*enter 0 if volunteer*)						
Salary is per (year, week, hour)						
Average percent fringe benefits						
If volunteer, equivalent salary						
Total hours worked per week						
Breakdown of work time[a]						
Hours on activities related only to congregate meals						
Hours on activities related only to home-delivered meals						
Hours on activities related to both congregate and home-delivered meals						
Hours on nonmeal-related activities						

[a]Entries should add to total hours worked from previous line.

Mathematica Reference No.: 06669.202

MATHEMATICA Policy Research

National Evaluation of Title III-C Services

Client Outcomes Survey

CAPI Questionnaire

May 23, 2012

INTRODUCTION

INTERVIEWER: SELECT PARTICIPANT TYPE:

CONGREGATE NUTRITION PARTICIPANT	1	SET PTCPT = CM
HOME-DELIVERED NUTRITION PARTICIPANT	2	SET PTCPT = HDM
CONGREGATE NUTRITION NONPARTICIPANT	3	SET PTCPT = NON; MATCH = CM
HOME-DELIVERED NUTRITION NONPARTICIPANT	4	SET PTCPT = NON; MATCH = HDM

INTERVIEWER: WILL INTERVIEW BE CONDUCTED WITH A PROXY?

YES	1	SET PROXY STATUS = Y
NO	0	SET PROXY

INTERVIEWER: ENTER NAME OF PERSON

INTERVIEWER: ENTER NAME OF PROGRAM

REQUIRED
IF PTCPT = CM OR HDM AND PROXY = N

INTRO1. My name is [NAME] and I am from Mathematica Policy Research. I am here on behalf of the U.S. Department of Health and Human Services, Administration on Aging. I would like your help with a survey to find out how the Administration on Aging can help meet the needs of older Americans.

This survey has two parts. The first part of the survey is about your participation in the nutrition program at [NAME OF PROGRAM SITE] and your satisfaction with aspects of the nutrition program there. The second part of the survey is about what you ate and drank over the past 24 hours. Your participation is voluntary but we would really like your help. This survey is for research purposes only and will help to improve services for older adults in the future. All of your answers will be kept strictly confidential. Your eligibility for services from this and other programs will not be affected by your decision to participate. The entire survey takes about 75 minutes to complete. We'll mail you a $50 gift card for completing the survey.

CONTINUE	1	SKIP TO A1
REFUSED	r	Thank you for your time

REQUIRED
IF PTCPT = CM OR HDM AND PROXY = Y

INTRO2. My name is [NAME] and I am from Mathematica Policy Research. I am here on behalf of the U.S. Department of Health and Human Services, Administration on Aging. I would like your help with completing a survey on behalf of [NAME OF PARTICIPANT]. The purpose of the survey is to find out how the Administration on Aging can help meet the needs of older Americans.

This survey has two parts. The first part of the survey is about [NAME OF PARTICIPANT]'s participation in the nutrition program at [NAME OF PROGRAM SITE] and [his/her] satisfaction with aspects of the nutrition program there. The second part of the survey is about what [he/she] ate and drank over the past 24 hours. Your participation is voluntary but we would really like your help. This survey is for research purposes only and will help to improve services for older adults in the future. All of your answers will be kept strictly confidential. [NAME OF PARTICIPANT]'s eligibility for services for this and other programs will not be affected by your decision to participate. The entire survey takes about 75 minutes to complete. We'll mail you a $50 gift card for completing the survey.

For the remainder of the survey I would like you to answer as though you are [NAME OF PARTICIPANT]. All of the following questions pertain to [him/her]. Please provide your best estimate as to [his/her] own response or opinion.

CONTINUE	1	SKIP TO A1
REFUSED	r	Thank you for your time

REQUIRED
IF PTCPT = NON AND PROXY = N

INTRO3. My name is [NAME] and I am from Mathematica Policy Research. I am here on behalf of the U.S. Department of Health and Human Services, Administration on Aging. I would like your help with a survey to find out how the Administration on Aging can help meet the needs of Older Americans.

This survey has two parts. The first part has some general questions, as well as questions about your general health and dietary habits. The second part is about what you ate and drank over the past 24 hours. Your participation is voluntary but we would really like your help. This survey is for research purposes only and will help to improve services for older adults in the future. All of your answers will be kept strictly confidential. Your eligibility for services from this and other programs will not be affected by your decision to participate. The entire survey takes about 55 minutes to complete. We'll mail you a $50 gift card for completing the survey.

CONTINUE	1	SKIP TO A1
REFUSED	r	Thank you for your time

REQUIRED
IF PTCPT = NON AND PROXY = Y

INTRO4. My name is [NAME] and I am from Mathematica Policy Research. I am here on behalf of the U.S. Department of Health and Human Services, Administration on Aging. I would like your help with completing a survey on behalf of [NAME OF PARTICIPANT]. The purpose of the survey to find out how the Administration on Aging can help meet the needs of older Americans.

This survey has two parts. The first part of the survey is about [NAME OF PARTICIPANT]'s general health and dietary habits. The second part of the survey is about what (he/she) ate and drank over the past 24 hours. Your participation is voluntary but we would really like your help. This survey is for research purposes only and will help to improve services for older adults in the future. All of your answers will be kept strictly confidential. [NAME OF PARTICIPANT]'s eligibility for services for this and other programs will not be affected by your decision to participate. The entire survey takes about 55 minutes to complete. We'll mail you a $50 gift card for completing the survey.

For the remainder of the survey I would like you to answer as though you were [NAME OF PARTICIPANT]. All of the following questions pertain to [him/her]. Please provide your best estimate as to [his/her] own response or opinion.

CONTINUE	1	SKIP TO A1
REFUSED	r	Thank you for your time

A. NUTRITION PROGRAM PARTICIPATION

PROGRAMMER BOX A1

CATI: CONTINUE IF PTCPT = CM OR HDM. IF PTCPT = NON, SKIP TO SECTION B.

REQUIRED

IF PTCPT = CM

A_Intro: My first questions are about [your/his/her] participation in the congregate nutrition program at [NAME OF PROGRAM SITE].

A1. During a typical week, how many days [do you/does he/does she] eat at [NAME OF PROGRAM SITE] or another place like it?

|__|__| DAYS (0-999)

PER WEEK (Range 1-7) 1

PER MONTH (Range 1-31) 2

PER YEAR (Range 1-99) 3

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF DAYS PER WEEK GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill A1] days per week? INTERVIEWER: ANSWER CANNOT EXCEED 7 DAYS PER WEEK.**

HARD CHECK: IF DAYS PER MONTH GT 31; **I want to be sure I recorded your answer correctly. Did you say [fill A1] days per month? INTERVIEWER: ANSWER CANNOT EXCEED 31 DAYS PER MONTH.**

HARD CHECK: IF A1 GT 99; **I want to be sure I recorded your answer correctly. Did you say [fill A1] days? INTERVIEWER: ANSWER CANNOT EXCEED 99 DAYS.**

HARD CHECK: IF A1 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A1] days? INTERVIEWER: ANSWER CANNOT BE 0.**

REQUIRED
IF PTCPT = HDM

A_Intro: My first questions are about [your/his/her] participation in the home-delivered nutrition program from [NAME OF PROGRAM SITE]. You may also know this as the meals-on-wheels program from [NAME OF PROGRAM SITE].

A1.1 During a typical week, how many days does [NAME OF PROGRAM SITE] or another program like it deliver meals to [your/his/her] home?

|___|___| DAYS (0-999)

PER WEEK (Range 1-7) 1

PER MONTH (Range 1-31) 2

PER YEAR (Range 1-99) 3

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF DAYS PER WEEK GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill A1.1] days per week? INTERVIEWER: ANSWER CANNOT EXCEED 7 DAYS PER WEEK.**
HARD CHECK: IF DAYS PER MONTH GT 31; **I want to be sure I recorded your answer correctly. Did you say [fill A1.1] days per month? INTERVIEWER: ANSWER CANNOT EXCEED 31 DAYS PER MONTH.**
HARD CHECK: IF A1.1 GT 99; **I want to be sure I recorded your answer correctly. Did you say [fill A1.1] days? INTERVIEWER: ANSWER CANNOT EXCEED 99 DAYS.**
HARD CHECK: IF A1.1 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A1.1] days? INTERVIEWER: ANSWER CANNOT BE 0.**

REQUIRED

IF PTCPT = CM

A2. Thinking about meals [you eat/he eats/she eats] at [NAME OF PROGRAM SITE] or other places like this, during a typical week, how many times per week [do you/does he/does she] eat . . .

a. Breakfast there?

|___| TIMES (0-99)

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF A2a GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill A2a] times per week? INTERVIEWER: ANSWER CANNOT EXCEED 7 TIMES PER WEEK.**

b. Lunch there?

|___| TIMES (0-99)

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF A2b GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill A2b] times per week? INTERVIEWER: ANSWER CANNOT EXCEED 7 TIMES PER WEEK**

c. Dinner there?

|___| TIMES (0-99)

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF A2c GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill A2c] times per week? INTERVIEWER: ANSWER CANNOT EXCEED 7 TIMES PER WEEK.**

REQUIRED

IF PTCPT = HDM

A2.1 Thinking about meals [you receive/he receives/she receives] from [NAME OF PROGRAM SITE, how many of each of the following meals [do you/does he/does she] receive during a typical week?

a. Breakfast

|___| MEALS (0-99)

DON'T KNOW ..... d

REFUSED ..... r

MEALS ARE NOT DESIGNATED ..... 99 SKIP TO UNDESIGNATED MEALS

HARD CHECK: IF A2.1a GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill A2.1a] meals per week? INTERVIEWER: ANSWER CANNOT EXCEED 7 MEALS PER WEEK.**

b. Lunch

|___| MEALS (0-99)

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF A2.1b GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill A2.1b] meals per week? INTERVIEWER: ANSWER CANNOT EXCEED 7 MEALS PER WEEK.**

c. Dinner

|___| MEALS (0-99)

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF A2.1c GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill A2.1c] meals per week? INTERVIEWER: ANSWER CANNOT EXCEED 7 MEALS PER WEEK.**

ASK ONLY IF RESPONDENT SAYS MEALS ARE NOT DESIGNATED:

d. Undesignated meals

|___|___| MEALS (0-99)

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF A2.1d GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill A2.1d] meals per week?**

HARD CHECK: IF A2.1d GT 21; **I want to be sure I recorded your answer correctly. Did you say [fill A2.1d] meals per week? INTERVIEWER: ANSWER CANNOT EXCEED 21 MEALS PER WEEK.**

REQUIRED
IF A2.1 LUNCHES IS LT 5

A2.2 [Do you/Does he/Does she] receive fewer than five lunches a week because [you prefer/he prefers/she prefers] it that way, or because [you/he/she] can only get fewer than five lunches a week?

CODE ONE ONLY

PREFER IT THAT WAY 1

CANNOT GET MORE LUNCHES 2

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = HDM

A2.3. How long ago was the last time [NAME OF PROGRAM SITE] delivered a meal to [your/his/her] home? You can tell me the number of days, weeks, months, or years.

INTERVIEWER: IF RESPONDENT HAD A MEAL DELIVERED TODAY, PLEASE CODE 0 DAYS AGO

|___|___| (0-999)

DAYS AGO (Range 0-45) 1

WEEKS AGO (Range 1-30) 2

MONTHS AGO (Range 1-13) 3

YEARS AGO (Range 1-40) 4

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF A2.3 GT 45; **I want to be sure I recorded your answer correctly. Did you say [fill A2.3]? INTERVIEWER: ANSWER CANNOT EXCEED 45.**
HARD CHECK: IF WEEKS AGO GT 30; **I want to be sure I recorded your answer correctly. Did you say [fill A2.3] weeks ago? INTERVIEWER: ANSWER CANNOT EXCEED 30 WEEKS AGO.**
HARD CHECK: IF MONTHS AGO GT 13; **I want to be sure I recorded your answer correctly. Did you say [fill A2.3] months ago? INTERVIEWER: ANSWER CANNOT EXCEED 13 MONTHS AGO.**
HARD CHECK: IF YEARS AGO GT 40; **I want to be sure I recorded your answer correctly. Did you say [fill A2.3] years ago? INTERVIEWER: ANSWER CANNOT EXCEED 40 YEARS AGO.**
HARD CHECK: IF WEEKS AGO = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A2.3] weeks ago? INTERVIEWER: ANSWER CANNOT BE 0 WEEKS AGO.**
HARD CHECK: IF MONTHS AGO = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A2.3] months ago? INTERVIEWER: ANSWER CANNOT BE 0 MONTHS AGO.**
HARD CHECK: IF YEARS AGO = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A2.3] years ago? INTERVIEWER: ANSWER CANNOT BE 0 YEARS AGO.**

REQUIRED
IF PTCPT = CM

A3. Thinking back to 6 months ago (that is, last [CURRENT MONTH – 6 MONTHS]), did [you/he/she] eat meals at the [NAME OF PROGRAM SITE] or other places like this more often, less often, or about as often as [you do/he does/she does] now?

CODE ONE ONLY

MORE OFTEN	1	
LESS OFTEN	2	
ABOUT AS OFTEN	3	SKIP TO A5
DON'T KNOW	d	SKIP TO A5
REFUSED	r	SKIP TO A5

REQUIRED
IF A3 = 1

A4. Why [do you/does he/does she] eat at [NAME OF PROGRAM SITE] more often than [you/he/she] did 6 months ago?

PROBE: That is, since last [CURRENT MONTH – 6 MONTHS].

CODE ALL THAT APPLY

HAVE NO ONE AT HOME TO EAT WITH	1
MADE FRIENDS AT MEAL SITE	2
GOT INVOLVED IN ACTIVITIES AT MEAL SITE	3
COSTS LESS TO EAT AT MEAL SITE THAN ELSEWHERE	4
THE MEAL SITE IS WARM AND INVITING	5
NO LONGER HAVE A PLACE TO PREPARE MEALS	6
PHYSICALLY DIFFICULT TO MAKE OWN MEALS	7
I LIKE THE KINDS OF FOODS THEY SERVE	8
OTHER (PLEASE SPECIFY)	99
_____ (STRING (30))	
DON'T KNOW	d
REFUSED	r

REQUIRED
IF A3 = 2

A4.1 Why [do you/does he/does she] eat at [NAME OF PROGRAM SITE] less often than [you/he/she] did 6 months ago?

PROBE: That is, since last [CURRENT MONTH – 6 MONTHS].

CODE ALL THAT APPLY

HAVE FEW OR NO FRIENDS AT MEAL SITE 1

HAVE OTHER PLACES TO EAT 2

HAVEN'T GOTTEN INVOLVED OR NOT INTERESTED IN ACTIVITIES AT MEAL SITE 3

CAN'T AFFORD TO DONATE AT MEAL SITE 4

SOMETIMES DIFFICULT TO GET TO MEAL SITE 5

I FOUND THAT I DON'T ALWAYS LIKE THE KINDS OF FOODS THEY SERVE 6

STILL ABLE TO PREPARE OWN MEALS 7

OTHER (PLEASE SPECIFY) 99

_____ (STRING (30))

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM

A5. When [you eat/he eats/she eats] at [NAME OF PROGRAM SITE], [are you/is he/is she] able to take leftovers or seconds home with [you/him/her]?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM

A6. When [you go/he goes/she goes] to [NAME OF PROGRAM SITE], [do you/does he/does she] ever get meals to take home to eat later? Please do not include leftovers [you/he/she] might take home from a meal [you/he/she] ate at [NAME OF PROGRAM SITE].

YES 1

NO ..... 0 SKIP TO A11

DON'T KNOW ..... d SKIP TO A11

REFUSED ..... r SKIP TO A11

REQUIRED
IF A6 = 1

A7. How would [you/he/she] describe those take home meals? Are they full meals, just snacks, supplements such as Ensure or Boost, or something else?

CODE ONE ONLY

FULL MEALS 1
SNACKS 2
SUPPLEMENTS 3
OTHER (PLEASE SPECIFY) 99
_____ (STRING (30))
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = HDM

A8. How often [do you/does he/does she] eat the entire delivered meal in one sitting? Would [you/he/she] say . . .

CODE ONE ONLY

Always, ... 1 SKIP TO A10
Usually, ... 2 SKIP TO A9
Sometimes, ... 3 SKIP TO A9
Seldom, or ..... 4 SKIP TO A9
Never? ..... 5 SKIP TO A9
DON'T KNOW ..... d SKIP TO A9
REFUSED ..... r SKIP TO A9

REQUIRED
IF PTCPT = HDM AND A8 DNE 1

A9. When [you do/he does/she does] not eat [your/his/her] entire delivered meal in one sitting, do [you/he/she] usually eat <u>all</u> of what is left as another meal, eat only <u>part</u> of what is left as another meal, or do you usually throw the rest of the meal away?

CODE ONE ONLY

ALL OF ANOTHER MEAL 1
PART OF ANOTHER MEAL 2
THROW IT AWAY 3
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = HDM

A10. [Do you/Does he/Does she] currently have any diet and nutritional supplements at home, such as Ensure or Boost, that [NAME OF PROGRAM SITE] gave [you/him/her]?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM OR HDM

A11. [Do you/Does he/Does she] currently any emergency meals at home that the [NAME OF PROGRAM SITE] gave [you/him/her]?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF A11 = YES

A12. How many emergency meals [do you/does he/does she] have from [NAME OF PROGRAM SITE]? Your best estimate is fine.

|___|___| NUMBER OF MEALS (0-99)

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF A12 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A12] meals? INTERVIEWER: ANSWER CANNOT BE 0.**
HARD CHECK: IF A12 GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill A12] meals? INTERVIEWER: ANSWER CANNOT EXCEED 10 MEALS.**

REQUIRED
IF PTCPT = CM OR HDM

A13. If the [NAME OF PROGRAM SITE] wasn't available to provide meals, how often would (INSERT a-h) . . . Would you say most of the time, sometimes, or never?

CODE ALL THAT APPLY

		MOST OF THE TIME	SOMETIMES	NEVER	DON'T KNOW	REFUSED
a.	[You/He/She] cook for [yourself/himself/herself]?	1	2	3	d	r
b.	Family or friends provide [you/him/her] with meals?	1	2	3	d	r
c.	[You/He/She] eat at restaurants or have food delivered from restaurants?	1	2	3	d	r
d.	[You/He/She] eat meals that were easy to fix like sandwiches, microwavable meals, or soups?	1	2	3	d	r
e.	[You/He/She] eat meals that were ready to eat right out of the package?	1	2	3	d	r
f.	Skip meals or eat less than [you do/he does/she does] now?	1	2	3	d	r
g.	Eat foods saved from other meals?	1	2	3	d	r
h.	[You/He/She] get food in some other way? (PLEASE SPECIFY) _____(STRING (30))	1	2	3	d	r

REQUIRED
IF PTCPT = CM

A14. Excluding [NAME OF PROGRAM SITE], how many other places like [NAME OF PROGRAM SITE] [do you/does he/does she] usually go for [your/his/her] meals? These could be senior centers, senior lunch programs, or other congregate meals programs.

|__|__| NUMBER OF PLACES (0-99)

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF A14 GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill A14] places? INTERVIEWER: ANSWER CANNOT EXCEED 10 PLACES.**

REQUIRED
IF PTCPT = HDM

A14.1 Excluding [NAME OF PROGRAM SITE], how many other similar places usually deliver meals to [your/his/her] home?

|___|___| NUMBER OF PLACES (0-99)

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF A14.1 GT 5; **I want to be sure I recorded your answer correctly. Did you say [fill A14.1] other places usually deliver meals to [your/his/her] home?**
HARD CHECK: IF A14.1 GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill A14.1] other places usually deliver meals to [your/his/her] home? INTERVIEWER: ANSWER CANNOT EXCEED 10 OTHER PLACES.**

REQUIRED
IF PTCPT = CM

A15. How long ago did [you/he/she] first begin eating at a congregate meal site, senior center, or senior lunch program for a meal?

PROBE: You may answer in days, weeks, months, or years. Your best estimate is fine.

|___|___| (0-999)

DAYS AGO (Range 0-45) 1

WEEKS AGO (Range 1-30) 2

MONTHS AGO (Range 1-13) 3

YEARS AGO (Range 1-40) 4

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF A15 GT 45; **I want to be sure I recorded your answer correctly. Did you say [fill A15]? INTERVIEWER: ANSWER CANNOT EXCEED 45.**
HARD CHECK: IF WEEKS AGO GT 30; **I want to be sure I recorded your answer correctly. Did you say [fill A15] weeks ago? INTERVIEWER: ANSWER CANNOT EXCEED 30 WEEKS AGO.**
HARD CHECK: IF MONTHS AGO GT 13; **I want to be sure I recorded your answer correctly. Did you say [FILL A15] months ago? INTERVIEWER: ANSWER CANNOT EXCEED 13 MONTHS AGO.**
HARD CHECK: IF YEARS AGO GT 40; **I want to be sure I recorded your answer correctly. Did you say [fill A15] years ago? INTERVIEWER: ANSWER CANNOT EXCEED 40 YEARS AGO.**
HARD CHECK: IF WEEKS AGO = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A15] weeks ago? INTERVIEWER: ANSWER CANNOT BE 0 WEEKS AGO.**
HARD CHECK: IF MONTHS AGO = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A15] months ago? INTERVIEWER: ANSWER CANNOT BE 0 MONTHS AGO.**
HARD CHECK: IF YEARS AGO = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A15] years ago? INTERVIEWER: ANSWER CANNOT BE 0 YEARS AGO.**

REQUIRED
IF PTCPT = HDM

A15.1 How long ago did [you/he/she] first receive a home-delivered meal?

PROBE: You may answer in days, weeks, months, or years. Your best estimate is fine.

|__|__| (0-999)

DAYS AGO (Range 0-45) 1

WEEKS AGO (Range 1-30) 2

MONTHS AGO (Range 1-13) 3

YEARS AGO (Range 1-40) 4

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF A15.1 GT 45; **I want to be sure I recorded your answer correctly. Did you say [fill A15.1]? INTERVIEWER: ANSWER CANNOT EXCEED 45.**
HARD CHECK: IF WEEKS AGO GT 30; **I want to be sure I recorded your answer correctly. Did you say [fill A15.1] weeks ago? INTERVIEWER: ANSWER CANNOT EXCEED 30 WEEKS AGO.**
HARD CHECK: IF MONTHS AGO GT 13; **I want to be sure I recorded your answer correctly. Did you say [fill A15.1] months ago? INTERVIEWER: ANSWER CANNOT EXCEED 13 MONTHS AGO.**
HARD CHECK: IF YEARS AGO GT 40; **I want to be sure I recorded your answer correctly. Did you say [fill A15.1] years ago? INTERVIEWER: ANSWER CANNOT EXCEED 40 YEARS AGO.**
HARD CHECK: IF WEEKS AGO = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A15.1] weeks ago? INTERVIEWER: ANSWER CANNOT BE 0 WEEKS AGO.**
HARD CHECK: IF MONTHS AGO = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A15.1] months ago? INTERVIEWER: ANSWER CANNOT BE 0 MONTHS AGO.**
HARD CHECK: IF YEARS AGO = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A15.1] years ago? INTERVIEWER: ANSWER CANNOT BE 0 YEARS AGO.**

REQUIRED
IF PTCPT = CM

A16. How did [you/he/she] first learn about the nutrition program like the one at [NAME OF PROGRAM SITE]?

CODE ALL THAT APPLY

FROM ANOTHER PERSON 1
MEDICAL DOCTOR 2
MEDICAL PERSONNEL OTHER THAN A DOCTOR 3
SOCIAL WORKER 4
FAMILY MEMBER 5
FRIEND 6
NEWSPAPER, TV, RADIO, INTERNET 7
POSTERS, SOMETHING IN THE MAIL 8
ANNOUNCEMENT IN CLUB OR CHURCH 9
REFERRED BY A COMMUNITY-BASED AGENCY (HOSPITAL, SOCIAL SERVICES AGENCY, ETC.) 10
OTHER (PLEASE SPECIFY) 99
_____ (STRING (30))
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = HDM

A16.1 How did [you/he/she] first learn about the home-delivered nutrition program like the one at [NAME OF PROGRAM SITE]?

CODE ALL THAT APPLY

FROM ANOTHER PERSON 1
MEDICAL DOCTOR 2
MEDICAL PERSONNEL OTHER THAN A DOCTOR 3
SOCIAL WORKER 4
FAMILY MEMBER 5
FRIEND 6
NEWSPAPER, TV, RADIO, INTERNET 7
POSTERS, SOMETHING IN THE MAIL 8
ANNOUNCEMENT IN CLUB OR CHURCH 9
REFERRED BY A COMMUNITY-BASED AGENCY (HOSPITAL, SOCIAL SERVICES AGENCY, ETC.) 10
OTHER (PLEASE SPECIFY) 99
_____ (STRING (30))
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM OR HDM

A17. [Were you/Was he/Was she] on a waiting list before [you were/he was/she was] able to take part in the [NAME OF PROGRAM SITE] nutrition program?

YES 1
NO ..... 0 SKIP TO B1
DON'T KNOW ..... d SKIP TO B1
REFUSED ..... r SKIP TO B1

REQUIRED
IF A17 = 1

A18. How long [were you/was he/was she] on the waiting list before [you/he/she] received a program meal? You can tell me the number of days, weeks, months, or years.

|__|__| (0-999)

DAYS (Range 1-99) 1

WEEKS (Range 1-20) 2

MONTHS (Range 1-12) 3

YEARS (Range 1-5) 4

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF A18 GT 99; **I want to be sure I recorded your answer correctly. Did you say [fill A2.3]? INTERVIEWER: ANSWER CANNOT EXCEED 99.**
HARD CHECK: IF WEEKS GT 20; **I want to be sure I recorded your answer correctly. Did you say [fill A18] weeks? INTERVIEWER: ANSWER CANNOT EXCEED 20 WEEKS.**
HARD CHECK: IF MONTHS GT 12; **I want to be sure I recorded your answer correctly. Did you say [fill A18] months? INTERVIEWER: ANSWER CANNOT EXCEED 12 MONTHS.**
HARD CHECK: IF YEARS GT 5; **I want to be sure I recorded your answer correctly. Did you say [fill A18] years? INTERVIEWER: ANSWER CANNOT EXCEED 5 YEARS.**
HARD CHECK: IF A18 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill A18]? INTERVIEWER: ANSWER CANNOT BE 0.**

B. OTHER SERVICES

PROGRAMMER BOX B1

CATI: CONTINUE IF PTCPT = CM, HDM, OR NON.

REQUIRED

IF PTCPT = CM OR HDM

B1. In the past 6 months, other than meals from [NAME OF PROGRAM SITE], [have you/has he/has she] gotten other types of help or services from either [NAME OF PROGRAM SITE], [NAME OF AREA AGENCY ON AGING], or some other agency or provider?

YES	1	
NO	0	SKIP TO B3
DON'T KNOW	d	SKIP TO B3
REFUSED	r	SKIP TO B3

REQUIRED

IF PTCPT = NON

B1.1 In the past 6 months, [have you/has he/has she] gotten any help or received any services from [NAME OF AREA AGENCY ON AGING] or some other agency?

YES	1	
NO	0	SKIP TO C1
DON'T KNOW	d	SKIP TO C1
REFUSED	r	SKIP TO C1

REQUIRED
IF B1 OR B1.1 =1

B2. In the past 6 months . . .

	YES	NO	DON'T KNOW	REFUSED
a. [Have you/Has he/Has she] participated in an adult day care program?	1	0	d	r
b. [Have you/Has he/Has she] received personal care services for help with dressing or bathing?	1	0	d	r
c. Did [a visiting nurse or therapist come to [your/his/her] home to provide physical, occupational, or speech therapy?	1	0	d	r
d. Did a nutritional counselor give [you/him/her] individual advice on what [you/he/she] should eat?	1	0	d	r
e. [Have you/Has he/Has she] received case management services in which a case manager set up in-home services for [you/him/her] such as homemaker or personal care services, or called to see how [you are/he is/she is] doing?	1	0	d	r
f. [Have you/Has he/Has she] received free or discounted housing?	1	0	d	r
g. Did [you/he/she] participate in a support group to talk with other people who have the same kind of problems [you have/he has/she has]?	1	0	d	r
h. [Have you/Has he/Has she] received homemaker or housekeeping services to help with light housework, preparing meals, or shopping?	1	0	d	r
i. [Have you/Has he/Has she] received chore services to help with heavier housecleaning or yard work?	1	0	d	r

REQUIRED
IF PTCPT = CM

B3. In the past 6 months, [have you/has he/has she] attended a class or lecture about any of the following at [NAME OF PROGRAM SITE]?

		YES	NO	DON'T KNOW	REFUSED
a.	A specific chronic disease (e.g., Diabetes, heart disease)?	1	0	d	r
b.	Nutrition or healthy eating habits?	1	0	d	r
c.	Safety issues such as falls prevention?	1	0	d	r
d.	Health insurance or Medicare Part D?	1	0	d	r
e.	How to manage [your/his/her] medications?	1	0	d	r
f.	How to manage [your/his/her] finances?	1	0	d	r

REQUIRED
IF PTCPT = CM

B3.1 Thinking about other activities at [NAME OF PROGRAM SITE], in the past 6 months [have you/has he/has she] . . .

		YES	NO	DON'T KNOW	REFUSED
a.	Participated in an exercise or fitness class there?	1	0	d	r
b.	Received assistance in finding employment there?	1	0	d	r
c.	Received legal services such as help with making a will or understanding a bill or other legal matter there?	1	0	d	r
d.	Received counseling about your housing situation or problems with your housing there?	1	0	d	r

C. SERVICES, ACTIVITIES, AND TRANSPORTATION

PROGRAMMER BOX C1

CATI: CONTINUE IF PTCPT = CM, HDM, or NON.

REQUIRED

IF PTCPT = CM

C_Intro: The next questions are about how [you get/he gets/she gets] to and from [NAME OF PROGRAM SITE].

C1. During the past 30 days, [have you/has he/has she] done any of the following to get to or from [NAME OF PROGRAM SITE]? Did you . . .

	YES	NO	DON'T KNOW	REFUSED	NOT APPLICABLE (SITE IN BUILDING WHERE PARTICIPANT RESIDES)
a. Drive [yourself/himself/herself]?	1	0	d	r	n SKIP TO C5
b. Share a ride with a friend or family member but were not the driver?	1	0	d	r	n
c. Use private transportation such as a taxi, limousine, or car service?	1	0	d	r	n
d. Use public transportation such as buses, light rail transit, trains, subways, community shuttles or jitneys?	1	0	d	r	n
e. Use para transportation such as ADA transit or Dial-A Ride transit?	1	0	d	r	n
f. Use specialized transportation such as nutrition program or senior program sponsored bus/van/car, church or faith-based program bus/van/car, or volunteer driver?	1	0	d	r	n
g. Use some other form of transportation such as walking, biking, or using a scooter?	1	0	d	r	n

REQUIRED
IF C1e OR C1f = 1

C2. During the past 30 days, how often did [you/he/she] use para or special transportation to get to and from [NAME OF PROGRAM SITE]?

|__|__| (0-999) TIMES

PER DAY (Range 1-5) 1

PER WEEK (Range 1-25) 2

PER MONTH (Range 1-50) 3

PER YEAR (Range 1-99) 4

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF C2 GT 99; **I want to be sure I recorded your answer correctly. Did you say [fill C2]? INTERVIEWER: ANSWER CANNOT EXCEED 99.**
HARD CHECK: IF PER DAY GT 5; **I want to be sure I recorded your answer correctly. Did you say [fill C2] times per day? INTERVIEWER: ANSWER CANNOT EXCEED 5 TIMES PER DAY.**
HARD CHECK: IF PER WEEK GT 25; **I want to be sure I recorded your answer correctly. Did you say [fill C2] times per week? INTERVIEWER: ANSWER CANNOT EXCEED 25 TIMES PER WEEK.**
HARD CHECK: IF PER MONTH GT 50 1; **I want to be sure I recorded your answer correctly. Did you say [fill C2] times per month? INTERVIEWER: ANSWER CANNOT EXCEED 50 TIMES PER MONTH.**
HARD CHECK: IF C2 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill C2]? INTERVIEWER: ANSWER CANNOT BE 0.**

REQUIRED
IF ANY C1B-G = 1

C3. How easy is it to obtain transportation to the [NAME OF PROGRAM SITE]? Would [you/he/she] say . . .

CODE ONE ONLY

Very easy, ... 1

Somewhat easy, ... 2

Not too easy, or 3

Not easy at all? 4

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF C1e OR C1f = 1

C4. If the transportation service [you use/he uses/she uses] to get to and from [NAME OF PROGRAM SITE] was not available, would [you/he/she] go . . .

CODE ONE ONLY

About as often as now, ... 1

Somewhat less often, ... 2

A lot less often, or 3

Wouldn't go at all? 4

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM, OR NON

C5. During the past year, [have you/has he/has she] used any of the following transportation services to go to the store, bank, doctor's office, or some other place?

	YES	NO	DON'T KNOW	REFUSED
a. Para transportation such as ADA transit or Dial-A Ride transit?	1	0	d	r
b. Specialized transportation such as a senior program sponsored bus/van/car, church or faith-based program bus/van/car, or volunteer driver?	1	0	d	r

REQUIRED
IF C5a OR C5b = 1

C6. Where did the transportation service take [you/him/her]?

CODE ALL THAT APPLY

Grocery shopping, ... 1

Other types of shopping, ... 2

Doctor or other health care visit, ... 3

Bank or other errand, or 4

Some place else? (PLEASE SPECIFY) 99

_____ (STRING (30))

DON'T KNOW ..... d

REFUSED ..... r

D. RECREATIONAL AND SOCIAL ACTIVITIES

PROGRAMMER BOX D1

CATI: CONTINUE IF PTCPT = CM. IF PTCPT = HDM OR NON, SKIP TO SECTION E.

D_Intro: The next questions are about recreational and social activities [you/he/she] may participate in at [NAME OF PROGRAM SITE].

REQUIRED

IF PTCPT = CM

D1. In general, how satisfied [are you/is he/is she] with opportunities [you have/he has/she has] to spend time with other people at [NAME OF PROGRAM SITE]? Would [you/he/she] say [you are/he is/she is] . . .

CODE ONE ONLY

Very satisfied, ... 1

Somewhat satisfied, ... 2

Not too satisfied, or 3

Not at all satisfied? 4

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED

IF PTCPT = CM

D2. [Do you/Does he/Does she] spend a lot of time, some time, just a little time, or no time participating in other activities or receiving other services at the [NAME OF PROGRAM SITE] meal site?

CODE ONE ONLY

A LOT OF TIME 1

SOME TIME 2

JUST A LITTLE TIME 3

NO TIME 4

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM

D3. How long [do you /does he/does she] usually stay at the [NAME OF PROGRAM SITE] meal site each time [you go/he goes/she goes]? Please include the time [you spend/he spent/she spent] getting a meal.

|__|__| (0-999)

MINUTES (1-90) 1

HOURS (1-10) 2

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF D3 GT 90; **I want to be sure I recorded your answer correctly. Did you say [fill D3]? INTERVIEWER: ANSWER CANNOT EXCEED 90.**
HARD CHECK: IF HOURS GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill D3] hours? INTERVIEWER: ANSWER CANNOT EXCEED 10 HOURS.**
HARD CHECK: IF D3 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill D3]? INTERVIEWER: ANSWER CANNOT BE 0.**

E. INFORMATION AND REFERRAL, OTHER SERVICES

PROGRAMMER BOX E1

CATI: CONTINUE IF PTCPT = CM OR HDM. IF PTCPT = NON, CONTINUE IF B1.1 = 1. ELSE, SKIP TO SECTION J.

REQUIRED

IF PTCPT = CM OR HDM

E_Intro: The next set of questions are about services, help, or information [you/he/she] may receive from [NAME OF PROGRAM SITE].

REQUIRED

IF PTCPT = NON

E_Intro: The next set of questions are about services, help, or information [you/he/she] may receive from [NAME OF AREA AGENCY ON AGING] or another organization.

REQUIRED

IF PTCPT = CM OR HDM

E1. During the past year, did someone from the [NAME OF PROGRAM] provide information or refer [you/him/her] to places to learn about financial, social, or health services that are available or tell [you/him/her] how to get the help [you need/he needs/she needs]?

YES	1	
NO	0	SKIP TO F1
DON'T KNOW	d	SKIP TO F1
REFUSED	r	SKIP TO F1

REQUIRED

IF PTCPT = NON

E1.1 During the past year, did someone from [NAME OF AREA AGENCY ON AGING] or another organization provide information or refer [you/him/her] to places to learn about financial, social, or health services that are available or tell [you/him/her] how to get the help [you need/he needs/she needs]?

YES	1	
NO	0	SKIP TO J1
DON'T KNOW	d	SKIP TO J1
REFUSED	r	SKIP TO J1

REQUIRED
IF E1 = 1

E2. How often did [you/he/she] seek out this kind of information or help from the [NAME OF PROGRAM] in the past year?

|__|__| TIMES (0-999)

PER WEEK (Range 1-7) 1

PER MONTH (Range 1-31) 2

PER YEAR (Range 1-90) 3

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF E2 GT 90; **I want to be sure I recorded your answer correctly. Did you say [fill E2] times? INTERVIEWER: ANSWER CANNOT EXCEED 90 TIMES.**
HARD CHECK: IF PER WEEK GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill E2] times per week? INTERVIEWER: ANSWER CANNOT EXCEED 7 TIMES PER WEEK.**
HARD CHECK: IF PER MONTH GT 31; **I want to be sure I recorded your answer correctly. Did you say [fill E2] times per month? INTERVIEWER: ANSWER CANNOT EXCEED 31 TIMES PER MONTH.**
HARD CHECK: IF E2 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill E2] times? INTERVIEWER: ANSWER CANNOT BE 0.**

REQUIRED
IF E1.1 = 1

E2.1 How often did [you/he/she] seek out this kind of information or help from [NAME OF AREA AGENCY ON AGING] or another organization in the past year?

|__|__| TIMES (0-999)

PER WEEK (Range 1-7) 1

PER MONTH (Range 1-31) 2

PER YEAR (Range 1-90) 3

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF E2.1 GT 90; **I want to be sure I recorded your answer correctly. Did you say [fill E2.1] times? INTERVIEWER: ANSWER CANNOT EXCEED 90 TIMES.**
HARD CHECK: IF PER WEEK GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill E2.1] times per week? INTERVIEWER: ANSWER CANNOT EXCEED 7 TIMES PER WEEK.**
HARD CHECK: IF PER MONTH GT 31; **I want to be sure I recorded your answer correctly. Did you say [fill E2.1] times per month? INTERVIEWER: ANSWER CANNOT EXCEED 31 TIMES PER MONTH.**
HARD CHECK: IF E2.1 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill E2.1] times? INTERVIEWER: ANSWER CANNOT BE 0.**

REQUIRED
IF E1 OR E1.1 = 1

E3. [Were you/was he/was she] looking for information or a referral to any of the following . . .

		YES	NO	DON'T KNOW	REFUSED
a.	An adult day care program?	1	0	d	r
b.	Personal care services for help with dressing or bathing?	1	0	d	r
c.	A visiting nurse or therapist that would come to your home to provide physical, occupational, or speech therapy?	1	0	d	r
d.	A nutritional counselor who would give [you/him/her] individual advice on what [you/he/she] should eat?	1	0	d	r
e.	Case management services in which a case manager would set up in-home services for [you/him/her] such as homemaker or personal care services, or calls to see how [you are/he is/she is] doing?	1	0	d	r
f.	A support group to talk with other people who have the same kind of problems [you have/he has/she has]?	1	0	d	r
g.	Homemaker or housekeeping services to help with light housework, preparing meals, or shopping?	1	0	d	r
h.	Chore services to help with heavier housecleaning or yard work?	1	0	d	r
i.	Housing assistance?	1	0	d	r
j.	Transportation services?	1	0	d	r

REQUIRED
IF E1 = 1

E4. During the past year, when [you/he/she] sought out information about services or help from [NAME OF PROGRAM] staff and were referred to an agency other than [NAME OF PROGRAM SITE], did the program staff ever . . .

		YES	NO	DON'T KNOW	REFUSED
a.	Give [you/him/her] printed information, brochures, applications, or phone numbers?	1	0	d	r
b.	Fill out or help [you/him/her] to fill out an application or paperwork for services?	1	0	d	r
c.	Make an appointment for [you/him/her] at the other agency or notify them that [you were/he was/she was] coming?	1	0	d	r
d.	Accompany [you/him/her] to the other agency?	1	0	d	r
e.	Provide or arrange for transportation to the other agency?	1	0	d	r
f.	Follow-up with [you/him/her] to see that [you were/he was/she was] served by the other agency?	1	0	d	r

REQUIRED
IF E1 = 1

E5. Overall, how helpful was the program staff in getting [you/him/her] the information, services, help, or benefits [you were/he was/she was] looking for? Were they . . .

CODE ONE ONLY

Very helpful, ... 1

Somewhat helpful, ... 2

Not too helpful, or 3

Not at all helpful? 4

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF E1 = 1

E6. Has [NAME OF PROGRAM] staff ever given [you/him/her] information or helped [you/him/her] with making decisions on Medicare Part D, the prescription drug benefit?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

F. HELPFULNESS OF PROGRAM

PROGRAMMER BOX F1

CATI: CONTINUE IF PTCPT = CM OR HDM. IF PTCPT = NON, SKIP TO SECTION J.

REQUIRED

IF PTCPT = CM OR HDM

F1. Overall, how helpful has [NAME OF PROGRAM]'s nutrition program been? Would [you/he/she] say it has. . .

CODE ONE ONLY

Helped [you/him/her] a lot, ... 1

Helped [you/him/her] somewhat, ... 2

Helped [you/him/her] a little, ... 3

Didn't help [you/him/her], or 4

Made things worse? 5

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED

IF PTCPT = CM OR HDM

F2. Has [NAME OF PROGRAM SITE]'s nutrition program . . .

	YES	NO	DON'T KNOW	REFUSED
a. Helped [you/him/her] eat healthier foods?	1	0	d	r
b. Improved [your/his/her] health?	1	0	d	r
c. Helped [you/him/her] follow the special diet that is prescribed by [your/his/her] doctor or dietician?	1	0	d	r
d. Helped [you/him/her] achieve or maintain a healthy weight?	1	0	d	r
e. Helped [you/him/her] to live independently and stay in [your/his/her] home?	1	0	d	r

G. VOLUNTEER WORK FOR [NAME OF PROGRAM SITE] NUTRITION PROGRAM

PROGRAMMER BOX G1

CATI: CONTINUE IF PTCPT = CM. IF PTCPT = HDM, SKIP TO SECTION H. IF PTCPT = NON, SKIP TO SECTION J.

G_Intro: The next set of questions are about volunteer work for [NAME OF PROGRAM SITE]'s nutrition program.

REQUIRED

IF PTCPT = CM

G1. [Do you/Does he/Does she] do volunteer work for [NAME OF PROGRAM SITE]'s nutrition program?

YES	1	
NO	0	SKIP TO H1
DON'T KNOW	d	SKIP TO H1
REFUSED	r	SKIP TO H1

REQUIRED

IF G1 = 1

G2. How often [do you/does he/does she] do volunteer work for [NAME OF PROGRAM SITE]'s nutrition program?

|__|__| TIMES (0-999)

PER WEEK (Range 1-7)	1
PER MONTH (Range 1-31)	2
PER YEAR (Range 1-90)	3
DON'T KNOW	d
REFUSED	r

HARD CHECK: IF G2 GT 90; **I want to be sure I recorded your answer correctly. Did you say [fill G2] times? INTERVIEWER: ANSWER CANNOT EXCEED 90 TIMES.**

HARD CHECK: IF PER WEEK GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill G2] times per week? INTERVIEWER: ANSWER CANNOT EXCEED 7 TIMES PER WEEK.**

HARD CHECK: IF PER MONTH GT 31; **I want to be sure I recorded your answer correctly. Did you say [fill G2] times per month? INTERVIEWER: ANSWER CANNOT EXCEED 31 TIMES PER MONTH.**

HARD CHECK: IF G2 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill G2] times? INTERVIEWER: ANSWER CANNOT BE 0.**

REQUIRED
IF G1 = 1

G3. On average, how long [do you/does he/does she] volunteer each time [you do/he does/she does] volunteer work?

PROBE: Your best estimate is fine.

|__|__| (0-999)

MINUTES (Range 1-90) 1

HOURS (Range 1-10) 2

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF G3 GT 90; **I want to be sure I recorded your answer correctly. Did you say [fill G3]? INTERVIEWER: ANSWER CANNOT EXCEED 90.**
HARD CHECK: IF HOURS GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill G3] hours? INTERVIEWER: ANSWER CANNOT EXCEED 10 HOURS.**
HARD CHECK: IF G3 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill G3]? INTERVIEWER: ANSWER CANNOT BE 0.**

REQUIRED
IF G1 = 1

G4. [Do you/Does he/Does she] do volunteer work for the congregate nutrition program, the home-delivered nutrition program, or both programs?

CODE ONE ONLY

CONGREGATE NUTRITION PROGRAM 1

HOME-DELIVERED NUTRITION PROGRAM 2

BOTH NUTRITION PROGRAMS 3

DON'T KNOW ..... d

REFUSED ..... r

H. IMPRESSIONS OF THE NUTRITION PROGRAM

PROGRAMMER BOX H1

CATI: CONTINUE IF PTCPT = CM OR HDM. IF PTCPT = NON, SKIP TO SECTION J.

H_Intro: The next questions are about [your/his/her] general impression of the [NAME OF PROGRAM].

REQUIRED

IF PTCPT = CM

H1. Overall, how would [you/he/she] rate the nutrition program at [NAME OF PROGRAM SITE]? Would [you/he/she] say it is . . .

CODE ONE ONLY

Excellent, ... 1

Very good, ... 2

Good, ... 3

Fair, or 4

Poor? 5

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED

IF PTCPT = HDM

H1.1 Overall, how would [you/he/she] rate [NAME OF PROGRAM SITE]'s home-delivered nutrition program? Would [you/he/she] say it is . . .

CODE ONE ONLY

Excellent, ... 1

Very good, ... 2

Good, ... 3

Fair, or 4

Poor? 5

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM OR HDM

H1.2 Which of the following best describes the meals provided by [NAME OF PROGRAM SITE]?

CODE ONE ONLY

There is a set menu that does not give [me/him/her] any choice of food items, ... 1

[I have/He has/She has] a choice of different complete meal options (e.g., Meal A or Meal B), or 2

[I have/He has/She has] a choice of different food items within the meal (e.g., Choice of entrée, choice of vegetables, fruit, dessert, salad bar). 3

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM

H2. What [do you/does he/does she] like most about the [NAME OF PROGRAM SITE]'s nutrition program? Would [you/he/she] say the . . .

CODE ONE ONLY

Food, ... 1

Other services, ... 2

Participants, ... 3

Staff, ... 4

Activities, ... 5

Location, or 6

Something else? (PLEASE SPECIFY) 99

_____ (STRING (30))

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = HDM

H2.1 What [do you/does he/does she] like most about the [NAME OF PROGRAM SITE]'s nutrition program? Would [you/he/she] say the . . .

CODE ONE ONLY

Food,.....1

Delivery staff, or.....2

Something else? (PLEASE SPECIFY).....99

_____ (STRING (30))

DON'T KNOW.....d

REFUSED.....r

REQUIRED
IF PTCPT = CM

[PROGRAMMER: EXCLUDE RESPONSES GIVEN TO H2 FROM H3]

H3. What [do you/does he/does she] like least about the [NAME OF PROGRAM SITE]'s nutrition program? Would [you/he/she] say the . . .

CODE ONE ONLY

Food,.....1

Services,.....2

Participants,.....3

Staff,.....4

Activities,.....5

Location, or.....6

Something else? (PLEASE SPECIFY).....99

_____ (STRING (30))

DON'T KNOW.....d

REFUSED.....r

REQUIRED
IF PTCPT = HDM

[PROGRAMMER: EXCLUDE RESPONSES GIVEN TO H2.1 FROM H3.1]

H3.1 What [do you/does he/does she] like least about the [NAME OF PROGRAM SITE]'s nutrition program? Would [you/he/she] say the . . .

CODE ONE ONLY

Food, ... 1

Delivery staff, or 2

Something else? (PLEASE SPECIFY) 99

_____ (STRING (30))

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM OR HDM

H6. How would [you/he/she] rate the [NAME OF PROGRAM SITE]'s staff overall? Would [you/he/she] say they are . . .

CODE ONE ONLY

Excellent, ... 1

Very good, ... 2

Good, ... 3

Fair, or 4

Poor? 5

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM OR HDM

Next I'm going to read you some statements about [NAME OF PROGRAM SITE]'s nutrition program.

H7. Think about all the foods [you receive/he receives/she receives] from [NAME OF PROGRAM SITE]'s nutrition program. Would [you/he/she] say [you are/he is/she is] always, usually, sometimes, seldom, or never satisfied . . .

	ALWAYS	USUALLY	SOMETIMES	SELDOM	NEVER	DON'T KNOW	REFUSED
a. with the way the food tastes?	1	2	3	4	5	d	r
b. with the way the food smells?	1	2	3	4	5	d	r
c. with the way the food looks?	1	2	3	4	5	d	r
d. with the variety of food?	1	2	3	4	5	d	r
e. that hot foods are hot and cold foods are cold?	1	2	3	4	5	d	r
f. that you get foods that [you like/he likes/she likes]?	1	2	3	4	5	d	r
g. that [your/his/her] special dietary needs or restrictions are met?	1	2	3	4	5	d	r
h. with the amount of food [you receive/he receives/ she receives]?	1	2	3	4	5	d	r
(PTCPT = CM):							
i. with the tables and table settings?	1	2	3	4	5	d	r

REQUIRED
IF PTCPT = CM OR HDM

H8. [Do you/Does he/Does she] like the meals that [you get/he gets/she gets] from [NAME OF PROGRAM SITE]?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM

H9. [Are you/Is he/Is she] greeted when [you arrive/he arrives/she arrives] at [NAME OF PROGRAM SITE]?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = HDM

H10. How often does the meal arrive at the scheduled time? Would [you/he/she] say . . .

CODE ONE ONLY

Always, ... 1
Usually, ... 2
Sometimes, ... 3
Seldom, or 4
Never? 5
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = HDM

H11. How often does the person who delivers [your/his/her] meals stay and spend some time talking with [you/him/her]? Would [you/he/she] say . . .

CODE ONE ONLY

Always, ... 1

Usually, ... 2

Sometimes, ... 3

Seldom, or 4

Never? 5

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = HDM

H12. How often is the person who delivers [your/his/her] meals pleasant? Would [you/he/she] say . . .

CODE ONE ONLY

Always, ... 1

Usually, ... 2

Sometimes, ... 3

Seldom, or 4

Never? 5

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM OR HDM

H13. Would [you/he/she] recommend [NAME OF PROGRAM SITE]'s nutrition program to [your/his/her] friends or relatives?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

I. MEAL CONTRIBUTIONS

PROGRAMMER BOX I1

CATI: CONTINUE IF PTCPT = CM OR HDM. IF PTCPT = NON, SKIP TO SECTION J.

I_Intro: The next set of questions are about monetary contributions to the nutrition program at [NAME OF PROGRAM SITE].

REQUIRED

IF PTCPT = CM OR HDM

I1. [Do you/Does he/Does she] make monetary contributions to [NAME OF PROGRAM SITE]'s nutrition program?

YES	1	
NO	0	SKIP TO J1
DON'T KNOW	d	SKIP TO J1
REFUSED	r	SKIP TO J1

REQUIRED

IF I1 = 1

I2. Does the program have a suggested amount that [you/he/she] should contribute for each meal?

YES	1	
NO	0	SKIP TO I4
DON'T KNOW	d	SKIP TO I4
REFUSED	r	SKIP TO I4

REQUIRED

IF I2 = 1

I3. [Do you/Does he/Does she] think the suggested amount [you are/he is/she is] asked to contribute is too much, too little, or about right?

CODE ONE ONLY

TOO MUCH	1
TOO LITTLE	2
ABOUT RIGHT	3
DON'T KNOW	d
REFUSED	r

REQUIRED
IF I1 = 1

I4. [Do you/Does he/Does she] decide for [yourself/himself/herself] how much to contribute for each meal?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF I1 = 1

I5. [Do you/Does he/Does she] feel pressured to contribute for each meal?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

J. EATING BEHAVIOR, DIET AND FOOD PREPARATION

PROGRAMMER BOX I1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM OR NON) ANSWER QUESTIONS IN SECTION J.

J_Intro: The next questions are about the meals [you eat/he eats/she eats] each day.

REQUIRED

IF PTCPT = CM, HDM OR NON

J1. In total, how many different meals do you usually eat each day? Please include meals you eat at home or away from home.

ENTER MEALS PER DAY 0
NOT REGULAR, EAT WHEN HUNGRY 99
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED

IF J1 = 0

J1_Meals. ENTER NUMBER OF MEALS PER DAY

|___| MEALS PER DAY (0-99)
DON'T KNOW ..... d
REFUSED ..... r

HARD CHECK: IF J1_Meals = 0; **I want to be sure I recorded your answer correctly. Did you say [fill J1_Meals] meals per day? INTERVIEWER: ANSWER CANNOT BE 0**

HARD CHECK: IF J1_Meals GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill J1_Meals] meals per day? INTERVIEWER: ANSWER CANNOT EXCEED 7 MEALS PER DAY**

REQUIRED
IF PTCPT = CM, HDM OR NON

J2. When at home, [do you/does he/does she] usually prepare [your/his/her] own meals, help someone else cook, or don't cook at all?

CODE ONE ONLY

PREPARE OWN MEALS	1	
HELP SOMEONE ELSE COOK	2	
DON'T COOK	3	
DON'T KNOW	d	
REFUSED	r	

REQUIRED
IF PTCPT = CM, HDM OR NON

J3. Can [you/he/she] prepare hot meals for [yourself/himself/herself] if [you need/he needs/she needs] to?

YES	1	
NO	0	
DON'T KNOW	d	
REFUSED	r	

REQUIRED
IF PTCPT = CM, HDM OR NON

J4. [Are you/Is he/Is she] currently on any special diet for health, medication, religious, or cultural reasons?

YES	1	
NO	0	SKIP TO J7
DON'T KNOW	d	SKIP TO J7
REFUSED	r	SKIP TO J7

REQUIRED
IF J4 = 1

J5. What kind of special diet [are you/is he/is she] on?

CODE ALL THAT APPLY

DIABETIC 1
LOW SODIUM/SALT 2
LOW CHOLESTEROL 3
LOW CALORIE 4
LOW SUGAR 5
LOW FAT 6
LOW FIBER 7
HIGH FIBER 8
GROUND OR PUREED 9
VEGETARIAN 10
NON-DAIRY/ LACTOSE-FREE 11
KOSHER 12
HALAL 13
OTHER (PLEASE SPECIFY) 99
_____ (STRING (30))
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM OR HDM AND J4 = 1

J6. How often does [NAME OF PROGRAM SITE]'s nutrition program serve foods that help meet [your/his/her] special dietary needs? Would [you/he/she] say . . .

CODE ONE ONLY

Almost always, ... 1
Often, ... 2
Sometimes, ... 3
Seldom, or 4
Never? 5
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

J7. How is [your/his/her] appetite? Would [you/he/she] say it is usually excellent, good, fair, or poor?

CODE ONE ONLY

EXCELLENT 1
GOOD 2
FAIR 3
POOR 4
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

J8. [Do you/Does he/Does she] eat alone most of the time?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

J9. [Do you/Does he/Does she] have a refrigerator that works?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

J10. [Do you/Does he/Does she] have a freezer that works?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

J11. [Do you/Does he/Does she] have a stove or toaster oven that works?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

J12. [Do you/Does he/Does she] have a microwave that works?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

K. FOOD SECURITY

PROGRAMMER BOX I1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM OR NON) ANSWER QUESTIONS IN SECTION K.

K_Intro: These next questions are about the food eaten in [your/his/her] household in the last 30 days and whether [you were/he was/she was] able to afford the food [you need/he needs/she needs].

REQUIRED

IF PTCPT = CM, HDM OR NON

K1. I'm going to read you several statements that people have made about their food situation. For these statements, please tell me whether the statement was OFTEN, SOMETIMES, or NEVER true for [your/his/her] household in the last 30 days.

The first statement is, "The food that [I/he/she] bought just didn't last, and [I/he/she] didn't have money to get more." Was that often, sometimes, or never true for [your/his/her] household in the last 30 days?

CODE ONE ONLY

OFTEN TRUE 1

SOMETIMES TRUE 2

NEVER TRUE 3

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED

IF PTCPT = CM, HDM OR NON

K2. "[I/he/she] couldn't afford to eat balanced meals." Was that often, sometimes, or never true for [your/his/her] household in the last 30 days?

CODE ONE ONLY

OFTEN TRUE 1

SOMETIMES TRUE 2

NEVER TRUE 3

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

K3. In the last 30 days, did anyone in [your/his/her] household ever cut the size of [your/his/her] meals or skip meals because there wasn't enough money for food?

YES 1
NO ..... 0 SKIP TO K5
DON'T KNOW ..... d SKIP TO K5
REFUSED ..... r SKIP TO K5

REQUIRED
IF K3 = 1

K4. In the last 30 days, how many days did this happen?

|__|__| DAYS (1-99)
DON'T KNOW ..... d
REFUSED ..... r

HARD CHECK: IF K4 = 0; **In a previous question you answered that in the last 30 days, someone in your household cut the size of [your/his/her] meals because there wasn't enough money for food. However, in K4 you answered that this happened on 0 days. Have I entered something incorrectly? INTERVIEWER: ANSWER MUST BE GREATER THAN 0 DAYS.**
HARD CHECK: IF K4 GT 30; **I want to be sure I recorded your answer correctly. Did you say [fill K4] days? INTERVIEWER: ANSWER CANNOT EXCEED 30 DAYS.**

REQUIRED
IF PTCPT = CM, HDM OR NON

K5. In the last 30 days, did [you/he/she] ever eat less than [you/he/she] felt [you/he/she] should because there wasn't enough money to buy food?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

K6. In the last 30 days, [were you/was he/was she] ever hungry but didn't eat because [you/he/she] couldn't afford enough food?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

L. HEALTH STATUS

PROGRAMMER BOX L1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM OR NON) ANSWER QUESTIONS IN SECTION L.

L_Intro: The next questions are about [your/his/her] health.

REQUIRED

IF PTCPT = CM, HDM OR NON

L1. In general, would [you/he/she] say [your/his/her] health is excellent, very good, good, fair, or poor?

CODE ONE ONLY

EXCELLENT 1

VERY GOOD 2

GOOD 3

FAIR 4

POOR 5

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED

IF PTCPT = CM, HDM OR NON

L2. During the past year, about how many different times [were you/was he/was she] treated in an emergency room?

|__|__| TIMES (0-99)

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF L2 GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill L2] times?**

HARD CHECK: IF L2 GT 50; **I want to be sure I recorded your answer correctly. Did you say [fill L2] times? INTERVIEWER: ANSWER CANNOT EXCEED 50 TIMES.**

REQUIRED
IF PTCPT = CM, HDM OR NON

L3. During the past year, about how many different times did [you/he/she] spend at least one night in the hospital?

|__|__| TIMES (0-99)

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF L3 GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill L3] times?**
HARD CHECK: IF L3 GT 50; **I want to be sure I recorded your answer correctly. Did you say [fill L3] times? INTERVIEWER: ANSWER CANNOT EXCEED 50 TIMES.**

REQUIRED
IF PTCPT = CM, HDM OR NON

L4. During the past year, did [you/he/she] stay in a nursing home, convalescent home, or rehabilitation center?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

L5. During the past year, was there a particular clinic, health center, medical doctor's office, or other place that [you/he/she] usually went to if [you were/he was/she was] sick, needed advice about your health, or for routine care?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

L6. During the past 30 days, about how many times did [you/he/she] see or talk to a medical doctor or other health care professional? Do not count doctors seen while being an overnight patient in a hospital or nursing home.

|__|__| TIMES (0-99)

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF L6 GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill L6] times?**
HARD CHECK: IF L6 GT 30; **I want to be sure I recorded your answer correctly. Did you say [fill L6] times? INTERVIEWER: ANSWER CANNOT EXCEED 30 TIMES.**

REQUIRED
IF L6 = 0 TIMES

L6a. During the past year, about how many times did [you/he/she] see or talk to a medical doctor or other health care professional? Do not count doctors seen while being an overnight patient in a hospital or nursing home.

|__|__| TIMES (0-99)

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF L6a GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill L6a] times?**
HARD CHECK: IF L6a GT 30; **I want to be sure I recorded your answer correctly. Did you say [fill L6a] times? INTERVIEWER: ANSWER CANNOT EXCEED 30 TIMES.**

REQUIRED
IF PTCPT = CM, HDM OR NON

L7. Has a doctor <u>ever</u> told [you/he/she] that [you have/he has/she has]:

		YES	NO	DON'T KNOW	REFUSED
a.	Arthritis or rheumatism?	1	0	d	r
b.	High blood pressure or hypertension?	1	0	d	r
c.	A heart attack, coronary heart disease, angina, congestive heart failure, or any other heart problems?	1	0	d	r
d.	High cholesterol?	1	0	d	r
e.	Diabetes or high blood sugar?	1	0	d	r
f.	Allergies, asthma, emphysema, chronic bronchitis, or other breathing and lung problems?	1	0	d	r
g.	Cancer or malignant tumor, excluding minor skin cancer?	1	0	d	r
h.	A hearing impairment?	1	0	d	r
i.	Stroke?	1	0	d	r
j.	Anemia?	1	0	d	r
k.	Osteoporosis?	1	0	d	r
l.	Kidney disease?	1	0	d	r
m.	Eye or vision conditions such as glaucoma, cataracts, macular degeneration or other medical conditions of the eye? [INTERVIEWER NOTE: THIS DOES NOT INCLUDE JUST WEARING GLASSES OR CONTACTS.]	1	0	d	r

REQUIRED
IF PTCPT = CM, HDM OR NON

L8. [Do you/Does he/Does she] currently wear dentures?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

L9. In the past year, did [you/he/she] get a flu shot?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON AND RESPONDENT AGE < 65

L10. [Have you/Has he/Has she] ever had a vaccination to protect [you/him/her] from pneumonia?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON AND RESPONDENT AGE > OR = 65

L11. Since age 65, [have you/has he/has she] had a vaccination to protect [you/him/her] from pneumonia?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

L12. In the past 12 months, how many times have you fallen?

|__|__| TIMES (0-99)

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF L12 GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill L12] times?**
HARD CHECK: IF L12 GT 30; **I want to be sure I recorded your answer correctly. Did you say [fill L12] times? INTERVIEWER: ANSWER CANNOT EXCEED 30 TIMES.**

REQUIRED
IF L12 = DK

L13. In the past 12 months, have you fallen more than two times?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

M. SMOKING

PROGRAMMER BOX M1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM, OR NON) ANSWER QUESTIONS IN SECTION M.

M_Intro: The next questions are about cigarette smoking.

REQUIRED

IF PTCPT = CM, HDM OR NON

M1. [Have you/Has he/Has she] smoked at least 100 cigarettes in [your/his/her] entire life?

YES	1	
NO	0	GO TO N1
DON'T KNOW	d	GO TO N1
REFUSED	r	GO TO N1

REQUIRED

IF M1 = 1

M2. [Do you/Does he/Does she] now smoke cigarettes . . .

CODE ONE ONLY

Every day,	1
Some days, or	2
Not at all?	3
DON'T KNOW	d
REFUSED	r

N. ALCOHOL CONSUMPTION

PROGRAMMER BOX N1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM OR NON) ANSWER QUESTIONS IN SECTION M.

N_Intro: The next set of questions are about alcohol consumption.

REQUIRED

IF PTCPT = CM, HDM OR NON

N1. During the past 30 days, how many days did [you/he/she] have at least one drink of any alcoholic beverage?

|__|__| DAYS (Range 0-99)

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF N1 GT 20; **I want to be sure I recorded your answer correctly. Did you say [fill N1] days?**

HARD CHECK: IF N1 GT 30; **I want to be sure I recorded your answer correctly. Did you say [fill N1] days? INTERVIEWER: ANSWER CANNOT EXCEED 30 DAYS.**

REQUIRED

IF N1 > 0

N2. On the days when [you/he/she] drank, about how many drinks did [you/he/she] drink on average?

|__|__| DRINKS PER DAY (1-99)

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF N2 GT 5; **I want to be sure I recorded your answer correctly. Did you say [fill N2] drinks per day?**

HARD CHECK: IF N2 GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill N2] drinks per day? INTERVIEWER: ANSWER CANNOT EXCEED 10 DRINKS .**

HARD CHECK: IF N2 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill N2] drinks per day? INTERVIEWER: ANSWER CANNOT BE 0.**

O. MEDICAL INSURANCE

PROGRAMMER BOX O1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM OR NON).

O_Intro: The next questions are about health insurance and health care coverage.

PROGRAMMER NOTE: IF STATE IS CALIFORNIA, FILL STATE NAME FOR MEDICAID WITH MEDIC-CAL; IF MASSACHUSETTS, FILL WITH MASS-HEALTH; IF OREGON, FILL WITH OREGON HEALTH PLAN; IF TENNESSEE, FILL WITH TENNCARE; IF ARIZONA, FILL WITH AHCCCS/ACCESS; IF MAINE, FILL WITH MAINECARE.

REQUIRED

IF PTCPT = CM, HDM OR NON

O1. What kind of health insurance plan or health care coverage [do you/does he/does she] have right now? Please include those that pay for only one type of service (nursing home care, accidents, or dental care). Please exclude private plans that only provide extra cash while hospitalized. If [you have/he has/she has] more than one kind of health insurance, tell me all plans that [you have/he has/she has].

CAPI INSTRUCTION: DO NOT ALLOW MORE THAN ONE ANSWER WHEN 10 (NO COVERAGE OF ANY TYPE) IS CODED.

CODE ALL THAT APPLY

MEDICARE	1	
MEDI-GAP	2	
OTHER PRIVATE HEALTH INSURANCE	3	
MEDICAID ({DISPLAY STATE PLAN NAME})	4	
MILITARY HEALTH CARE (TRICARE/VA/CHAMP-VA)	5	
INDIAN HEALTH SERVICE	6	
STATE-SPONSORED HEALTH PLAN ({DISPLAY STATE PLAN NAME})	7	
OTHER GOVERNMENT PROGRAM	8	
SINGLE SERVICE PLAN (E.G., DENTAL, VISION)	9	
NO COVERAGE OF ANY TYPE	10	SKIP TO O3
DON'T KNOW	d	SKIP TO O3
REFUSED	r	SKIP TO O3

REQUIRED
IF O1 = 1

O2. [Are you/Is he/Is she] currently enrolled in Medicare Part D, also known as the Medicare Prescription Drug Plan?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF O2 IS YES

O3. [Are you/Is he/Is she] currently getting Extra Help from the government to pay for Medicare Part D monthly premiums, annual deductibles, and prescription co-payments?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF O1 >= 2 AND <=9

O4. Do any of [your/his/her] [IF O2=1 add "other"] health insurance plans cover any part of the cost of [your/his/her] prescriptions?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF O4 IS YES

O4.1 Which of [your/his/her] other health insurance plans cover part of the cost of [your/his/her] prescriptions?

CODE ALL THAT APPLY

A STATE PRESCRIPTION ASSISTANCE PROGRAM (FILL STATE PROGRAM NAME). 1

A DRUG MANUFACTURER PRESCRIPTION ASSISTANCE PROGRAM 2

A COPAYMENT PROGRAM (FOUNDATION, NONPROFIT)..... 3

SAVINGS CARD 4

OTHER (PLEASE SPECIFY)..... 99

_____ (STRING (30))

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

O5. [Do you/Does he/Does she] have a Medicare Savings Program to pay for Medicare Part A or Part B insurance premiums?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF O4.1 DOES NOT INCLUDE 1

O6. During the past 30 days, did [you/he/she] receive assistance from [STATE NAME PRESCRIPTION PROGRAM] to help with prescription drug expenses?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

P. MOBILITY

PROGRAMMER BOX P1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM OR NON) ANSWER QUESTIONS IN SECTION P.

P_Intro: The next set of questions are about [your/his/her] physical and mental health.

REQUIRED
IF PTCPT = CM, HDM OR NON

P1. (ASK IF NOT APPARENT) Is [respondent/he/she] . . .

CODE ONE ONLY

Able to walk,	1	SKIP TO P4
Bed bound,	2	SKIP TO P2
Chair bound or in a wheelchair?	3	SKIP TO P3

REQUIRED
IF P1 = 2

P2. How long [have you/has he/has she] been confined to a bed?

|___|___| (0-999)

DAYS (Range 1-99)	1	SKIP TO P6
WEEKS (Range 1-30)	2	SKIP TO P6
MONTHS (Range 1-13)	3	SKIP TO P6
YEARS (Range 1-10)	4	SKIP TO P6
DON'T KNOW	d	SKIP TO P6
REFUSED	r	SKIP TO P6

HARD CHECK: IF P2 GT 99; **I want to be sure I recorded your answer correctly. Did you say [fill P2]? INTERVIEWER: ANSWER CANNOT EXCEED 99.**
HARD CHECK: IF WEEKS GT 30; **I want to be sure I recorded your answer correctly. Did you say [fill P2] weeks? INTERVIEWER: ANSWER CANNOT EXCEED 30 WEEKS.**
HARD CHECK: IF MONTHS GT 13; **I want to be sure I recorded your answer correctly. Did you say [fill P2] months? INTERVIEWER: ANSWER CANNOT EXCEED 13 MONTHS.**
HARD CHECK: IF YEARS GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill P2] years? INTERVIEWER: ANSWER CANNOT EXCEED 10 YEARS.**
HARD CHECK: IF P2 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill P2]? INTERVIEWER: ANSWER CANNOT BE 0.**

REQUIRED
IF P1 = 3

P3. How long [have you/has he/has she] been confined to a chair or a wheelchair?

|___|___| (0-999)

DAYS (Range 1-99)	1	SKIP TO P6
WEEKS (Range 1-30)	2	SKIP TO P6
MONTHS (Range 1-13)	3	SKIP TO P6
YEARS (Range 1-10)	4	SKIP TO P6
DON'T KNOW	d	SKIP TO P6
REFUSED	r	SKIP TO P6

HARD CHECK: IF P3 GT 99; **I want to be sure I recorded your answer correctly. Did you say [fill P3]? INTERVIEWER: ANSWER CANNOT EXCEED 99.**
HARD CHECK: IF WEEKS GT 30; **I want to be sure I recorded your answer correctly. Did you say [fill P3] weeks? INTERVIEWER: ANSWER CANNOT EXCEED 30 WEEKS.**
HARD CHECK: IF MONTHS GT 13; **I want to be sure I recorded your answer correctly. Did you say [fill P3] months? INTERVIEWER: ANSWER CANNOT EXCEED 13 MONTHS.**
HARD CHECK: IF YEARS GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill P3] years? INTERVIEWER: ANSWER CANNOT EXCEED 10 YEARS.**
HARD CHECK: IF P3 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill P3]? INTERVIEWER: ANSWER CANNOT BE 0.**

REQUIRED
IF P1 = 1

P4. [Do you/Does he/Does she] currently use a cane or walker?

YES	1
NO	0
DON'T KNOW	d
REFUSED	r

REQUIRED
IF P1 = 1

P5. [Do you/Does he/Does she] have serious difficulty walking or climbing stairs?

YES	1
NO	0
DON'T KNOW	d
REFUSED	r

REQUIRED
IF PTCPT = CM, HDM OR NON

P6. Because of a physical, mental, or emotional condition, [do you/does he/does she] have serious difficulty concentrating, remembering, or making decisions?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

P7. The next questions ask about difficulties [you/he/she] may have doing certain activities. [Do you/Does he/Does she] have difficulty . . .

		YES	NO	NOT APPLICABLE	DON'T KNOW	REFUSED
a.	shopping for personal items, such as toilet items or medicine?	1	0	99	d	r
b.	getting to a grocery store?	1	0	99	d	r
c.	shopping for groceries?	1	0	99	d	r
d.	carrying a bag of groceries?	1	0	99	d	r
e.	using the telephone?	1	0	99	d	r
f.	doing light housework?	1	0	99	d	r
g.	preparing meals?	1	0	99	d	r
h.	using public transportation or riding in a private automobile?	1	0	99	d	r
i.	taking medications?	1	0	99	d	r
j.	managing money or balancing a checkbook?	1	0	99	d	r
k.	taking a bath or shower?	1	0	99	d	r
l.	dressing?	1	0	99	d	r
[ASK ONLY IF P1=1]						
m.	getting in or out of a bed or chair?	1	0	99	d	r
n.	eating?	1	0	99	d	r
o.	using the toilet?	1	0	99	d	r
p.	chewing or swallowing?	1	0	99	d	r

Q. PHYSICAL ACTIVITY

PROGRAMMER BOX Q1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM, OR NOM) ANSWER QUESTIONS IN SECTION Q.

Q_Intro: The next questions are about physical activity.

REQUIRED

IF PTCPT = CM, HDM OR NON

Q1. During the past 30 days, [have you/has he/has she] done any exercise, sports, or physical activities?

YES	1	
NO	0	SKIP TO R1
DON'T KNOW	d	SKIP TO R1
REFUSED	r	SKIP TO R1

REQUIRED

IF Q1 = 1

Q2. How many times per week did [you/he/she] do those kinds of activities?

|___|___| TIMES PER WEEK (1-99)

DON'T KNOW	d
REFUSED	r

SOFT CHECK: IF Q2 GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill Q2] times per week?**

HARD CHECK: IF Q2 GT 30; **I want to be sure I recorded your answer correctly. Did you say [fill Q2] times per week? INTERVIEWER: ANSWER CANNOT EXCEED 30 TIMES PER WEEK.**

HARD CHECK: IF Q2 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill Q2] times per week? INTERVIEWER: ANSWER CANNOT BE 0**.

R. HEIGHT AND WEIGHT

PROGRAMMER BOX R1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM OR NON) ANSWER QUESTIONS IN SECTION R.

R_Intro: The next questions are about [your/his/her] height and weight.

REQUIRED

IF PTCPT = CM, HDM OR NON

R1. How tall [are you/is he/is she] without shoes?

|__| FEET (0-99)

|__|__| INCHES (0-99)

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF FEET LT 4; **I want to be sure I recorded your answer correctly. Did you say [fill R1] feet? INTERVIEWER: ANSWER CANNOT BE LESS THAN 4 FEET.**

HARD CHECK: IF FEET GT 7; **I want to be sure I recorded your answer correctly. Did you say [fill R1] feet? INTERVIEWER: ANSWER CANNOT EXCEED 7 FEET.**

HARD CHECK: IF INCHES GT 11; **I want to be sure I recorded your answer correctly. Did you say [fill R1] inches? INTERVIEWER: ANSWER CANNOT EXCEED 11 INCHES**.

REQUIRED

IF PTCPT = CM, HDM OR NON

R2. How much [do you/does he/does she] weigh without clothes or shoes?

|__|__|__| POUNDS (0-999)

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF POUNDS GT 300; **I want to be sure I recorded your answer correctly. Did you say [fill R2] pounds?**

HARD CHECK: IF POUNDS LT 50 **I want to be sure I recorded your answer correctly. Did you say [fill R2] pounds? INTERVIEWER: ANSWER CANNOT BE LESS THAN 50 POUNDS.**

HARD CHECK: IF POUNDS GT 500; **I want to be sure I recorded your answer correctly. Did you say [fillR2] pounds? INTERVIEWER: ANSWER CANNOT EXCEED 500 POUNDS.**

REQUIRED
IF PTCPT = CM, HDM OR NON

R3. Without trying to, [have you/has he/has she] gained or lost ten pounds in the last six months?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

S. PRESCRIPTIONS

PROGRAMMER BOX S1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM, OR NON) ANSWER QUESTIONS IN SECTION S.

S_Intro: The next set of questions are about prescription medications.

REQUIRED

IF PTCPT = CM, HDM OR NON

S1. How many different prescription medications [do you/does he/does she] take every day?

|__|__| NUMBER (0-99)

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF S1 GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill S1] prescriptions?**

HARD CHECK: IF S1 GT 30; **I want to be sure I recorded your answer correctly. Did you say [fill S1] prescriptions? INTERVIEWER: ANSWER CANNOT EXCEED 30.**

T. VITAMIN AND MINERAL SUPPLEMENTS

PROGRAMMER BOX T1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM OR NON) ANSWER QUESTIONS IN SECTION T.

T_Intro: The following questions are about vitamin and mineral supplements.

REQUIRED

IF PTCPT = CM, HDM OR NON

T1. [Do you/Does he/Does she] take any of the following on a regular basis . . .

	YES	NO	DON'T KNOW	REFUSED
a. Multivitamin without minerals?	1	0	d	r
b. Multivitamin plus minerals?	1	0	d	r
c. Individual vitamin and mineral supplements?	1	0	d	r
d. Herbal supplements?	1	0	d	r

REQUIRED

IF PTCPT = CM, HDM OR NON

T2. [Do you/Does he/Does she] currently use any diet or nutritional supplements, such as Boost or Ensure?

YES 1

NO ..... 0 SKIP TO U1

DON'T KNOW ..... d SKIP TO U1

REFUSED ..... r SKIP TO U1

REQUIRED
IF T2 = 1

T3. How often [do you/does he/does she] use diet or nutritional supplements?

|__|__| TIMES (0-999)

PER DAY (Range 1-10) 1

PER WEEK (Range 1-21) 2

PER MONTH (Range 1-50) 3

PER YEAR (Range 1-90) 4

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF T3 GT 90; **I want to be sure I recorded your answer correctly. Did you say [fill T3]? INTERVIEWER: ANSWER CANNOT EXCEED 90.**
HARD CHECK: IF PER DAY GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill T3] times per day? INTERVIEWER: ANSWER CANNOT EXCEED 10 TIMES PER DAY.**
HARD CHECK: IF PER WEEK GT 21; **I want to be sure I recorded your answer correctly. Did you say [fill T3] times per week? INTERVIEWER: ANSWER CANNOT EXCEED 21 TIMES PER WEEK.**
HARD CHECK: IF PER MONTH GT 50; **I want to be sure I recorded your answer correctly. Did you say [fill T3] times per month? INTERVIEWER: ANSWER CANNOT EXCEED 50 TIMES PER MONTH.**
HARD CHECK: IF T3 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill T3] times? INTERVIEWER: ANSWER CANNOT BE 0.**

U. DEPRESSION, LONELINESS, SOCIAL ISOLATION

PROGRAMMER BOX U1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM OR NON) ANSWER QUESTION IN SECTION U.

U_Intro: The next set of questions are about [your/his/her] social life.

REQUIRED

IF PTCPT = CM, HDM OR NON

U1. Overall, how satisfied [are you/is he/is she] with the opportunities [you have/he has/she has] to spend time with other people? Would [you/he/she] say [you are/he is/she is] . . .

CODE ONE ONLY

Very satisfied, ... 1

Somewhat satisfied, ... 2

Not too satisfied, or 3

Not at all satisfied? 4

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED

IF PTCPT = CM, HDM OR NON

U2. [Do you/Does he/Does she] belong to any religious or social groups, book clubs, special interest groups, or other organizations?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

U3. How often [do you/does he/does she] feel that you lack companionship?

CODE ONE ONLY

Hardly ever,.....1
Some of the time, or.....2
Often?.....3
DON'T KNOW .....d
REFUSED .....r

REQUIRED
IF PTCPT = CM, HDM OR NON

U4. How often [do you/does he/does she] feel left out?

CODE ONE ONLY

Hardly ever,.....1
Some of the time, or.....2
Often?.....3
DON'T KNOW .....d
REFUSED .....r

REQUIRED
IF PTCPT = CM, HDM OR NON

U5. How often [do you/does he/does she] feel isolated from others?

CODE ONE ONLY

Hardly ever,.....1
Some of the time, or.....2
Often?.....3
DON'T KNOW .....d
REFUSED .....r

For the next three questions, please think about the past two weeks.

REQUIRED
IF PTCPT = CM, HDM OR NON

U6. [During the past two weeks], how often [have you/has he/has she] been bothered by any of the following problems? Little interest or pleasure in doing things. Would [you/he/she] say . . .

CODE ONE ONLY

Not at all, ... 1

Several days, ... 2

More than half of the days, or 3

Nearly every day? 4

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

U7. [During the past two weeks], how often [have you/has he/has she] felt down, depressed or hopeless. Would [you/he/she] say . . .

CODE ONE ONLY

Not at all, ... 1

Several days, ... 2

More than half of the days, or 3

Nearly every day? 4

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

U8. [During the past two weeks], how often was it difficult to get in touch with others when [you/he/she] wanted to. Would [you/he/she] say . . .

CODE ONE ONLY

Almost always, ... 1

Most of the time, ... 2

About half the time, ... 3

Occasionally, or 4

Not at all? 5

DON'T KNOW ..... d

REFUSED ..... r

V. DEMOGRAPHICS

PROGRAMMER BOX V1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM, OR NON) ANSWER QUESTIONS IN SECTION V.

V_Intro: The following questions are about [your/his/her] background and education.

REQUIRED

IF PTCPT = CM, HDM OR NON

V1. INTERVIEWER: ASK IF NOT OBVIOUS: WHAT IS [YOUR/HIS/HER] GENDER?

MALE.....1

FEMALE.....2

REQUIRED

IF PTCPT = CM, HDM OR NON

V2. In what year [were you/was he/was she] born?

|___|___|___|___| YEAR (Range 1800-2012)

DON'T KNOW.....d

REFUSED.....r

HARD CHECK: IF V2 LT 1900; **I want to be sure I recorded your answer correctly. Did you say you were born in [fill V2]? INTERVIEWER: YEAR OF BIRTH MUST BE GREATER THAN 1900.**

HARD CHECK: IF V2 GT 1965; **I want to be sure I recorded your answer correctly. Did you say you were born in [fill V2]? INTERVIEWER: YEAR OF BIRTH MUST BE PRIOR TO 1965.**

REQUIRED

IF PTCPT = CM, HDM OR NON

V3. Are you a veteran of the U.S. Armed Forces?

YES.....1

NO.....0

DON'T KNOW.....d

REFUSED.....r

REQUIRED
IF PTCPT = CM, HDM OR NON

V4. What is the highest grade or level of school [you have/he has/she has] completed or the highest degree [you have/he has/she has] received?

CODE ONE ONLY

NEVER ATTENDED/KINDERGARTEN ONLY 0
1ST GRADE 1
2ND GRADE 2
3RD GRADE 3
4TH GRADE 4
5TH GRADE 5
6TH GRADE 6
7TH GRADE 7
8TH GRADE 8
9TH GRADE 9
10TH GRADE 10
11TH GRADE 11
12TH GRADE, NO DIPLOMA 12
HIGH SCHOOL GRADUATE 13
GED OR EQUIVALENT 14
SOME COLLEGE, NO DEGREE 15
ASSOCIATE DEGREE; OCCUPATIONAL, TECHNICAL, OR VOCATIONAL PROGRAM 16
ASSOCIATE DEGREE: ACADEMIC PROGRAM 17
BACHELOR'S DEGREE(EXAMPLE: BA, AB, BS, BBA) 18
MASTER'S DEGREE (EXAMPLE: MA, MS, MEng, MEd, MBA) 19
PROFESSIONAL SCHOOL DEGREE (EXAMPLE: MD, DDS, DVM, JD) 20
DOCTORAL DEGREE (EXAMPLE: PhD, EdD) 21
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

V5. [Are you/Is he/Is she] of Hispanic or Latino origin?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

V6. I am going to read a list of five race categories. Please choose one or more races that [you consider yourself/he considers himself/she considers herself] to be. American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or other Pacific Islander or White.

CODE ALL THAT APPLY

AMERICAN INDIAN OR ALASKA NATIVE 1
ASIAN 2
AFRICAN AMERICAN OR BLACK 3
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER 4
WHITE 5
OTHER (PLEASE SPECIFY) 99
_____ (STRING (30))
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

V7. [Are you/Is he/Is she] now married, widowed, divorced, separated, never married or living with a partner?

CODE ONE ONLY

MARRIED 1
WIDOWED 2
DIVORCED 3
SEPARATED 4
NEVER MARRIED 5
LIVING WITH A PARTNER 6
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

V8. What is [your/his/her] home zip code?

_____
ZIP

DON'T KNOW ..... d
REFUSED ..... r

HARD CHECK: IF NUMBER OF DIGITS ENTER GT 5**; I want to be sure I entered your answer correctly. Did you say zip code [fill V8]? INTERVIEWER: ZIP CODE MUST HAVE 5 DIGITS.**
HARD CHECK: IF NUMBER OF DIGITS ENTER LT 5**; I want to be sure I entered your answer correctly. Did you say zip code [fill V8]? INTERVIEWER: ZIP CODE MUST HAVE 5 DIGITS.**

REQUIRED
IF PTCPT = CM, HDM OR NON

V9. Including [yourself/himself/herself], how many people live in [your/his/her] household? By "live in [your/his/her] household" I mean all people who usually stay in the household. Please do include people who are away, such as students, people on vacation, or traveling for business, or people who are in the hospital for a brief stay. Do not include people in institutions, in the military, or people who are temporary visitors.

|__|__| NUMBER OF PEOPLE IN HOUSEHOLD (0 – 99)

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF V9 GT 10; **I want to be sure I recorded your answer correctly. Did you say [fill V9] people live in your household?**
HARD CHECK: IF V9 = 0; **I want to be sure I recorded your answer correctly. Did you say [fill V9] people live in your household? INTERVIEWER: NUMBER OF PEOPLE IN HOUSEHOLD CANNOT BE 0.**
HARD CHECK: IF V9 GT 20; **I want to be sure I recorded your answer correctly. Did you say [fill V9] people live in your household? INTERVIEWER: NUMBER OF PEOPLE IN HOUSEHOLD CANNOT EXCEED 20.**

REQUIRED
IF V9 = 1, GO TO V11
IF V9 NE 1

V10. Who are all the people who live in [your/his/her] household?

CODE ALL THAT APPLY

HUSBAND/WIFE/PARTNER 1

CHILD OR CHILDREN 2

BROTHER(S) OR SISTER(S) 3

GRANDCHILD OR GRANDCHILDREN 4

SON-IN-LAW OR DAUGHTER-IN-LAW 5

OTHER RELATIVE (PLEASE SPECIFY) 6

_____ (STRING (30))

NON RELATIVE OR FRIEND 7

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

V11. Now I'd like to ask you some questions about income and financial assistance [you/he/she] [IF V9 NE 1 fill (or others) in [your/his/her] household] may be receiving. During the past 30 days, did [you/he/she] (or anyone in [your/his/her] household) receive money from any of the following . . .

		YES	NO	DON'T KNOW	REFUSED
a.	Full- or part-time work?	1	0	d	r
b.	Social Security?	1	0	d	r
c.	Unemployment Compensation?	1	0	d	r
d.	Disability (SSDI) or Worker's Compensation?	1	0	d	r
e.	Supplemental Security Income or SSI?	1	0	d	r
f.	Pension or retirement fund?	1	0	d	r
g.	General Assistance?	1	0	d	r
h.	Money from relatives? or	1	0	d	r
i.	Other sources? (PLEASE SPECIFY)	1	0	d	r

_____(STRING (30))

REQUIRED
IF PTCPT = CM, HDM OR NON

V12. What was ([your/his/her] household's) total income last month before taxes? Please include all types of income received by all household members last month, including all earnings, pensions, Social Security, cash welfare benefits and SSI. Do not include the value of SNAP benefits or food stamps, Medicaid, or public housing.

$ |__|__| **,** |__|__|__| (0-99,999)

NO INCOME 0

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF V12 GT 5,000; **I want to be sure I recorded your answer correctly. Did you say [your/his/her] household's) total income last month before taxes was $[fill V12]?**
HARD CHECK: IF V12 GT 15,000; **I want to be sure I recorded your answer correctly. Did you say [your/his/her] household's) total income last month before taxes was $[fill V12]? INTERVIEWER: ANSWER CANNOT EXCEED $15,000.**

REQUIRED
IF V12 = d, r

V13. Please stop me when I reach [your/his/her] household's total income for last month. Was It . . .

CODE ONE ONLY

Less than $900, ... 1

$901 - $1,200, ... 2

$1,201 - $1,500, ... 3

$1,501 - $1,800, ... 4

$1,801 - $2,100, ... 5

$2,101 - $2,400, ... 6

$2,401 or more? 7

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

V14. What was ([your /his/her] household's) total income before taxes last year from all sources, including Social Security and other government programs but excluding the value of SNAP benefits or food stamps, Medicaid, or public housing. Your best estimate is fine.

$ |__|__|__| , |__|__|__| (0-999,999)

NO INCOME 0

DON'T KNOW ..... d

REFUSED ..... r

SOFT CHECK: IF V14 LT 1,000; **I want to be sure I recorded your answer correctly. Did you say [your/his/her] household's) total income last year before taxes was$[fill V14]?**
SOFT CHECK: IF V14 GT 100,000; **I want to be sure I recorded your answer correctly. Did you say [your/his/her] household's) total income last year before taxes was $[fill V14]?**
HARD CHECK: IF V14 GT 250,000; **I want to be sure I recorded your answer correctly. Did you say [your/his/her] household's) total income last year before taxes was $[fill V14]? INTERVIEWER: ANSWER CANNOT EXCEED $250,000.**

REQUIRED
IF V14 = d, r

V15. Please stop me when I reach [your/his/her] household's total income for last year. Was It . . .

CODE ONE ONLY

Less than $10,000, ... 1

$10,001 - $14,000, ... 2

$14,001 - $18,000, ... 3

$18,001 - $22,000, ... 4

$22,001 - $26,000, ... 5

$26,001 - $30,000, ... 6

$30,001 or more? 7

DON'T KNOW ..... d

REFUSED ..... r

W. ADEQUACY OF MONEY

PROGRAMMER BOX W1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM OR NON) ANSWER QUESTIONS IN SECTION W.

REQUIRED

IF PTCPT = CM, HDM OR NON

W1. How well does the amount of money [you have/he has/she has] take care of [your/his/her] needs? Would you say very well, fairly well, or poorly?

CODE ONE ONLY

VERY WELL 1
FAIRLY WELL 2
POORLY 3
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED

IF PTCPT = CM, HDM OR NON

W2. In the past month, did [you/he/she] ever have to choose between buying food and buying medications?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED

IF PTCPT = CM, HDM OR NON

W3. In the past month, did [you/he/she] ever have to choose between buying food and paying [your/his/her] utility bills?

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = CM, HDM OR NON

W4. In the past month, did [you/he/she] ever have to choose between buying food and paying [your/his/her] rent?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

X. PROGRAM PARTICIPATION

PROGRAMMER BOX X1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM OR NON) ANSWER QUESTIONS IN SECTION X.

X_Intro: The next questions are about [your/his/her] participation in different types of programs.

REQUIRED

IF PTCPT = CM, HDM OR NON

X1. Are [you/he/she] or anyone else in [your/his/her] household currently receiving SNAP benefits or food stamps?

YES 1
NO 0
DON'T KNOW .....d
REFUSED .....r

REQUIRED

IF PTCPT = CM, HDM OR NON

X2. During the past 30 days, did [you/he/she] or anyone else in [your/his/her] household get food from a food pantry or food bank?

YES 1
NO 0
DON'T KNOW .....d
REFUSED .....r

REQUIRED

IF PTCPT = CM, HDM OR NON

X3. During the past 30 days, did [you/he/she] receive any meals provided by churches or meals at a soup kitchen or emergency kitchen?

YES 1
NO 0
DON'T KNOW .....d
REFUSED .....r

REQUIRED
IF PTCPT = CM, HDM OR NON

X4. During the past 30 days, did [you/he/she] receive assistance to help with heating and cooling your home, such as LIHEAP?

INTERVIEWER: LIHEAP IS PRONOUNCED [LI-HEEP] AND STANDS FOR LOW INCOME HOME ENERGY ASSISTANCE PROGRAM.

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = NON AND MATCH = CM

X5. [Are you/Is he/Is she] aware that the Administration on Aging's Elderly Nutrition Program provides for meals and related nutrition services for individuals aged 60 years and older in group settings such as senior centers, faith-based settings, and schools? [You/He/She] may know of this as a congregate nutrition program.

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = NON AND MATCH = HDM

X5.1 Are you aware that the Administration on Aging's Elderly Nutrition Program provides for meals and related nutrition services for individuals aged 60 years and older who are homebound due to illness, disability, or geographic isolation? You may know of this as a home-delivered nutrition program.

YES 1
NO 0
DON'T KNOW ..... d
REFUSED ..... r

REQUIRED
IF PTCPT = NON AND MATCH = CM

X6. [Have you/Has he/Has she] ever been contacted about going to a congregate nutrition program?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = NON AND MATCH = HDM

X6.1 [Have you/Has he/Has she] ever been contacted about getting meals from a home-delivered nutrition program?

YES 1

NO 0

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = NON AND MATCH = CM

X7. What are the reasons that [you do/he does/she does] not participate in a congregate nutrition program?

CODE ONE ONLY

DON'T KNOW ABOUT THE PROGRAM/DON'T KNOW WHERE MEAL SITES ARE LOCATED 1

DON'T NEED THIS PROGRAM/NOT OLD ENOUGH/TOO HEALTHY 2

TRANSPORTATION PROBLEMS/BARRIERS 3

DO NOT NEED/WANT ASSISTANCE FROM THE GOVERNMENT 4

HEALTH IS TOO POOR/PHYSICAL IMPAIRMENT/MEAL SITE IS NOT ACCESSIBLE BASED ON PHYSICAL HEALTH 5

MEALS OFFERED DO NOT MEET NEEDS/TASTES/ETHNIC VALUES/NOT ENOUGH VARIETY IN MEALS 6

LANGUAGE BARRIER/DO NOT SPEAK ENGLISH WELL 7

MEAL SITE IS NOT IN A SAFE LOCATION/ DON'T FEEL SAFE AT MEAL SITE/DON'T FEEL SAFE LEAVING HOME TO GO TO MEAL SITE 8

HOURS THAT MEALS ARE OFFERED ARE TOO LIMITED 9

WANTED TO PARTICIPATE BUT WAS PLACED ON WAITING LIST 10

COST OF MEAL IS TOO HIGH 11

OTHER (PLEASE SPECIFY) 99

_____ (STRING (30))

DON'T KNOW ..... d

REFUSED ..... r

REQUIRED
IF PTCPT = NON AND MATCH = HDM

X7.1 What are the reasons that [you do/he does/she does] not participate in a home-delivered nutrition program?

CODE ONE ONLY

DON'T KNOW ABOUT THE PROGRAM.....1

DON'T NEED THIS PROGRAM/NOT OLD ENOUGH/TOO HEALTHY.....2

DO NOT NEED/WANT ASSISTANCE FROM THE GOVERNMENT.....3

MEALS OFFERED DO NOT MEET NEEDS/ TASTES/ETHNIC VALUES/NOT ENOUGH VARIETY IN MEALS.....4

LANGUAGE BARRIER/DO NOT SPEAK ENGLISH WELL.....5

COST OF MEAL IS TOO HIGH.....6

WANTED TO PARTICIPATE BUT WAS PLACED ON WAITING LIST.....7

APPLIED BUT WAS NOT ELIGIBLE TO RECEIVE MEALS.....8

DO NOT LIKE OTHER PEOPLE COMING INTO HOME.....9

OTHER (PLEASE SPECIFY).....99

_____ (STRING (30))

DON'T KNOW.....d

REFUSED.....r

REQUIRED
IF PTCPT = NON AND MATCH = CM

X8. [Do you/Does he/Does she] think [you/he/she] will be interested in going to a congregate nutrition program in the future?

YES.....1

NO.....0

DON'T KNOW.....d

REFUSED.....r

REQUIRED
IF PTCPT = NON AND MATCH = HDM

X8.1 [Do you/Does he/Does she] think [you/he/she] will be interested in getting meals from a home-delivered nutrition program in the future?

YES.....1

NO.....0

DON'T KNOW.....d

REFUSED.....r

Y. RELEASE OF SOCIAL SECURITY NUMBER

PROGRAMMER BOX Y1

CATI: ALL RESPONDENTS (PTCPT = CM, HDM OR NON) ANSWER QUESTIONS IN SECTION Y.

REQUIRED

IF PTCPT = CM, HDM OR NON

Y1. Mathematica Policy Research will conduct statistical research by combining your survey data with health and other related records. To obtain these records, we need your social security number. We will not release it to anyone, including any government agency, for any other reason. Providing this information is voluntary. There will be no effect on your benefits if you do not provide it.

|___|___|___|-|___|___|-|___|___|___|___| ENTER SOCIAL SECURITY NUMBER

DON'T KNOW/DOES NOT HAVE SOCIAL SECURITY NUMBER .....d SKIP TO SECTION Z

REFUSED .....r SKIP TO SECTION Z

INTERVIEWER: IF RESPONDENT CANNOT RECALL FROM MEMORY ASK {HIM/HER} TO GET CARD AT THIS TIME.

IF SOCIAL SECURITY NUMBER IS ENTERED AT Y1, A NEW SCREEN SHOULD APPEAR FOR THE INTERVIEWER TO VERIFY THE NUMBER THAT WAS ENTERED:

INTERVIEWER: READ THE NUMBER BACK TO THE RESPONDENT TO MAKE SURE IT WAS RECORDED CORRECTLY.

IF RESPONDENT REFUSES, DISPLAY THESE INTERVIEWER NOTES:

IF RESPONDENT IS RELUCTANT TO GIVE NUMBER OR IF RESPONDENTS ASK IF THEY MUST GIVE NUMBER: It is extremely useful to have this information to be able to link to health records such as Medicare records. Many years in the future, the information you gave me can be used to see how health habits and diet at one point in your life influence how healthy you are in the future. If you prefer, you can give us only the last four digits of your social security number, and we can use this number to access your records.

IF RESPONDENT CITES PRIVACY CONCERNS: I understand your concern. Mathematica has never had a breach of confidentiality in the more than 40 years we have been conducting research studies. I do not have access to this information after I type it. Once I complete the interview all the information is sent to a secure facility. Only one or two people have access to the file to use it for our health research. If you prefer, you can give us only the last four digits of your social security number, and we can use this number to access your records.

REQUIRED
IF Y1 = d

Y1_DK. INTERVIEWER: CODE PREVIOUS RESPONSE.

DOES NOT HAVE SOCIAL SECURITY NUMBER 1

DON'T KNOW 2

REQUIRED
IF Y1 NE d, r

Y2. INTERVIEWER: SELECT CATEGORY FOR REPORTING OF SOCIAL SECURITY NUMBER.

SELF REPORTED FROM MEMORY 1

SELF REPORTED FROM RECORDS 2

Z. 24 HOUR DIETARY RECALL

In the next part of the survey, I will ask you questions about what you ate and drank over the last 24 hours . . .

AA. RESPONDENT PAYMENT

Confirm1. Thank you very much for your time. You have really helped us with this study. I'd like to make sure the contact information we have on file for you is correct so that we can send you a $50 gift card within the next few weeks. According to our records we have . . .

[FILL NAME, ADDRESS, CITY, STATE, ZIP, PHONE NUMBER]

YES 1
NO 2
FIX THIS NAME/ADDRESS 3
NEW NAME/ADDRESS 4

_____ (STRING (30))
FIRST NAME

_____ (STRING (30))
MIDDLE INITIAL/NAME

_____ (STRING (30))
LAST NAME

_____
STREET 1

_____
STREET 2

_____
STREET 3

_____
CITY

_____
STATE

_____
ZIP

AA1_PhonNum1. According to our records your phone number is . . .

|___|___|___| - |___|___|___| - |___|___|___|___|
(RANGE) (RANGE) (RANGE)

AA2. In about 6 months, we will be contacting you again to see how you are doing. The interview will take no more than 5 minutes to complete. You will get a $10 gift card for participating in that interview. In case we can't reach you at the phone number we just discussed, is there another number we should try?

|___|___|___| - |___|___|___|___| - |___|___|___|___|
(RANGE) (RANGE) (RANGE)

DON'T KNOW ..... d GO TO THANK YOU

REFUSED ..... r GO TO THANK YOU

AA3. In case we have trouble reaching you in 6 months, please give me the name and telephone number of a relative or friend who would know where you could be reached. Please give me the name of someone not currently living in your household.

_____ (STRING (30))
FIRST NAME

_____ (STRING (30))
MIDDLE INITIAL/NAME

_____ (STRING (30))
LAST NAME

_____
STREET 1

_____
STREET 2

_____
STREET 3

_____
CITY

_____
STATE

_____
ZIP

|___|___|___| - |___|___|___|___| - |___|___|___|___|
(RANGE) (RANGE) (RANGE)

DON'T KNOW ..... d GO TO THANK YOU
REFUSED ..... r GO TO THANK YOU

AA4. How is this person related to you?

HUSBAND/WIFE/PARTNER 1
CHILD 2
BROTHER OR SISTER 3
GRANDCHILD 4
SON-IN-LAW OR DAUGHTER-IN-LAW 5
OTHER RELATIVE 6
NON RELATIVE OR FRIEND 7
DON'T KNOW ..... d
REFUSED ..... r

THANK YOU. Thank you very much for your help with this important study. We look forward to speaking with you again in about 6 months.

Mathematica Reference No.: 06669.202

MATHEMATICA Policy Research

National Evaluation of Title III-C Services

Nonparticipant Screener

CATI Questionnaire

May 10, 2012

INTRODUCTION

Hello. **Hello, my name is [NAME] from Mathematica Policy Research in Princeton, New Jersey. May I please speak to [SAMPLE MEMBER NAME]?**

SPEAKING TO [SAMPLE MEMBER NAME]	1	SampMemb
[SAMPLE MEMBER NAME] COMES TO THE PHONE	2	SampMemb
PERSON ASKS WHAT CALL IS ABOUT	3	WhatAbout
NEED TO CALL BACK	4	CALLBACK
SAMPLE MEMBER HAS A HEALTH PROBLEM/ IS DECEASED	5	HealthProb
SAMPLE MEMBER IS IN AN INSTITUTION	6	Institution
SAMPLE MEMBER HAS MOVED	7	KnowWhere
SAMPLE MEMBER DOES NOT SPEAK ENGLISH	8	Lang
NEVER HEARD OF SAMPLE MEMBER/WRONG NUMBER	9	Thanks
HUNG UP DURING INTRODUCTION	10	Thanks
REFUSED	r	Thanks

SampMemb. **[Hello, my name is [NAME] from Mathematica Policy Research in Princeton, New Jersey.] Recently, the U.S. Department of Health and Human Services, Administration on Aging and Mathematica Policy Research sent you a letter describing a study we are conducting to improve nutrition services for older adults.**

First I need to determine whether you are eligible to participate in this study. All of your answers will be kept strictly confidential and your participation is voluntary. May I ask you a few questions now?

BEGIN INTERVIEW	1	A1
DID NOT RECEIVE OR DOES NOT RECALL LETTER	2	NoLetter
WANTS MORE INFORMATION	3	MoreInfo
NOT A GOOD TIME	4	CallBack
HUNG UP DURING INTRODUCTION	5	Thanks
SUPERVISOR REVIEW	6	Thanks
REFUSED	r	RefusalReason

WhatAbout. **Recently, the U.S. Department of Health and Human Services, Administration on Aging and Mathematica Policy Research sent [SAMPLE MEMBER NAME] a letter describing a study we are conducting to improve nutrition services for older adults. May I speak with [SAMPLE MEMBER NAME]?**

SAMPLE MEMBER COMES TO THE PHONE	1	SampleMemb (2)
NEED TO CALL BACK	2	CallBack
SAMPLE MEMBER HAS A HEALTH PROBLEM/IS DECEASED	3	HealthProb
SAMPLE MEMBER IS IN AN INSTITUTION	4	Institution
SAMPLE MEMBER MOVED	5	KnowWhere
SAMPLE MEMBER DOES NOT SPEAK ENGLISH	6	Lang
SAMPLE MEMBER DIDN'T RECEIVE LETTER	7	NoLetter
HUNG UP DURING INTRODUCTION	8	Thanks
SUPERVISOR REVIEW	9	Thanks
REFUSED	r	Thanks

CALLBACK. **When would be a good time to call back?**

_____ (SPECIFY)

MoreInfo. **The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, is cooperating with the U.S. Department of Health and Human Services' Administration on Aging on a study to learn more about how well citizens are served by certain government programs. Mathematica Policy Research (Mathematica), an independent research company, is conducting the study.**

Today we will ask you a short series of questions about your health and use of nutrition services. If you are selected based on your responses, one of our interviewers will call you to schedule a time to meet with you and interview you about your health and well-being, and what you eat and drink.

Shall we begin?

BEGIN INTERVIEW	1	A1
WANTS ANOTHER LETTER	2	ReadLetter
NOT A GOOD TIME	3	Callback
HUNG UP DURING INTRODUCTION	4	Thanks

KnowWhere. Recently, the U.S. Department of Health and Human Services, Administration on Aging and Mathematica Policy Research sent [SAMPLE MEMBER NAME] a letter describing a study we are conducting to improve nutrition services for older adults. Do you or anyone there know how we can reach [SAMPLE MEMBER]?

YES	1	NewPhone
NO	0	Thanks

NewPhone. May I please have [his/her] telephone number?

ENTER 1 TO CONTINUE	1	PhoneNumber
|___|___|___| - |___|___|___| - |___|___|___|___| (RANGE) (RANGE) (RANGE)		
DON'T KNOW	d	
REFUSED	r	

HARD CHECK: IF AREA CODE LT 200; **Area code must be greater than 200**
HARD CHECK: IF PHONE NUMBER NE 10 DIGITS **Phone number should be 10 numeric digits, no spaces, dashes, parentheses, or other punctuation (or empty)**

NewAddress. May I please have [his/her] address?

ENTER 1 TO CONTINUE	1	AddrCheck

AddrCheck. The address we have is [SAMPLE MEMBER ADDRESS]. Is that correct?

YES	1	Thanks
NO	0	Address1
REFUSED	r	Thanks
DON'T KNOW	d	Thanks

Address1. What is the address?

_____ (STRING (NUM))
FIRST NAME

_____ (STRING (NUM))
MIDDLE INITIAL/NAME

_____ (STRING (NUM))
LAST NAME

_____
STREET 1

_____
STREET 2

_____
STREET 3

_____
CITY

_____
STATE

_____
ZIP

DON'T KNOW	d	Thanks
REFUSED	r	Thanks

HARD CHECK: IF ZIP CODE NE 5 OR 9 DIGITS; **The zip code must be 5 or 9 digits, please re-enter**

Lang. CODE LANGUAGE NEEDED TO COMPLETE INTERVIEW IF KNOWN:

SPANISH	1	Thanks
FRENCH	2	NeedProxy
CHINESE	3	NeedProxy
RUSSIAN	4	NeedProxy
GERMAN	5	NeedProxy
OTHER LANGUAGE	6	OtherLang (Skips to NeedProxy)

NoLetter. **The letter described the study and explained that your name was randomly selected from a list of Medicare beneficiaries in your area. The letter also explained that we would be calling to interview you. May I ask you a few questions now to determine if you are eligible to participate in this study?**

BEGIN INTERVIEW	1	A1
WANTS ANOTHER LETTER	2	ReadLetter
WANTS MORE INFORMATION	3	MoreInfo
NOT A GOOD TIME	4	CALLBACK
HUNG UP DURING INTRODUCTION	5	Thanks
REFUSED	r	RefusalReason

ReadLetter. **May I read the letter to you and then we can begin?**

YES, READ THE LETTER FROM THE HARD COPY	1	SKIP TO A1
NO, WANTS ANOTHER LETTER FIRST	2	SendLetter
HUNG UP DURING INTRODUCTION	3	Thanks
REFUSED	r	RefusalReason

SendLetter. **Okay, I'll mail another letter and call back in a few days.**

ENTER 1 TO CONTINUE	1	AddrCheck

Health Prob. **ENTER TYPE OF HEALTH PROBLEM**

HEARING PROBLEM	1	AmpTTY
SPEECH PROBLEM	2	AmpTTY
PHYSICAL PROBLEM	3	CallLater
COGNITIVE PROBLEM	4	NeedProxy
TOO OLD / FRAIL	5	CallLater
IN A COMA	6	NeedProxy
DECEASED	7	Deceased

AMPTTY. **I can get on a phone that will amplify my voice or [SAMPLE MEMBER]'s voice, or we could use a TTY service. Would either of these enable [him/her] to complete the interview?**

YES, USE AMPLIFIER PHONE	1	RespAvail
YES, USE TTY CAPABILITY	2	RespAvail
NO	3	NeedProxy

CallLater. **Will [SAMPLE MEMBER NAME] be able to talk on the telephone if I call back next week?**

YES/MAYBE, CALL BACK	1	CALLBACK
NO	2	NeedProxy
DON'T KNOW	d	Callback
REFUSED	r	RefusalReason

Institution. **ENTER TYPE OF INSTITUTION**

HOSPITAL/REHABILITATION CENTER	1	HomeSoon
HOSPICE	2	
NURSING HOME	3	Capable
ASSISTED LIVING FACILITY	4	Capable
GROUP HOME	5	Capable
JAIL OR PRISON	6	Thanks

HomeSoon. **Do you expect [SAMPLE MEMBER NAME] to come home from the hospital within a week or two?**

YES, ARRANGE CALLBACK	1	CallBack
NO	2	Capable
SM UNABLE TO RESPOND OVER THE TELEPHONE	3	NeedProxy

Deceased. **I am very sorry to hear that [he/she] passed away. I am calling on behalf of Mathematica Policy Research regarding the U.S. Department of Health and Human Services, Administration on Aging. A letter explaining why we are calling was recently sent to [SAMPLE MEMBER NAME].**

Please accept my condolences. Good-bye.

Capable. **Recently, the U.S. Department of Health and Human Services, Administration on Aging and Mathematica Policy Research sent [SAMPLE MEMBER NAME] a letter describing a study we are conducting for older adults. Would [he/she] be able to answer questions [himself/herself] or would someone need to answer the questions for [SAMPLE MEMBER NAME]?**

RESPONDENT IS ABLE TO RESPOND	1	Facility
RESPONDENT IS UNABLE TO RESPOND	2	NeedProxy

Facility. **What is the name of the hospital/group home/assisted living facility?**

Contact. **Do you have the name of the administrator or a contact person there?**

ENTER 1 TO CONTINUE ..... 1 FirstName

_____
FIRST NAME

_____
MIDDLE INITIAL

_____
LAST NAME

_____
CONFIRM

FacAddr. **What is the address of the hospital/group home/assisted living facility?**

_____
ADDRESS 1

_____
ADDRESS 2

_____
ADDRESS 3

_____
ADDRESS 4

_____
CITY

_____
STATE

_____
ZIP

_____
CONFIRM

DON'T KNOW ..... d Thanks

REFUSED ..... r Thanks

FacPhone. **May I please have the telephone number of the hospital/group home/assisted living facility?**

ENTER 1 TO CONTINUE ..... 1 PhoneNumber

|___|___|___| - |___|___|___| - |___|___|___|___|
(RANGE) (RANGE) (RANGE)

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF AREA CODE LT 200; **Area code must be greater than 200**
HARD CHECK: IF PHONE NUMBER NE 10 DIGITS **Phone number should be 10 numeric digits, no spaces, dashes, parentheses, or other punctuation (or empty)**

NeedProxy. Is there someone who could answer the questions for [SAMPLE MEMBER]?

YES, SPEAKING TO FAMILY MEMBER OR FRIENDS WHO WILL ACT AS PROXY	1	ProxyName
YES, BUT NOT A GOOD TIME/PROXY NOT AVAILABLE	2	ProxyName2
PROXY LIVES ELSEWHERE	3	ProxyName2
NO PROXY AVAILABLE	4	Thanks
SUPERVISOR REVIEW	5	Thanks

ProxyName. Before we begin, can you please tell me your name?

ENTER 1 TO CONTINUE 1

_____
FIRST NAME

_____
MIDDLE INITIAL

_____
LAST NAME

Confirm. [NAME] ProxyRel

ProxyName2. May I please have [his/her] name?

ENTER 1 TO CONTINUE 1

_____
FIRST NAME

_____
MIDDLE INITIAL

_____
LAST NAME

Confirm. [NAME] ProxyPhone

ProxyPhone. May I please have [his/her] telephone number?

ENTER 1 TO CONTINUE ..... 1 PhoneNumber

|___|___|___| - |___|___|___| - |___|___|___|___|
(RANGE) (RANGE) (RANGE)

DON'T KNOW ..... d

REFUSED ..... r

HARD CHECK: IF AREA CODE LT 200; **Area code must be greater than 200**
HARD CHECK: IF PHONE NUMBER NE 10 DIGITS **Phone number should be 10 numeric digits, no spaces, dashes, parentheses, or other punctuation (or empty)**

ProxyAddr. And [his/her] address?

ENTER 1 TO CONTINUE ..... 1 Addr

_____
STREET 1

_____
STREET 2

_____
STREET 3

_____
CITY

_____
STATE

_____
ZIP

_____ ProxyRel2
CONFIRM

ProxyRel. And how are you related to [SAMPLE MEMBER NAME]?

SPOUSE 1 A1

CHILD 2 A1

SIBLING 3 A1

PARENT 4 A1

NIECE/NEPHEW 5 A1

FRIEND/NEIGHBOR/OTHER RELATIVE 6 A1

GROUP/FOSTER HOME/ASSISTED LIVING FACILITY ADMINISTRATOR/CARER 7 A1

OTHER ..... 8 OtherRel

ProxyRel2. And how is [he/she] related to [SAMPLE MEMBER NAME]?

SPOUSE	1	Callback
CHILD	2	Callback
SIBLING	3	Callback
PARENT	4	Callback
NIECE/NEPHEW	5	Callback
FRIEND/NEIGHBOR/OTHER RELATIVE	6	Callback
GROUP/FOSTER HOME/ASSISTED LIVING FACILITY ADMINISTRATOR/CARER	7	Callback
OTHER	8	OtherRel

CallInInfo. You should call toll-free XXX-XXX-XXXX and ask for XXXXXXXXXXXXXXX. We look forward to hearing from you.

ENTER 1 TO CONTINUE	1	

Callback Screener - When calling back to complete screener after reaching A1 or if given a new number for a proxy.

Callback-Hello. Hello, my name is [NAME] from Mathematica Policy Research in Princeton, New Jersey. May I please speak to [RESPONDENT NAME]?

SPEAKING TO [RESPONDENT NAME]	1	SampMemb1 or New Proxy1
[RESPONDENT NAME] COMES TO THE PHONE	2	SampMemb2 or New Proxy2
PERSON ASKS WHAT CALL IS ABOUT	3	WhatAbout
NEED TO CALL BACK	4	CALLBACK
NEVER HEARD OF RESPONDENT/WRONG NUMBER	5	PhoneCheck

SampMemb (1). I am calling to complete the interview we are conducting about [your/SAMPLE MEMBER's NAME] health and use of nutrition services. Is now a good time?

CONTINUE THE INTERVIEW	1	Last question answered
NOT A GOOD TIME	3	Callback
SUPERVISOR REVIEW	3	Thanks

SampMemb (2). Hello, my name is [INTERVIEWER NAME] from Mathematica Policy Research in Princeton, New Jersey. I am calling to complete the interview we are conducting about [your/SAMPLE MEMBER's NAME] health and use of nutrition services. Is now a good time?

CONTINUE THE INTERVIEW	1	A1
NOT A GOOD TIME	2	CallBack
SUPERVISOR REVIEW	3	Thanks

NewProxy(1): PROGRAMMING NOTE: WHEN THERE IS A PROXY, USE THIS SCREEN IF ON THE FIRST CALL WE WERE GIVEN THE NAME OF THE PROXY BUT THAT PROXY WAS NOT AVAILABLE.

Recently , the U.S. Department of Health and Human Services, Administration on Aging and Mathematica Policy Research sent [SAMPLE MEMBER's NAME] a letter describing a study we are conducting to improve nutrition services for older adults. We wanted to interview [SAMPLE MEMBER's FIRST NAME], but I understand that [he/she] is unable to be interviewed and your name was given as someone who could answer on [his/her] behalf. Is now a good time?

CONTINUE THE INTERVIEW	1	A1
NOT A GOOD TIME	2	CallBack
WANTS MORE INFORMATION	3	MoreInfo
SUPERVISOR REVIEW	4	Thanks

NewProxy(2): PROGRAMMING NOTE: WHEN THERE IS A PROXY, USE THIS SCREEN IF ON THE FIRST CALL WE WERE GIVEN THE NAME OF THE PROXY BUT THAT PROXY WAS NOT AVAILABLE.

Hello, my name is [INTERVIEWER NAME] from Mathematica Policy Research in Princeton, New Jersey. Recently, the U.S. Department of Health and Human Services, Administration on Aging and Mathematica Policy Research sent [SAMPLE MEMBER NAME] a letter describing a study we are conducting to improve nutrition services for older adults. We wanted to interview [SAMPLE MEMBER's FIRST NAME], but I understand that [he/she] is unable to be interviewed and your name was given as someone who could answer on [his/her] behalf. Is now a good time?

CONTINUE THE INTERVIEW	1	A1
NOT A GOOD TIME	2	CallBack
WANTS MORE INFORMATION	3	MoreInfo
SUPERVISOR REVIEW	4	Thanks

MoreInfo. **The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, is cooperating with the U.S. Department of Health and Human Services, Administration on Aging on a study to learn more about how well citizens are served by certain government programs. Mathematica Policy Research (Mathematica), an independent research company, is conducting the study.**

Today **We will ask you a short series of questions about [SAMPLE MEMBER's NAME] health and use of nutrition services. If [he/she] is selected based on your responses, one of our interviewers will call you to schedule a time to meet with you and interview you about [his/her] health and well-being, and what [he/she] eats and drinks.**

Shall we begin?

BEGIN INTERVIEW	1	A1
WANTS ANOTHER LETTER	2	ReadLetter
NOT A GOOD TIME	3	Callback
HUNG UP DURING INTRODUCTION	4	Thanks

WhatAbout. **I am calling to complete the interview we are conducting with [RESPONDENT NAME]. When is a good time to reach [RESPONDENT]?**

[RESPONDENT] COMES TO THE PHONE	1	A1
NEED TO CALL BACK	2	NoLetter
SUPERVISOR REVIEW	3	MoreInfo

PhoneCheck. **I'm sorry, I must have misdialed, I thought I dialed [PHONE NUMBER]. Can you tell me what number I've reached to see what kind of mistake I made?**

RIGHT NUMBER, NO SUCH PERSON	1	WrongNumber
WRONG CONNECTION/MISDIAL	2	Thanks
SUPERVISOR REVIEW	3	Thanks
REFUSED TO CONFIRM NUMBER	3	Thanks

A. NONPARTICIPATION SCREENING

PROGRAMMING NOTE: For questions A1-A15, if there is a proxy (Respondent is not the sample member), text should fill with [Does he/does she, has he/has she, etc.] depending on the Sample Member.

If there is no proxy (Respondent is the Sample Member), text should fill with [do you, have you, etc.].

A1. [Do you/Does he/Does she] currently eat at a senior community meal program, for example, at a place like a senior center or community center or somewhere else where older adults get meals on a regular basis, other than a restaurant?

YES	1	THANK YOU(1)
NO	0	
DON'T KNOW	d	
REFUSED	r	

A2. During the past year, [have you/has he/has she] eaten at a senior community meal program?

YES	1	THANK YOU(1)
NO	0	
DON'T KNOW	d	
REFUSED	r	

PROGRAMMER BOX (NUM)

CATI: IF BOTH A1 AND A2 ARE DON'T KNOW OR REFUSED, SKIP TO THANK YOU(1).

A3. [Are you/Is he/Is she] currently in a home-delivered meals or meals-on-wheels program where meals are delivered to [your/his/her] home?

YES	1	THANK YOU(1)
NO	0	
DON'T KNOW	d	
REFUSED	r	

A4. During the past year, [have you/has he/has she] received home-delivered meals or meals-on-wheels?

YES	1	THANK YOU(1)
NO	0	
DON'T KNOW	d	
REFUSED	r	

PROGRAMMER BOX (NUM)

CATI: IF BOTH A3 AND A4 ARE DON'T KNOW OR REFUSED, GO TO THANK YOU.

A5. [Do you/Does he/Does she] currently live in a nursing home?

YES	1	THANK YOU(1)
NO	0	
DON'T KNOW	d	THANK YOU(1)
REFUSED	r	THANK YOU(1)

A6. [Do you/Does he/Does she] currently live in a rehabilitation facility?

YES	1	
NO	0	A8
DON'T KNOW	d	A8
REFUSED	r	A8

A7. Will [you/he/she] be living in the rehabilitation facility for more than two more weeks?

YES	1	THANK YOU(1)
NO	0	
DON'T KNOW	d	THANK YOU(1)
REFUSED	r	THANK YOU(1)

A8. Please tell me how difficult it is for [you/him/her] to go out of [your/his/her] house on [your/his/her] own without the help of another person.

[Do you/Does he/Does she] have no difficulty, some difficulty, much difficulty, or [are you/is he/is she] unable to leave the house on [your/his/her] own without the help of another person?

CODE ONE ONLY

NO DIFFICULTY	1	GO TO A13
SOME DIFFICULTY	2	
MUCH DIFFICULTY	3	
UNABLE TO DO	4	
DON'T KNOW	d	
REFUSED	r	

A9. Is the difficulty because of a medical problem, a physical condition, an emotional or psychological problem, or a lack of transportation?

CODE ALL THAT APPLY

MEDICAL PROBLEM	1
PHYSICAL CONDITION	2
EMOTIONAL OR PSYCHOLOGICAL PROBLEM	3
LACK OF TRANSPORTATION	4
NONE OF THE ABOVE	5
DON'T KNOW	d
REFUSED	r

PROGRAMMER BOX A10

CATI: IF A8 = 3 OR 4 AND A9 = 1, 2, OR 3, ASK A10; ELSE GO TO A13

A10. Please tell me how difficult it is for [you/him/her] to walk from one room to another on the same level by [yourself/himself/herself].

[Do you/Does he/Does she] have no difficulty, some difficulty, much difficulty, or [are you/is he/is she] unable to go from room to room by [yourself/himself/herself] without the help of another person?

CODE ONE ONLY

NO DIFFICULTY	1
SOME DIFFICULTY	2
MUCH DIFFICULTY	3
UNABLE TO DO	4
DON'T KNOW	d
REFUSED	r

A11. Please tell me how difficult it is for [you/him/her] to stand up from an armless chair by [yourself/himself/herself].

[Do you/Does he/Does she] have no difficulty, some difficulty, much difficulty, or [are you/is he/is she] unable to get up from an armless chair by [yourself/himself/herself] without the help of another person?

CODE ONE ONLY

NO DIFFICULTY	1
SOME DIFFICULTY	2
MUCH DIFFICULTY	3
UNABLE TO DO	4
DON'T KNOW	d
REFUSED	r

A12. Please tell me how difficult it is for [you/him/her] to get in or out of bed by [yourself/himself/herself].

[Do you/Does he/Does she] have no difficulty, some difficulty, much difficulty, or [are you/is he/is she] unable to get in or out of bed by [yourself/himself/herself] without the help of another person?

CODE ONE ONLY

NO DIFFICULTY	1
SOME DIFFICULTY	2
MUCH DIFFICULTY	3
UNABLE TO DO	4
DON'T KNOW	d
REFUSED	r

A13. [Are you/Is he/Is she] able to prepare hot meals [yourself/himself/herself]?

YES	1	Confirm1
NO	0	
DON'T KNOW	d	Confirm1
REFUSED	r	Confirm1

A14. Is there someone living in [your/his/her] household who can prepare hot meals for [you/him/her]?

YES	1
NO	0
DON'T KNOW	d
REFUSED	r

Confirm1

(IF SAMPLE MEMBER) I would like your help with a survey to find out how the U.S. Department of Health and Human Services, Administration on Aging can help meet the needs of older Americans. The survey has two parts. The first part is about your general health and dietary habits. The second part is about what you ate and drank over a 24 hour period. Your participation is voluntary but we would really like your help. This survey is for research purposes only and will help to improve services for older adults in the future. All of your answers will be kept strictly confidential. Your eligibility for services for this and other programs will not be affected by your decision to participate. The survey takes about 55 minutes to complete. We'll mail you a $50 gift card within a few weeks of completing the survey.

(IF PROXY) I would like your help with a survey to find out how the U.S. Department of Health and Human Services, Administration on Aging can help meet the needs of older Americans. The survey has two parts. The first part is about [SAMPLE MEMBER's FIRST NAME] general health and dietary habits. The second part is about what [he/she] ate and drank over a 24 hour period. Your participation is voluntary but we would really like your help. This survey is for research purposes only and will help to improve services for older adults in the future. All of your answers will be kept strictly confidential. [SAMPLE MEMBER's FIRST NAME] eligibility for services for this and other programs will not be affected by your decision to participate. The survey takes about 55 minutes to complete. We'll mail you a $50 gift card within a few weeks of completing the survey.

(IF SAMPLE MEMBER OR PROXY) One of our trained interviewers will be calling you shortly to set up an appointment to complete the interview at your convienence. May I please confirm some information…

_____ (STRING (NUM))
FIRST NAME

_____ (STRING (NUM))
MIDDLE INITIAL/NAME

_____ (STRING (NUM))
LAST NAME

_____
STREET 1

_____
STREET 2

_____
STREET 3

_____
CITY

_____
STATE

_____
ZIP

DON'T KNOW ..... d GO TO END

REFUSED ..... r GO TO END

HARD CHECK: IF ZIP CODE NE 5 OR 9 DIGITS; **The zip code must be 5 or 9 digits, please re-enter**

Is that correct?

YES 1
NO 0
DON'T KNOW .....d
REFUSED .....r

ConfPhoneNumb **The phone number we have on record for you is XXX-XXX-XXXX. Is that the best number where we can reach you?**

YES .....1 ThankYou(2)
NO .....0 PhoneNumber

PhoneNumber **Please give me the telephone number, area code first.**

|___|___|___| - |___|___|___| - |___|___|___|___|
(RANGE) (RANGE) (RANGE)

DON'T KNOW .....d
REFUSED .....r

HARD CHECK: IF AREA CODE LT 200; **Area code must be greater than 200**
HARD CHECK: IF PHONE NUMBER NE 10 DIGITS **Phone number should be 10 numeric digits, no spaces, dashes, parentheses, or other punctuation (or empty)**

ThankYou(1). **Thank you for your time.**

ThankYou(2). **Thank you for your time. We look forward to your participation in our study.**

MATHEMATICA Policy Research

2011 National Evaluation of Title III-C Nutrition Services
[FILL SUA NAME] Data Verification

The information in Column 1 about [FILL SUA NAME] comes from the State Program Report and the NASUA State of Aging report. Please review the information about your SUA in Column 1. If the information is correct, check the box in Column 2 and continue to the next row. If the information is incorrect, please make corrections in Column 3.

COLUMN 1	COLUMN 2	COLUMN 3
Organizational Structure		
1. The SUA is… an independent agency within state government part of an umbrella agency part of a board or commission	☐ Correct	☐ Incorrect. The SUA is… ☐ an independent agency within state government ☐ part of an umbrella agency ☐ part of a board or commission
2. (ANSWER 2 ONLY IF SUA IS PART OF UMBRELLA AGENCY) The umbrella agency of the SUA is best described as… Human service Health Medicaid Welfare Health and Social/Human/ Family services Governor/Lt. Governor's Office Community/Cultural Affairs None of the above	☐ Correct	☐ Incorrect. The umbrella agency of the SUA is best described as… ☐ Human service ☐ Health ☐ Medicaid ☐ Welfare ☐ Health and Social/Human/ Family services ☐ Governor/Lt. Governor's Office ☐ Community/Cultural Affairs ☐ None of the above

COLUMN 1	COLUMN 2	COLUMN 3
3. The SUA administers the following non-Older Americans Act (OAA) programs: Medicaid institutional care Medicaid Waiver(s) Energy assistance (LIHEAP) State health insurance counseling and assistance program (SHIP) Pre-admission screening and resident review screening for mental illness (PASRR) State funded HCBS SNAP (Food Stamps) CACFP Emergency Food Assistance (TEFAP) Commodity Supplemental Food Program (CSFP) Senior Farmers Market (SFMP) None of the above	☐ Correct	☐ Incorrect. The SUA administers the following non-Older Americans Act (OAA) programs: **CHECK ALL THAT APPLY** ☐ Medicaid institutional care ☐ Medicaid Waiver(s) ☐ Energy assistance (LIHEAP) ☐ State health insurance counseling and assistance program (SHIP) ☐ Pre-admission screening and resident review screening for mental illness (PASRR) ☐ State funded HCBS ☐ SNAP (Food Stamps) ☐ CACFP ☐ Emergency Food Assistance (TEFAP) ☐ Commodity Supplemental Food Program (CSFP) ☐ Senior Farmers Market (SFMP) ☐ None of the above
4. There are [**FILL NUMBER**] tribal organizations with Title VI grants in this state.	☐ Correct	☐ Incorrect. The state has… |__|__| TRIBAL ORGANIZATIONS
Staff and Volunteers		
5. This SUA has [**FILL # FTEs**] full-time equivalent employees, including yourself.	☐ Correct	☐ Incorrect. The SUA has… |__|__|__| FULL-TIME EQUIVALENT EMPLOYEES INCLUDING YOURSELF
6. Of the total number of full-time equivalent employees, [**FILL # FTEs**] work on the Elderly Nutrition Program and are funded in whole or in part by the Older Americans Act.	☐ Correct	☐ Incorrect. The number of employees who work on the Elderly Nutrition Program is… |__|__|__| FULL-TIME EQUIVALENT EMPLOYEES INCLUDING YOURSELF
Aging and Disability Resource Centers (ADRCs)		
7. An Aging and Disability Resource Center [**exists/does not exist**] in your state.	☐ Correct	☐ Incorrect. An Aging and Disability Resource Center [exists/does not exist] in your state.
8. (ANSWER QUESTION 2 ONLY IF ADRC EXISTS) The Aging and Disability Resource Center [**provides/does not provide**] statewide coverage.	☐ Correct	☐ Incorrect. An Aging and Disability Resource Center [exists/does not exist] in your state.

COLUMN 1	COLUMN 2	COLUMN 3
Service Population		
9. The SUA serves the following populations through all programs and services: Adults 60 years and older Family caregivers Adults with physical disabilities regardless of age Adults with mental retardation or developmental disability regardless of age Children with physical disabilities Children with mental retardation or developmental disability	☐ Correct	☐ Incorrect. The SUA serves… **CHECK ALL THAT APPLY** ☐ Adults 60 years and older ☐ Family caregivers ☐ Adults with physical disabilities regardless of age ☐ Adults with mental retardation or developmental disability regardless of age ☐ Children with physical disabilities ☐ Children with mental retardation or developmental disability
10. Between October 2010 and September 2011, the SUA served [**FILL NUMBER**] unduplicated congregate nutrition clients in the Older Americans Act (OAA) Title III-C Congregate Nutrition Program.	☐ Correct	☐ Incorrect. In the most recently completed fiscal year, the SUA served… |___|___|___|,|___|___|___| UNDUPLICATED CONGREGATE NUTRITION PROGRAM CLIENTS
11. Between October 2010 and September 2011, the SUA served [**FILL NUMBER**] unduplicated home-delivery nutrition clients in the Older Americans Act (OAA) Title III-C Home-Delivered Nutrition Program.	☐ Correct	☐ Incorrect. In the most recently completed fiscal year, the SUA served… |___|___|___|,|___|___|___| UNDUPLICATED HOME-DELIVERED NUTRITION PROGRAM CLIENTS
Transfer of Older Americans Act Funds		
***THE INFORMATION IN THIS SECTION APPLIES TO FUNDS TRANSFERRED IN THE MOST RECENTLY COMPLETED FISCAL YEAR**		
12. The SUA transferred $[**FILL AMOUNT**] in OAA funds from Congregate Meal to Home-Delivered Meals.	☐ Correct	☐ Incorrect. The SUA transferred… $|___|,|___|___|___|,|___|___|___| FROM CONGREGATE TO HOME-DELIVERED MEALS
13. The SUA transferred $[**FILL AMOUNT**] in OAA funds from Home-Delivered Meals to Congregate Meals.	☐ Correct	☐ Incorrect. The SUA transferred… $|___|,|___|___|___|,|___|___|___| FROM HOME-DELIVERED TO CONGREGATE MEALS
14. The SUA transferred $[**FILL AMOUNT**] in OAA funds from Congregate Meals to Supportive Services.	☐ Correct	☐ Incorrect. The SUA transferred… $|___|,|___|___|___|,|___|___|___| FROM CONGREGATE MEALS TO SUPPORTIVE SERVICES

COLUMN 1	COLUMN 2	COLUMN 3
15. The SUA transferred $[**FILL AMOUNT**] in OAA funds from Home-Delivered Meals to Supportive Services.	☐ Correct	☐ Incorrect. The SUA transferred… $|___|,|___|___|___|,|___|___|___| FROM HOME-DELIVERED MEALS TO SUPPORTIVE SERVICES
16. The SUA transferred $[**FILL AMOUNT**] in OAA funds from Supportive Services to Congregate Meals.	☐ Correct	☐ Incorrect. The SUA transferred… $|___|,|___|___|___|,|___|___|___| FROM SUPPORTIVE SERVICES TO CONGREGATE MEALS
17. The SUA transferred $[**FILL AMOUNT**] in OAA funds from Supportive Services to Home-Delivered Meals	☐ Correct	☐ Incorrect. The SUA transferred… $|___|,|___|___|___|,|___|___|___| FROM SUPPORTIVE SERVICES TO HOME-DELIVERED MEALS
Program Characteristics		
18. The SUA [administers/does not administer] a state funded HCBS program that includes home-delivered meals.	☐ Correct	☐ Incorrect. The SUA [administers/does not administer] a state funded HCBS program that includes home-delivered meals.
Medicaid Waiver		
19. The state offers the following nutrition services in Medicaid HCBS: Home delivered meals Nutrition supplements None of the above	☐ Correct	☐ Incorrect. The state offers the following nutrition services in Medicaid HCBS: ☐ Home delivered meals ☐ Nutrition supplements ☐ None of the above

MATHEMATICA
Policy Research

2011 National Evaluation of the Title III-C Elderly Nutrition Services

State Unit on Aging (SUA) Survey

INTRODUCTION

Thank you for helping us with the National Evaluation of the Title III-C Elderly Nutrition Services. The study will involve a census of all State Units on Aging as well as a large number of Area Agencies on Aging, Local Service Providers, program participants and eligible non-participants. This survey will collect information that is not available either in the State Program Report or the NASUA State of Aging report.

- The survey should be completed by the person in the SUA who is most familiar with the Elderly Nutrition Program.
- When completing the survey, please use a black or blue pen and write in the spaces provided.
- Unless questions specifically indicate that more than one answer may be given, please mark only one answer per question.
- If you have any questions regarding the study or completing the State Unit on Aging Survey, please contact Rhoda Cohen at 1-800-232-8024 or email: rcohen@mathematica-mpr.com
- The information you provide will be used only for statistical purposes. In accordance with the Confidential Information Protection and Statistical Efficiency Act of 2002, your responses will not be disclosed in identifiable form without your consent.
- Participation is completely voluntary. We thank you for your cooperation and participation in this very important study.
- If you do not have exact information available to answer certain questions, your best estimate will be fine.

A. ORGANIZATIONAL STRUCTURE, STAFF AND VOLUNTEERS

A1. How many Area Agencies on Aging (AAA) are there currently in your state?

|__|__| AAAs

A2. Of the total number of Area Agencies on Aging currently in your state, please record the number of AAAs that are characterized by each of the various types of planning and service area boundaries.

Planning and Service Area Boundaries	Number of AAAs	Don't Know
a. Single-county	|__|__|	d ☐
b. Multi-county	|__|__|	d ☐
c. Single city/metro area	|__|__|	d ☐
d. Multiple city/metro area	|__|__|	d ☐
e. Other *(Specify)* ..... _____	|__|__|	d ☐

A3. Does the SUA currently employ a Nutrition Program Administrator who plans, develops, administers, implements and evaluates the Elderly Nutrition Program?

1 ☐ Yes

0 ☐ No → **GO TO A6**

d ☐ Don't know → **GO TO A6**

A4. Is the Nutrition Program Administrator a registered dietitian or state credentialed nutrition professional?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

A5. What program responsibilities does the Nutrition Program Administrator currently have other than the Elderly Nutrition Program?

MARK ALL THAT APPLY

1 ☐ Other food and nutrition programs (e.g., SNAP, Senior Farmers' Market Nutrition Program (SFMNP), etc.)

2 ☐ Non-food and nutrition programs (e.g., transportation services, senior centers, etc.) *(Specify)*

_____

3 ☐ No other program responsibilities

A6. How many employees who are registered dietitians and/or state credentialed nutrition professionals currently work at least part of their time on the Elderly Nutrition Program?

|___| EMPLOYEES

B. AGING AND DISABILITY RESOURCE CENTERS (ADRCS)

B1. Has the Elderly Nutrition Program staff been involved in developing or reviewing the current intake process or assessment tools for nutrition services for the Aging and Disability Resource Center site(s) in your state?

1 ☐ Yes

0 ☐ No

2 ☐ ADRC is not operational → **GO TO C1**

d ☐ Don't know

B2. Do Aging and Disability Resource Center sites in your state currently assess clients for nutrition service needs as part of the client intake and assessment?

1 ☐ Yes, all sites

2 ☐ Yes, some sites

0 ☐ No

d ☐ Don't know

B3. Do the Aging and Disability Resource Center sites currently use client intake and assessments for nutrition services that are consistent across the state?

1 ☐ Yes

0 ☐ No

2 ☐ Only one site in state

d ☐ Don't know

C. CONSUMER DIRECTION

The next questions are about self-directed care. Self-directed care is defined as programs and services, in which clients can choose to select, manage and dismiss their workers. This may also be referred to as "consumer-directed" care.

C1. Does the SUA currently have policies that permit self-directed home and community-based services for older adults?

1 ☐ Yes

0 ☐ No → **GO TO D1**

d ☐ Don't know → **GO TO D1**

C2. Do the self-directed home and community-based service programs for older adults include nutrition services as allowable services?

1 ☐ Yes, all self-directed programs allow nutrition services

2 ☐ Yes, some self-directed programs allow nutrition services

0 ☐ No → **GO TO D1**

d ☐ Don't know → **GO TO D1**

C3. What options are currently allowed for delivery of self-directed nutrition services?

MARK ALL THAT APPLY

1 ☐ Payments to friends or family

2 ☐ Restaurant vouchers

3 ☐ Congregate nutrition services

4 ☐ Home-delivered nutrition services

5 ☐ No policy exists about allowable service delivery

6 ☐ Other *(Specify)*

_____

D. FOOD SAFETY

D1. Does the SUA currently have any formal policies, guidance or regulations for managing food borne illnesses in the Elderly Nutrition Program?

1 ☐ Yes

0 ☐ No → **GO TO D3**

d ☐ Don't know → **GO TO D3**

D2. Which of the following entities were involved in the development of the SUA's current food borne illness policy for the Elderly Nutrition Program?

1 ☐ AAAs

2 ☐ Local service providers

3 ☐ State or local health department

4 ☐ State department of agriculture

5 ☐ None of the above

d ☐ Don't know

D3. Does the SUA currently have formal policies, guidance or regulations for managing food recalls?

1 ☐ Yes

0 ☐ No → **GO TO D5**

d ☐ Don't know → **GO TO D5**

D4. Which of the following entities were involved in the development of the SUA's current food recall policy?

1 ☐ AAAs

2 ☐ Local service providers

3 ☐ State or local health department

4 ☐ State department of agriculture

5 ☐ None of the above

d ☐ Don't know

D5. Are local service providers currently required by the SUA to report incidents of food borne illness that occur in the Elderly Nutrition Program (congregate or home-delivered nutrition programs) to each of the following entities?

	Yes	No	Don't Know
a. AAA.....	1 ☐	0 ☐	d ☐
b. SUA	1 ☐	0 ☐	d ☐
c. State or local health department	1 ☐	0 ☐	d ☐

D6. During the past 3 years, how many different times was the food served in the congregate nutrition program associated with an outbreak of food-borne illness?

|__|__| TIMES

0 ☐ Zero → **GO TO D8**

d ☐ Don't know

D7. In total, how many clients got sick during the past 3 years?

|__|__|__|__| CONGREGATE NUTRITION PROGRAM CLIENTS

d ☐ Don't know

D8. During the past 3 years, how many different times was food served in the home-delivered nutrition program associated with an outbreak of food-borne illness?

|__|__| TIMES

0 ☐ Zero → **GO TO E1**

d ☐ Don't know

D9. In total, how many clients got sick in the past 3 years?

|__|__|__|__| HOME-DELIVERED NUTRITION PROGRAM CLIENTS

d ☐ Don't know

E. NUTRITION PROGRAM QUALITY/MONITORING/SITE VISITS

E1. Please indicate how the DRIs (dietary reference intakes) and Dietary Guidelines for Americans (2005) had been implemented throughout the Elderly Nutrition Program in your state as of December 2010?

Implementation Status	Dietary Reference Intakes (DRIs)	Dietary Guidelines for Americans
a. Full implementation throughout the state	1 ☐	1 ☐
b. Full implementation ***in portions*** of the state.....	2 ☐	2 ☐
c. Partial implementation throughout the state.....	3 ☐	3 ☐
d. Very little implementation throughout the state	4 ☐	4 ☐
e. Don't Know	d ☐	d ☐

E2. Has the SUA established a formal policy for the Elderly Nutrition Program regarding the implementation of the DRI or the Dietary Guidelines for Americans?

1 ☐ Yes, DRI only

2 ☐ Yes, Dietary Guidelines for Americans only

3 ☐ Yes, both DRI and the Dietary Guidelines

0 ☐ No, neither DRI or the Dietary Guidelines → **GO TO E4**

E3. When were the SUA's formal policies regarding the DRI or Dietary Guidelines last updated?

|__|__|__|__| YEAR

d ☐ Don't know

E4. How frequently are SUA policies on the implementation of the DRIs or Dietary Guidelines in the Elderly Nutrition Program updated?

1 ☐ Yearly

2 ☐ After every reauthorization of the Older Americans Act (OAA)

3 ☐ After changes are made to the DRI, Dietary Guidelines for Americans or food service codes

4 ☐ Every 1-5 years

5 ☐ Other *(Specify)*

_____

6 ☐ No schedule is used

d ☐ Don't know

E5. Has the SUA established a formal policy for the Elderly Nutrition Program regarding the implementation of state and local food service codes?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

E6. Does the SUA currently include assessments in any of the following areas to monitor the AAAs' implementation of the Elderly Nutrition Program?

MARK ALL THAT APPLY

1 ☐ Nutrient quality

2 ☐ Client satisfaction

3 ☐ Food service quality

4 ☐ Targeting of service

5 ☐ Outreach activities

6 ☐ Access to service

7 ☐ Reporting of data

8 ☐ Fiscal management

9 ☐ None of the above

d ☐ Don't know

E7. Which of the following does the SUA currently use to contribute to the nutrient quality of the meals in the Elderly Nutrition Program?

MARK ALL THAT APPLY

1 ☐ Statewide catering contract

2 ☐ State approved menus to AAAs

3 ☐ Credentialed nutrition professional to approve AAA submitted menus

4 ☐ Computer assisted menu analysis

5 ☐ Site visits

6 ☐ Training of AAAs and local service providers

7 ☐ Technical assistance

8 ☐ Monitoring of AAAs

9 ☐ AAA assurance of nutrient quality

0 ☐ None of the above

d ☐ Don't know

F. DATA AND PERFORMANCE

F1. How do AAAs currently report Elderly Nutrition Program data to the SUA?

MARK ALL THAT APPLY

1 ☐ Software/computer system

2 ☐ Email

3 ☐ Phone

4 ☐ Mail

5 ☐ Other *(Specify)*

_____

d ☐ Don't know

→ **GO TO F3**

F2. Are all AAAs in your state currently required to use the same software for reporting Elderly Nutrition Program data?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

F3. Does the SUA currently require AAAs to report Elderly Nutrition Program data beyond that required in the AoA State Program Report?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

→ **GO TO F5**

F4. What specific data are currently collected beyond what is required for the State Program Report?

MARK ALL THAT APPLY

1 ☐ Nutrition program service reports/program performance data

2 ☐ Quality assurance findings

3 ☐ Fiscal management reports

4 ☐ None of the above

d ☐ Don't know

F5. Has the SUA or AAA established Elderly Nutrition Program performance measures at the AAA level?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

F6. Does the SUA currently share Elderly Nutrition Program performance data with the public?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

F7. How frequently are AAAs required to report Elderly Nutrition Program data to the SUA?

1 ☐ Continuously

2 ☐ Monthly

3 ☐ Quarterly

4 ☐ Semi-annually

5 ☐ Annually

6 ☐ Other *(Specify)*

_____

d ☐ Don't know

F8. Does the SUA currently use Elderly Nutrition Program performance data for any of the following purposes?

MARK ALL THAT APPLY

1 ☐ To monitor AAAs' Elderly Nutrition Program performance

2 ☐ To provide the basis for technical assistance

3 ☐ To provide information to other state agencies

4 ☐ To provide information to the state legislature

5 ☐ To justify or prepare state budget requests

6 ☐ To develop new programs

7 ☐ To improve existing programs

8 ☐ To inform program planning

9 ☐ None of the above

d ☐ Don't know

G. NUTRITION NEEDS ASSESSMENT (COMMUNITY/INDIVIDUAL)

G1. During the previous 5 years, have *community* needs assessments for elderly nutrition services been conducted?

1 ☐ Yes, a state-wide community needs assessment that includes nutrition has been done → **GO TO G3**

2 ☐ Yes, one or more local level (PSA-level) community needs assessments that include nutrition have been done

3 ☐ No assessment has been done

d ☐ Don't know

→ **GO TO G4**

G2. Did the local level community needs assessment(s) follow a consistent protocol that included nutrition?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

G3. Were results from the community needs assessment(s) pertaining to nutrition utilized or incorporated into the state plan?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

G4. Does the SUA currently issue formal policies or guidance to the AAAs or local service providers on the conduct of *individual* nutrition needs assessment in the Elderly Nutrition Program?

1 ☐ Yes

0 ☐ No → **GO TO H1**

d ☐ Don't know → **GO TO H1**

G5. Is a consistent *individual* nutrition needs assessment currently required at the local level (AAA or local service provider) for the Elderly Nutrition Program? Please exclude the NSI/DETERMINE Checklist from your response.

1 ☐ Yes

0 ☐ No

d ☐ Don't know

H. STATE AND AREA PLANS

H1. Does the OAA required State Plan on Aging currently include a nutrition services component?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

H2. How was the Elderly Nutrition Program staff involved in developing the current OAA required State Plan on Aging?

MARK ALL THAT APPLY

1 ☐ Consulted during development

2 ☐ Participated in writing nutrition related components

3 ☐ Reviewed or commented on drafts of the state plan

4 ☐ None of the above

5 ☐ ENP staff were not involved in the development of the current OAA required State Plan on Aging

d ☐ Don't know

H3. Does the Area Plan for Aging format currently include a nutrition services component?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

I. EMERGENCY NUTRITION SERVICE

I1. Does the SUA currently have an Emergency Preparedness Plan that includes nutrition services?

MARK ALL THAT APPLY

1 ☐ Yes, for short-term emergencies

2 ☐ Yes, for long-term emergencies

0 ☐ No → **GO TO I4**

d ☐ Don't know → **GO TO I4**

I2. Does the SUA currently have policies that require AAA contracts or grants to local service providers to include how nutrition services are to be provided during local emergencies?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

I3. Which of the following components are included in the current SUA Emergency Preparedness Plan for nutrition services?

MARK ALL THAT APPLY

1 ☐ Plan for communications between organizations as well as with clients

2 ☐ Plan for the provision of food and water

3 ☐ Plan for identifying and addressing the health and wellness needs of nutrition clients

4 ☐ None of the above

d ☐ Don't know

I4. With which of the following entities does the SUA currently have a relationship to help meet the needs of Elderly Nutrition Program clients during emergencies?

MARK ALL THAT APPLY

1 ☐ County/local organizations

2 ☐ Red Cross

3 ☐ FEMA citizens' corps

4 ☐ National Voluntary Organizations Active in Disasters (VOAD) or their members (e.g., Feeding America, Catholic Charities, The Jewish Federations)

5 ☐ Private sector entities involved in disasters

6 ☐ None of the above

d ☐ Don't know

J. TRAINING AND TECHNICAL ASSISTANCE

J1. During the past 2 years, which of the following has the SUA done to provide training and technical assistance for the Elderly Nutrition Program?

MARK ALL THAT APPLY

1 ☐ Held specific trainings that focus on the Elderly Nutrition Program and related topics

2 ☐ Held general trainings that cover a range of programs and services, including the Elderly Nutrition Program and related topics

3 ☐ Held trainings on the Elderly Nutrition Program and related topics in conjunction with other state or local agencies or organizations (e.g., state health department)

4 ☐ None of the above

d ☐ Don't know

J2. During the past 2 years, on which of the following topics has the SUA provided training to AAAs or local service providers?

MARK ALL THAT APPLY

1 ☐ Nutrition quality

2 ☐ Food safety

3 ☐ Food service

4 ☐ Nutrition education

5 ☐ Nutrition counseling

6 ☐ Program evaluation or outcome measurement

7 ☐ None of the above

d ☐ Don't know

K. TARGETING

The next question is about targeting. Targeting is defined as modifying or adapting services and outreach to attract and meet the needs of identified groups who may be under-represented or are considered in special need of services. Target populations are defined by the Older Americans Act as… "older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas)."

K1. What mechanisms does the SUA use to insure targeting of Elderly Nutrition Program services?

1 ☐ Formal policies

2 ☐ Guidance

3 ☐ Regulations

4 ☐ Contract language

5 ☐ Area plan review and approval

6 ☐ Monitoring of AAAs

7 ☐ None of the above

d ☐ Don't know

L. PRIORITIZATION OF SERVICES

The next 3 questions are about prioritization. Prioritization is defined as establishing criteria to be used as a basis for making decisions to serve some individuals before others when resources are limited.

L1. Which of the following best describes how the SUA's current prioritization policy was set for the Elderly Nutrition Program?

1 ☐ Prioritization policy is set by the SUA

2 ☐ Prioritization policy is set by the SUA with input from AAAs

3 ☐ Prioritization policy is set by the AAAs with input from SUA

4 ☐ Prioritization policy is set by the AAAs

5 ☐ Prioritization policy is set by the local service providers

6 ☐ No prioritization policy exists

d ☐ Don't know

L2. Are prioritization criteria statewide or do they vary by AAA?

1 ☐ Prioritization criteria are statewide

2 ☐ Prioritization criteria are AAA specific

3 ☐ Prioritization criteria are local service provider specific

d ☐ Don't know

L3. Which of the following criteria are used to determine Elderly Nutrition Program service priority according to SUA policy?

MARK ALL THAT APPLY

Criteria	Congregate meal prioritization	Home-delivered meal prioritization
a. ADL and/or IADL impairment minimum (e.g., 3+ ADL impairments)	1 ☐	2 ☐
b. Lack of informal/family support	1 ☐	2 ☐
c. Geographic isolation (e.g., rural)	1 ☐	2 ☐
d. Social isolation (e.g., lives alone)	1 ☐	2 ☐
e. Chronic health condition (e.g., diabetes)	1 ☐	2 ☐
f. Poor housing or lack of kitchen access	1 ☐	2 ☐
g. Homebound	1 ☐	2 ☐
h. Racial/ethnic minority	1 ☐	2 ☐
i. Advanced age (e.g., 75+, 85+)	1 ☐	2 ☐
j. Low income (e.g., % of federal poverty level)	1 ☐	2 ☐
k. Limited English proficiency	1 ☐	2 ☐
l. Dementia or cognitive impairment	1 ☐	2 ☐
m. Food insecurity/hunger	1 ☐	2 ☐
n. Nutrition risk assessment	1 ☐	2 ☐
o. Adult day care participation	1 ☐	2 ☐
p. Long-term care need for service	1 ☐	2 ☐
q. Short-term care need for service	1 ☐	2 ☐
r. Other *(Specify)* _____	1 ☐	2 ☐
s. No prioritization criteria	1 ☐	2 ☐
t. Criteria are not set by the SUA	1 ☐	2 ☐

M WAITING LISTS

M1. Does the SUA currently have policies, guidance or regulations pertaining to the creation and management of waiting lists for Elderly Nutrition Program services?

MARK ALL THAT APPLY

1 ☐ Yes, for the home-delivered nutrition service

2 ☐ Yes, for the congregate nutrition service

0 ☐ No

d ☐ Don't know

M2. Does the SUA currently maintain or have access to information on waiting lists for any of the following services?

MARK ALL THAT APPLY

1 ☐ Yes, for home-delivered nutrition service

2 ☐ Yes, for congregate nutrition service

3 ☐ Yes, for other OAA services

0 ☐ No

d ☐ Don't know

N. ACCESSING SERVICES/ELIGIBILITY

The following two questions ask about eligibility criteria. Eligibility criteria refer to criteria used to determine who may receive services regardless of program resource limitations.

N1. Does the SUA have specific policies, guidance or regulations on the eligibility criteria for the Home-Delivered Nutrition Program?

1 ☐ Yes

0 ☐ No → **GO TO N3**

d ☐ Don't know → **GO TO N3**

N2. Which of the following best describes how eligibility criteria are set for the home-delivered nutrition program?

MARK ONE

1 ☐ Eligibility is set by the SUA

2 ☐ Eligibility is set at the AAA level but must be consistent with SUA policy

3 ☐ Eligibility is set at the AAA level

4 ☐ Eligibility is set at the local service provider level

d ☐ Don't know

N3. Does the SUA currently have policies, guidance or regulations regarding the location of congregate nutrition sites?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

N4. Does the SUA currently have policies, guidance or regulations regarding the accessibility of congregate nutrition sites, that is, sites are compliant with the Americans with Disabilities Act?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

N5. What percent of congregate sites in your state are accessible as defined by the Americans with Disabilities Act?

|___|___|___| %

d ☐ Don't know

O. NUTRITION EDUCATION

O1. Currently, how often does the SUA require the AAA or local service provider to offer nutrition education?

MARK ONE

1 ☐ Monthly

2 ☐ Quarterly

3 ☐ Semi-annually

4 ☐ Annually

5 ☐ No policy exists at the SUA level on frequency of nutrition education

6 ☐ Nutrition education only provided by the SUA and not by AAA or local service provider

7 ☐ Other *(Specify)*

_____

d ☐ Don't know

O2. Currently, does the SUA have formal policies, guidance or regulations on the qualifications of staff that provide nutrition education at the AAA or local service provider level?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

O3. Currently, does the SUA require that AAAs or local service providers develop a nutrition education plan?

1 ☐ Yes

0 ☐ No → **GO TO P1**

d ☐ Don't know → **GO TO P1**

O4. What is the SUA's role with regard to the AAA/local service provider nutrition education plan?

MARK ALL THAT APPLY

1 ☐ The SUA must approve the plan

2 ☐ The SUA provides guidance on developing the plan

3 ☐ The SUA sets minimum components of the plan

4 ☐ The SUA monitors the plan

5 ☐ Other *(Specify)*

_____

d ☐ Don't know

P. NUTRITION COUNSELING

P1. Currently, does the SUA require that nutrition counseling be available in each PSA (provided by the AAA or their service providers)?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

P2. Currently, does the SUA have policies, guidance or regulations related to nutrition counseling on any of the following topics?

MARK ALL THAT APPLY

1 ☐ Criteria for authorizing nutrition counseling

2 ☐ Qualifications of the nutrition counseling staff

3 ☐ Content of the nutrition counseling

4 ☐ None of the above

d ☐ Don't know

Q. BUDGET AND FISCAL

Q1. Which of the following budget related activities involve the participation of Elderly Nutrition Program staff?

MARK ALL THAT APPLY

1 ☐ Providing research or analysis on the implications of budget options

2 ☐ Preparing or reviewing budget justification materials

3 ☐ Determining budget request amounts

4 ☐ Determining budget allocation

5 ☐ None of the above

d ☐ Don't know

Q2. Which of the following does the Elderly Nutrition Program staff currently monitor at the SUA or AAA level?

MARK ALL THAT APPLY

1 ☐ Expenditures per meal

2 ☐ Expenditures per client

3 ☐ Contract costs

4 ☐ Program income

5 ☐ Funding sources

6 ☐ None of the above

d ☐ Don't know

Q3. Does the SUA have policy, guidance, or regulations related to AAA and local service provider offering private pay/fee-for-service nutrition services?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

Q4. Please indicate how much your SUA encourages or discourages AAAs or service providers to operate private pay/fee-for-service nutrition programs for older adults?

1 ☐ Strongly encourages

2 ☐ Encourages

3 ☐ Allows private pay but neither encourages nor discourages the activity

4 ☐ Discourages

5 ☐ Prohibits

d ☐ Don't know

Q5. Is there a statewide unit rate for the following nutrition services programs and were nutrition program staff involved in setting the unit rate?

Nutrition Program	Statewide Unit Rate			Program staff involved in setting unit rate		
	Yes	No	Don't know	Yes	No	Don't know
a. Congregate nutrition program.....	1 ☐	0 ☐	d ☐	1 ☐	0 ☐	d ☐
b. Home-delivered nutrition program.....	1 ☐	0 ☐	d ☐	1 ☐	0 ☐	d ☐
c. Medicaid waiver nutrition services.....	1 ☐	0 ☐	d ☐	1 ☐	0 ☐	d ☐

R. PROGRAM CONTRIBUTIONS

The next questions ask about the SUA policy regarding participant contributions for the Elderly Nutrition Program.

R1. Does the SUA currently have a policy regarding the…

	Yes	No	Don't know
a. Collection and/or management of participant contributions for the Elderly Nutrition Program?.....	1 ☐	0 ☐	d ☐
b. Distribution of participant contributions for the Elderly Nutrition Program?.....	1 ☐	0 ☐	d ☐
c. Spending of participant contributions for the Elderly Nutrition Program?.....	1 ☐	0 ☐	d ☐

R2. Does the SUA currently have specific policies on the non-coercion of participants with regard to participant contributions?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

R3. How does the SUA determine if participant contributions to the Elderly Nutrition Program are used to expand services?

MARK ALL THAT APPLY

1 ☐ AAAs and local service providers are required to spend participant contributions first and then other funds

2 ☐ AAAs and local service providers are required to report data on services delivered using participant contributions

3 ☐ The SUA monitors program data (e.g., service units, people served) in relation to participant contributions reported.

4 ☐ Other *(Specify)*

_____

d ☐ Don't know

S. FACILITIES AND EQUIPMENT

S1. Currently, does the SUA provide equipment, either directly or through designated funding, for use by the Elderly Nutrition Program (home-delivered nutrition or congregate nutrition programs)?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

S2. Currently, does the SUA provide any facilities, either directly or through designated funding for use by the Elderly Nutrition Program (home-delivered nutrition or congregate nutrition programs)?

1 ☐ Yes

0 ☐ No

d ☐ Don't know

T. INTEGRATION WITH OTHER FOOD AND NUTRITION PROGRAMS

T1. Currently, to what extent does the Elderly Nutrition Program staff collaborate with each of the following food and nutrition partners to improve access or service delivery to older adults (e.g., through modification/streamlining of application process, review or development of policies, etc.)?

	Extent of Collaboration				
	Very much	**Somewhat**	**A little**	**Not at all**	**Not applicable**
a. Supplemental Nutrition Assistance Program (SNAP).....	1 ☐	2 ☐	3 ☐	4 ☐	n ☐
b. Senior Farmers' Market Nutrition Program (SFMNP).....	1 ☐	2 ☐	3 ☐	4 ☐	n ☐
c. Commodity Supplemental Food Program (CSFP).....	1 ☐	2 ☐	3 ☐	4 ☐	n ☐
d. Child and Adult Care Food Program (CACFP)	1 ☐	2 ☐	3 ☐	4 ☐	n ☐
e. The Emergency Food Assistance Program (TEFAP).....	1 ☐	2 ☐	3 ☐	4 ☐	n ☐

T2. Have the Elderly Nutrition Program staff collaborated with the following food and nutrition programs in any of the following ways?

	MARK ALL THAT APPLY				
Type of Collaboration	**SNAP**	**SFMNP**	**CSFP**	**CACFP**	**TEFAP**
a. Participate in review or development of policies or procedures.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Promote older adult access to the program	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Participate in training and technical assistance.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. Participate in committees and workshops	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

U. INTEGRATION WITH NON-FOOD AND NUTRITION PROGRAMS

U1. Have the Elderly Nutrition Program staff been involved with case management, information and referral/assistance or ADRC services in any of the following ways?

MARK ALL THAT APPLY

1 ☐ Review or development of policies, guidance or regulations regarding the inclusion of nutrition services

2 ☐ Development or review of screening protocols

3 ☐ Implementation of screening protocols

4 ☐ Development or review of assessment tools

5 ☐ Development or review of referral/assistance process

6 ☐ Implementation of referral/assistance process

7 ☐ Provision of training

8 ☐ Receipt of training from non-food nutrition program

n ☐ Not applicable, no consistent state level intake, assessment or referral process

U2. Have the Elderly Nutrition Program staff been involved with evidence-based health promotion and disease prevention programs (e.g., chronic disease self-management program) in any of the following way?

1 ☐ Management of evidence-based health promotion and disease prevention grants

2 ☐ Promotion of inclusion of nutrition program clients as participants

3 ☐ Participation in outreach activities

4 ☐ Coordination with state health department evidence-based grantees

5 ☐ None of the above

n ☐ Not applicable, no evidence-based health promotion and disease prevention grants

V. MEDICAID WAIVER

V1. Currently, does the SUA administer a Medicaid waiver program for the elderly?

1 ☐ Yes

0 ☐ No → **GO TO V3**

2 ☐ State does not have a Medicaid waiver program for the elderly

d ☐ Don't know

→ **GO TO W1**

V2. Which of the following services are provided under the current state Medicaid waiver program for the elderly?

MARK ALL THAT APPLY

1 ☐ Nutrition assessment

2 ☐ Nutrition counseling

3 ☐ Nutrition risk reduction

4 ☐ Home-delivered meals

5 ☐ Medical nutrition therapy

6 ☐ Dietitian services

7 ☐ Nutritional supplements

8 ☐ None of the above

d ☐ Don't know

V3. Was the SUA Elderly Nutrition Program staff involved with the current state Medicaid waivers for the elderly by…

	Yes	No	Don't know
a. Reviewing policies related to nutrition services?.....	1 ☐	0 ☐	d ☐
b. Providing input regarding the use of nutritional supplements in the waiver programs?.....	1 ☐	0 ☐	d ☐

V4. Are the following consistent across Medicaid waiver and the Elderly Nutrition Programs?

	Yes	No	Don't know
a. Are nutrition standards consistent?	1 ☐	0 ☐	d ☐
b. Are food safety standards consistent?	1 ☐	0 ☐	d ☐
c. Are nutrition counseling services consistent?	1 ☐	0 ☐	d ☐
d. Are cost or rates for nutrition services consistent?.....	1 ☐	0 ☐	d ☐

W. COORDINATION/COLLABORATION/PARTNERSHIPS

W1. Please mark your five most important partners or collaborators specifically for the Elderly Nutrition Program.

MARK ONLY FIVE

1 ☐ Hospital or nursing facility state associations
2 ☐ State transportation department or agency
3 ☐ State Medicaid agency/unit
4 ☐ State Medicaid waiver agency/unit
5 ☐ Veterans Affairs (state or federal)
6 ☐ State public housing department or agency
7 ☐ Supplemental Nutrition Assistance Program (SNAP)
8 ☐ Supplemental Nutrition Assistance Program – Education (SNAP-Ed)
9 ☐ Food Distribution Program on Indian Reservations (FDPIR)
10 ☐ Commodity Supplemental Nutrition Program (CSNP)
11 ☐ The Emergency Food Assistance Program (TFAP)
12 ☐ Child and Adult Care Food Program (CACFP)
13 ☐ Senior Farmers Market Nutrition Program (SFMNP)
14 ☐ OAA Title VI (Native American, Alaska Native and Native Hawaiian Elders) program
15 ☐ Other Older Americans Act (OAA) programs
16 ☐ Aging and Disability Resource Center program
17 ☐ Non OAA funded Home delivered nutrition programs (e.g. Meals on Wheels)
18 ☐ State public health departments or agencies
19 ☐ Other state human services agencies or programs
20 ☐ Elder abuse prevention programs or Adult Protective Services (APS)
21 ☐ Legal services for older adults
22 ☐ Energy assistance (LIHEAP)
23 ☐ State association of area agencies on aging
24 ☐ Other stakeholder organizations
25 ☐ Professional Organizations
26 ☐ Foundations
27 ☐ Churches, synagogues, mosques, faith-based organizations
28 ☐ College or university
29 ☐ Volunteer bureaus/organizations
30 ☐ Private Industry
31 ☐ Other *(Specify)*

_____

32 ☐ None of the above → **GO TO W3**
d ☐ Don't know → **GO TO W3**

W2. For each partner/collaborator that you marked in Question W1, please record the partner/collaborator number from Question W1 and indicate which activities you jointly engage in for the Elderly Nutrition Program.

	First Partner Number |__|__|	Second Partner Number |__|__|	Third Partner Number |__|__|	Fourth Partner Number |__|__|	Fifth Partner Number |__|__|
a. TA or training about fundraising	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Shared resources	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Advocacy	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. Strategic planning	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
e. Public education	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
f. Development of policies, guidance or regulations	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
g. Development of procedures	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
h. Service delivery	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
i. Shared outreach	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
j. Targeting special populations.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
k. Training/technical assistance	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
l. Development of consumer materials.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
m. Promotion of older adult nutrition issues in other agencies/programs....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
n. None of the above	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Don't know	d ☐	d ☐	d ☐	d ☐	d ☐

W3. Is there one or more OAA Title VI Nutrition and Supportive Services for Native American, Alaska Native and Native Hawaiian Program in your state?

1 ☐ Yes

0 ☐ No → **GO TO X1**

d ☐ Don't know → **GO TO X1**

W4. What are the major areas in which your SUA currently collaborates with Title VI programs?

MARK ALL THAT APPLY

Areas of Partnership or Collaboration

1 ☐ TA or training about fundraising

2 ☐ Shared resources

3 ☐ Advocacy

4 ☐ Strategic planning

5 ☐ Public education

6 ☐ Development of policies, guidance or regulations

7 ☐ Development of procedures

8 ☐ Service delivery

9 ☐ Shared outreach

10 ☐ Targeting special populations

11 ☐ Training/technical assistance

12 ☐ Development of consumer materials

13 ☐ Promotion of older adult nutrition issues in other agencies/programs

14 ☐ None of the above

d ☐ Don't know

X. FUNDING/RESOURCE ALLOCATION

The next questions are about total expenditures incurred by your SUA during the most recently completed fiscal year. Total expenditures include service, administrative, and overhead expenditures.

X1. When did your most recently completed fiscal year end?

|__|__| / |__|__| / |__|__|__|__|
MONTH DAY YEAR

X2. During the most recently completed fiscal year, what were the <u>total expenditures for your SUA, including expenditures for the Elderly Nutrition Program</u>?

$ |__|,|__|__|__|,|__|__|__|,|__|__|__|

d ☐ Don't know

X3. During the most recently completed fiscal year, what were the <u>total expenditures for the Elderly Nutrition Program</u>? This includes expenditures from funds received from the OAA plus expenditures from any additional sources of funds for the Elderly Nutrition Program.

$ |___|___|___|,|___|___|___|,|___|___|___|

d ☐ Don't know

X4. During the most recently completed fiscal year, how much did your SUA spend for the Elderly Nutrition Program from each of the following sources?

Funding Category	Congregate nutrition expenditures	Home-delivered nutrition expenditures
a. All federal funding sources		
1. Older Americans Act funds including NSIP	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know
2. Other HHS funds (e.g., SSBG)	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know
3. Other non-HHS funds (e.g., USDA, VA)	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know
4. Multiple federal funds (unidentified)	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know
b. All state funding sources		
1. General state funds	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know
2. State lottery funds	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know
3. State targeted tax funds	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know
4. Other state funds *(Specify)* _____	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know
c. Other funding sources, excluding AAA and local service provider funds	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know	$ |___|___|,|___|___|___|,|___|___|___| d ☐ Don't know

X5. Which of the following statements best describes how decisions are currently made on transferring funds among congregate nutrition, home-delivered nutrition, and supportive services programs?

1 ☐ SUA alone determines amounts

2 ☐ SUA determines amounts with consultation with AAAs or local providers

3 ☐ SUA and AAAs make a joint decision

4 ☐ SUA determines the amounts based solely on the amounts requested by AAAs

d ☐ Don't know

Y. CONTACT INFORMATION

Y1. Please provide contact information for the person who completed this questionnaire.

Contact Name:_____

Title or Role in SUA:_____

Email Address:_____

Telephone Number: |___|___|___|-|___|___|___|-|___|___|___|___|
Area Code

THANK YOU FOR COMPLETING THIS SURVEY. WE VALUE YOUR PARTICIPATION.

Please Return to:

Rhoda Cohen, Survey Director
Mathematica Policy Research
P.O. Box 2393
Princeton, NJ 08543-2393

If you have any questions, please call Ms. Cohen at 1-800-232-8024.

MATHEMATICA
Policy Research

2011 National Evaluation of Title III-C Nutrition Services
Area Agency on Aging (AAA) Survey
Fax Back Form

A. ORGANIZATIONAL STRUCTURE

1. What was the end date of your most recently completed fiscal year? Note: You may use your organization's fiscal year or another entity's fiscal year (e.g. federal, state). Please use the same fiscal year as the reference for all questions that follow.

|__|__| / |__|__| / |__|__|__|__|
Month Day Year

2. During your most recently completed fiscal year, what was the total, unduplicated number of people who received <u>any registered service</u>, supported in whole or in part by Older Americans Act (OAA) Title III? Registered services include personal care, homemaker, chore, home-delivered meals, adult day care/health, case management, assisted transportation, congregate meals, and nutrition counseling.

|__|__|,|__|__|__| PEOPLE RECEIVED <u>ANY REGISTERED</u> OAA SERVICE

d ☐ Don't know

3. During your most recently completed fiscal year, what was the total, unduplicated number of people who received the following?

a. Congregate nutrition services for older adults? |__|__|,|__|__|__|

d ☐ Don't know

b. Home-delivered nutrition services for older adults? |__|__|,|__|__|__|

d ☐ Don't know

B. STAFF AND VOLUNTEERS

1. During your most recently completed fiscal year, including yourself, how many full-time equivalent <u>employees</u> did your AAA have?

|__|,|__|__|__| NUMBER OF FULL-TIME EQUIVALENT EMPLOYEES

d ☐ Don't know

2. During your most recently completed fiscal year, including yourself, how many full-time equivalent <u>employees</u> worked on the nutrition program (congregate and home-delivered) funded in whole or in part by the OAA?

|__|__|__| NUMBER OF FULL-TIME EQUIVALENT EMPLOYEES

d ☐ Don't know

3. During your most recently completed fiscal year, how many <u>individual volunteers</u> worked on the nutrition program (congregate and home delivered nutrition) at your AAA?

|__|__|,|__|__|__| NUMBER OF VOLUNTEERS

4. During your most recently completed fiscal year, in total, how many <u>volunteer hours</u> did the nutrition program at your AAA directly receive?

|__|,|__|__|__|,|__|__|__| NUMBER OF VOLUNTEER HOURS

d ☐ Don't know

C. TARGETING

1. In the table below, please record the number of AAA program participants that fell into each of the following racial or ethnic categories for both congregate and home-delivered nutrition programs during your most recently completed fiscal year. Also indicate whether each category is a target population for your AAA.

Racial or Ethnic Category	Number in Congregate Nutrition Program	Don't know	Number in Home-Delivered Nutrition Program	Don't know	Is this a target population? Yes	No	Don't know
a. American Indian or Alaska Native (alone)	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
b. Asian (alone)	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
c. Black or African American (alone)	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
d. Native Hawaiian or other Pacific Islander (alone)	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
e. White (alone)	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
f. Person reporting 2 or more races	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
g. Other *(Specify)* _____	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
h. Hispanic (Total)	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐

2. In the table below, please record the number of your AAA's program participants that fell into each of the categories listed below for both congregate and home-delivered nutrition programs during your most recently completed fiscal year. Also indicate whether each category is a target population for your AAA.

Category	Number in Congregate Nutrition Program	Don't know	Number in Home-Delivered Nutrition Program	Don't know	Is this a target population? Yes	No	Don't know
a. Impairments in 3 or more Activities of Daily Living			___,___,___	d ☐	1 ☐	0 ☐	d ☐
b. Impairments in 1-2 Activities of Daily Living			___,___,___	d ☐	1 ☐	0 ☐	d ☐
c. Living alone	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
d. Rural residents	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
e. Living below the federal poverty level	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
f. Female	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
g. 60-74 years old	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
h. 75-84 years old	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐
i. 85+ years old	___,___,___	d ☐	___,___,___	d ☐	1 ☐	0 ☐	d ☐

D. PROGRAM RESOURCES

The next questions concern the total expenditures incurred by your AAA during your most recently completed fiscal year. Total expenditures include service, administrative, and overhead expenditures. Unless specified, expenditures do not include the estimated value of donated goods and services (e.g., volunteers).

During your most recently completed fiscal year, ...

1. ...what were the total expenditures for your AAA?

$ |___|___|___|,|___|___|___|,|___|___|___|

d ☐ Don't know

2. ...what were the total expenditures for the Elderly Nutrition Program? This includes expenditures from funds received from the OAA plus expenditures from any additional sources of funds for the elderly nutrition program.

$ |___|___|___|,|___|___|___|,|___|___|___|

d ☐ Don't know

3. ...what were the total expenditures for the congregate nutrition program?

$ |___|___|___|,|___|___|___|,|___|___|___|

d ☐ Don't know

4. ...what were the total expenditures for the home-delivered nutrition program?

$ |___|___|___|,|___|___|___|,|___|___|___|

d ☐ Don't know

5. During your most recently completed fiscal year, what was the estimated annual value of donated facilities, equipment, goods and services for the Elderly Nutrition Program?

a. Congregate nutrition program $ |___|___|___|,|___|___|___|

b. Home-delivered nutrition program $ |___|___|___|,|___|___|___|

6. For each of the following funding sources, please indicate how much your AAA spent for congregate nutrition expenditures and home-delivered nutrition expenditures during your most recently completed fiscal year.

Funding Sources	Congregate Nutrition Expenditures	Don't know	Home-Delivered Nutrition Expenditures	Don't know
Direct Federal Sources				
a. Older Americans Act funds including NSIP	$_____	d ☐	$_____	d ☐
b. Other HHS (e.g., SSBG)	$_____	d ☐	$_____	d ☐
c. Other non-HHS (e.g., USDA, VA)	$_____	d ☐	$_____	d ☐
d. Multiple federal funds (unidentified)	$_____	d ☐	$_____	d ☐
e. Other state sources	$_____	d ☐	$_____	d ☐
Other Local Sources				
f. County Government	$_____	d ☐	$_____	d ☐
g. City Government	$_____	d ☐	$_____	d ☐
h. Other local funding	$_____	d ☐	$_____	d ☐
i. Multiple local funds (unidentified)	$_____	d ☐	$_____	d ☐
Private Sources				
j. Non-profit org (e.g., United Way, 501 3-c)	$_____	d ☐	$_____	d ☐
k. Private for-profit (e.g., food industry)	$_____	d ☐	$_____	d ☐
l. Participant contributions	$_____	d ☐	$_____	d ☐
m. Program income other than participant contributions	$_____	d ☐	$_____	d ☐
n. Other private funds	$_____	d ☐	$_____	d ☐
o. Other *(Specify)* _____	$_____	d ☐	$_____	d ☐

7. The Older Americans Act permits the transfer of funds between the congregate nutrition, home-delivered nutrition, and supportive services programs. During your most recently completed fiscal year, what were the total amounts of funds transferred from...

Funds transferred from…	Amount Transferred	Don't know
a. Congregate Nutrition to Home-Delivered Nutrition?	$ |___|___|___|,|___|___|___|	d ☐
b. Home-Delivered Nutrition to Congregate Nutrition?	$ |___|___|___|,|___|___|___|	d ☐
c. Congregate Nutrition to Supportive Services?	$ |___|___|___|,|___|___|___|	d ☐
d. Home-Delivered Nutrition to Supportive Services?	$ |___|___|___|,|___|___|___|	d ☐
e. Supportive Services to Congregate Nutrition?	$ |___|___|___|,|___|___|___|	d ☐
f. Supportive Services to Home-Delivered Nutrition?	$ |___|___|___|,|___|___|___|	d ☐

OMB: xxxx-xxxx
Expiration Date: xx/xx/xxxx

MATHEMATICA Policy Research

2011 National Evaluation of Title III-C Nutrition Services

Area Agency on Aging (AAA) Survey

INTRODUCTION

Thank you for helping us with the National Evaluation of Title III-C Elderly Nutrition Services. This study will examine how effectively and efficiently the Elderly Nutrition Program helps to keep older Americans healthy and active in their homes and communities. Results of the study will be used to support program planning and guide program practices at various levels of the aging network.

This survey contains questions about your AAA's characteristics and objectives, staffing, use of technology, program decision processes, and measures used to coordinate with internal staff and other organizations. The questionnaire takes approximately 60 minutes to complete.

- If you have any questions regarding the study or completing the Area Agency on Aging survey, please contact Rhoda Cohen at 1-800-232-8024 or email: rcohen@mathematica-mpr.com
- The information you provide will be used only for statistical purposes. In accordance with the Confidential Information Protection and Statistical Efficiency Act of 2002, your responses will not be disclosed in identifiable form without your consent.
- Participation is completely voluntary. We thank you for your cooperation and participation in this very important study.
- If you do not have exact information available to answer certain questions, your best estimate will be fine.
- After hitting the submit button, it may take a few seconds for the next page of the survey to load. Please be patient and your responses will be accepted.
- Please be aware that after using the "Review my answers" link to go back to a previous question of the survey, you will need to continue through the survey again from that point forward.

SECTION A. ORGANIZATIONAL STRUCTURE

REQUIRED

ALL

A1. Is your AAA currently a standalone organization or is it part of another organization?

- ❍ Standalone organization 1
- ❍ Part of another organization 2
- ❍ Don't know ..... d

REQUIRED

ALL

A2. Which of the following best describes the current management structure of your AAA?

- ❍ A not for profit private agency (non-governmental) 1
- ❍ For profit 2
- ❍ A division of city or county government 3
- ❍ Part of a council of governments or regional planning and development agency 4
- ❍ A Tribal Government entity 5
- ❍ Educational institution 6
- ❍ Other (SPECIFY) 7

  [ ]
- ❍ Don't know ..... d

NOTE: Responses to all questions regarding Older Americans Act programs and services should be based on **all funding sources** and not restricted to the federal share of the program or service unless otherwise specified. [FOOTER TO APPEAR ON THE BOTTOM OF EVERY PAGE ON THE WEB SURVEY]

REQUIRED

ALL

A3. Does a Title VI (Native American) program currently operate within your Planning and Service Area (PSA) or in an adjacent PSA?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

A4. Which of the following populations does the AAA currently serve through all its programs and services?

Select all that apply

- ☐ Adults 60 years and older 1
- ☐ Adults with physical disabilities regardless of age 2
- ☐ Adults with mental retardation or developmental disability regardless of age 3
- ☐ Children with physical disabilities 4
- ☐ Children with mental retardation or developmental disability 5
- ☐ Family caregivers 6
- ☐ Don't know ..... d

HARD CHECK: IF A4 = DON'T KNOW and any other answer category is selected. **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

A5. Please describe the areas included in your PSA.

Select all that apply

- ☐ Urban area 1
- ☐ Suburban area 2
- ☐ Rural area 3
- ☐ Frontier area 4
- ☐ Don't know ..... d

HARD CHECK: If A5 = DON'T KNOW and any other category is selected. **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

A6. Which of the following best describes the current boundaries of your PSA?

- ❍ Single county 1
- ❍ Multi-county 2
- ❍ Single city/Metro area 3
- ❍ Multiple city/Metro area 4
- ❍ Other (SPECIFY) 5

  [ ]
- ❍ Don't know ..... d

REQUIRED
ALL

A7. Currently, is there an Aging and Disability Resource Center (ADRC) in your PSA? In your state, the ADRC is known as [FILL ADRC NAME (to the public)].

- ❍ Yes 1
- ❍ Under development/in progress 2
- ❍ No ..... 0 SKIP TO B1
- ❍ Don't know ..... d SKIP TO B1

REQUIRED
A7=Yes OR Under development/in progress

A8. Which of the following best describes the relationship of the AAA to the Aging and Disability Resource Center (ADRC)?

- ❍ AAA is lead agency of the ADRC 1
- ❍ AAA partners with the ADRC 2
- ❍ AAA has a different relationship to the ADRC (SPECIFY) 3

  [ ]
- ❍ AAA has no relationship with the ADRC 4
- ❍ Don't know ..... d

REQUIRED
A7=Yes OR Under development/in progress

A9. Was your nutrition program staff involved in developing the Aging and Disability Resource Center (ADRC)?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
A7=Yes OR Under development/in progress

A9a. Is your nutrition staff currently, or was your nutrition staff ever, involved in operating the ADRC?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

SECTION B. TITLE III-C ELDERLY NUTRITION PROGRAM CHARACTERISTICS

REQUIRED
ALL

B1. Are the following services currently available in your PSA?

	YES	NO	DON'T KNOW
a. Nutrition education (a program to promote better health by providing nutrition, physical fitness, and nutrition-related health information and instruction in a group or individual setting)	1 ❍	0 ❍	d ❍
b. Nutrition counseling (individualized guidance provided one-on-one to address options and methods for improving nutritional status)	1 ❍	0 ❍	d ❍
c. Nutrition screening	1 ❍	0 ❍	d ❍

REQUIRED
ALL

B1.1. How are the following services currently provided in your PSA?

Note: Local service providers, at a minimum, have the following responsibilities for the meal portion of the OAA Elderly Nutrition Program: (1) are responsible for the delivery of the meal (not necessarily the production or responsible for the production – i.e., AAA could enter into a PSA wide catering contract through which all providers receive meals); (2) are responsible for providing an opportunity for and the collection of voluntary contributions; (3) are responsible for documenting and reporting meals served; and (4) are responsible for food safety and sanitation during meal delivery. In the case of a restaurant/voucher based-program, the provider is the entity that has entered into an agreement with the restaurant or other meal producer for the provision of meals that meet the OAA dietary requirements and is responsible for issuing the voucher for service. A caterer with no responsibility beyond production of the meal is not considered a local service provider for the OAA Elderly Nutrition Program.

Note: Nutrition counseling services and nutrition education services may also be provided through an agreement (e.g., contract, grant, MOU) with a local provider organization other than the Area Agency on Aging.

Select all that apply for each row

	DIRECTLY BY THE AAA	THROUGH A CONTRACT BETWEEN THE AAA AND ANOTHER ORGANIZATION	THROUGH A GRANT PROVIDED BY THE AAA TO ANOTHER ORGANIZATION	THROUGH SOME OTHER ARRANGEMENT	DON'T KNOW
a. Congregate meal	1 ☐	2 ☐	3 ☐	0 ☐	d ☐
b. Home-delivered meal	1 ☐	2 ☐	3 ☐	0 ☐	d ☐
B1a = Yes c. Nutrition education (a program to promote better health by providing nutrition, physical fitness, and nutrition-related health information and instruction in a group or individual setting)	1 ☐	2 ☐	3 ☐	0 ☐	d ☐
B1b = Yes d. Nutrition counseling (individualized guidance provided one-on-one to address options and methods for improving nutritional status)	1 ☐	2 ☐	3 ☐	0 ☐	d ☐
B1c = Yes e. Nutrition screening	1 ☐	2 ☐	3 ☐	0 ☐	d ☐

PROGRAMMER SKIP BOX B1.1

IF ANY B1.1a-e = "Through a contract between the AAA and another organization," CONTINUE TO B2. ELSE, SKIP TO B4

HARD CHECK: If B1.1 = DON'T KNOW and any other category is selected within a row. **Don't know cannot be selected along with other response options.**

REQUIRED
ANY B1.1 a-e = THROUGH A CONTRACT BETWEEN THE AAA AND ANOTHER ORGANIZATION

B2. What type of contracts does the AAA currently enter into with Elderly Nutrition Program service providers?

Select all that apply

- ☐ Unit rate 1
- ☐ Performance based 2
- ☐ Cost reimbursement 3
- ☐ Other (SPECIFY) 4

Specify [ ]

- ☐ Don't know ..... d

HARD CHECK: If B2 = DON'T KNOW and any other category is selected. **Don't know cannot be selected along with other response options.**

REQUIRED
ANY B1.1 a-e = THROUGH A CONTRACT BETWEEN THE AAA AND ANOTHER ORGANIZATION

B3. Which of the following are included in your AAA's current contracts or grants with Elderly Nutrition Program service providers?

Select all that apply

- ☐ Quality assurance component (e.g., HACCP (Hazard Analysis Critical Control Points), food safety, program participant satisfaction) 1
- ☐ Targets or goals 2
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: If B3 = NONE OF THE ABOVE and any other category is selected. **None of the above cannot be selected along with other response options.**
HARD CHECK: If B3 = DON'T KNOW and any other category is selected. **Don't know cannot be selected along with other response options.**

REQUIRED
IF B1.1a INCLUDES THROUGH A CONTRACT BETWEEN THE AAA AND ANOTHER ORGANIZATION, THROUGH A GRANT PROVIDED BY THE AAA TO ANOTHER ORGANIZATION, OR THROUGH SOME OTHER ARRANGEMENT

B4. Currently, how many nutrition service providers does your AAA have either through contract, grant, or other formal mechanism? These are nutrition providers funded by your AAA to provide nutrition services. Please do not include caterers or vendors that only prepare meals and perform no other program operation.

	Providers of congregate **and** home-delivered nutrition (0-999)
	Providers of congregate nutrition **only** (0-999)
	Providers of home-delivered nutrition **only** (0-999)

☐ Don't know ..... d

SOFT CHECK: IF LT1; **You have indicated that your AAA has 0 nutrition service providers of [congregate and home delivered nutrition/congregate nutrition only/home-delivered nutrition only]. Is this correct?**
SOFT CHECK: IF GT 50; **You have indicated that your AAA has more than 50 nutrition service providers of [congregate and home delivered nutrition/congregate nutrition only/home-delivered nutrition only]. Is this correct?**
HARD CHECK: IF GT 200; **The number of nutrition service providers cannot be greater than 200.**
HARD CHECK: If B4 = DK AND number is entered. **Don't know cannot be selected if a number is entered.**

REQUIRED
ALL

B5. How many different congregate nutrition locations currently exist in your PSA? A congregate nutrition location is any group dining setting such as, but not limited to, senior centers, adult day care centers, community centers, faith-based locations, and restaurants.

	Number of congregate nutrition locations (0-999)

☐ Don't know ..... d

SOFT CHECK: IF LT 1; **You have indicated that your PSA has 0 congregate nutrition locations. Is this correct?**
SOFT CHECK: IF GT 100; **You have indicated that your PSA has more than 100 congregate nutrition locations. Is this correct?**
HARD CHECK: IF GT 500; **The number of nutrition service providers cannot be greater than 500.**
HARD CHECK: If B5 = DK AND number is entered. **Don't know cannot be selected if a number is entered.**

REQUIRED
ALL

B6. What is the current availability of congregate nutrition services in your PSA?

	Number of Days Congregate Locations are Open in Your PSA		
	1 Day Per Week	2-4 Days Per Week	5 or More Days Per Week
Number of locations			

❍ Don't know ..... d

HARD CHECK: IF GT 500 in any column The **number of nutrition service locations cannot be greater than 500.**
HARD CHECK: If B6 = DK AND number is entered. **Don't know cannot be selected if any numbers are entered.**
HARD CHECK: IF B6 GT NUMBER OF CONGREGATE NUTRITION LOCATIONS IN B5, **Please enter a number that does not exceed the total number of congregate nutrition locations in the PSA.**

REQUIRED
ALL

B7. Which areas of your PSA currently <u>do not</u> have home-delivered nutrition services?

Select all that apply

☐ Some urban areas 1
☐ Some suburban areas 2
☐ Some rural areas 3
☐ Some frontier areas 4
☐ Some mixed areas 5
☐ All areas of the PSA <u>have</u> home-delivered nutrition services 6
☐ Don't know ..... d

HARD CHECK: If B7 = ALL AREAS OF THE PSA HAVE HOME-DELIVERED NUTRITION SERVICES and any other category selected. **All areas of the PSA <u>have</u> home-delivered nutrition services cannot be selected along with other response options.**
HARD CHECK: If B7 = DON'T KNOW and any other category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

B8. In what ways does your AAA and/or service providers respond to increased service costs such as labor, fuel, or food costs for the Elderly Nutrition Program?

Select all that apply

- ☐ Group purchasing 1
- ☐ Shared resources 2
- ☐ Changes in catering or service provider contract requirements/specifics to reduce costs 3
- ☐ Modification of menu (increased use of prepared food/use less expensive food) 4
- ☐ Additional restrictions in program eligibility criteria 5
- ☐ Reduced or eliminated compensation to volunteers (e.g., mileage to drivers) 6
- ☐ Reductions in staff or staff hours 7
- ☐ Reductions in the number of congregate nutrition locations 8
- ☐ Reductions in the number of days of service per week at congregate nutrition locations 9
- ☐ Reductions in the number of people served at congregate nutrition locations 10
- ☐ Reductions in home-delivered nutrition service area 11
- ☐ Reductions in the frequency of home-delivered nutrition deliveries 12
- ☐ Reductions in the number of home-delivered meals provided per participant 13
- ☐ Reductions in the number of home-delivered nutrition participants served 14
- ☐ Increased use of frozen meals in the home-delivered nutrition program 15
- ☐ Other response to increased costs (SPECIFY) 16

  [ ]
- ☐ No changes in response to increased costs 0
- ☐ Don't know ..... d

HARD CHECK: If B8 = NO CHANGES IN RESPONSE TO INCREASED COSTS and any other category is selected. **No changes in response to increased costs cannot be selected along with other response options.**
HARD CHECK: If B8 = DON'T KNOW and any other category is selected. **Don't know cannot be selected along with other response options.**

SECTION C. STAFF

REQUIRED
ALL

C1. Does your AAA currently have a paid staff member who is a registered dietician or state-credentialed nutrition professional working on the Elderly Nutrition Program?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

SECTION D. TECHNOLOGY AND DATA

REQUIRED
ALL

D1. Which of the following systems does your AAA currently use?

Select all that apply

- ☐ Computer-assisted menu planning and analysis 1
- ☐ Software to track inventory or order food 2
- ☐ Delivery systems for home-delivered nutrition (e.g., route mapping software) 3
- ☐ Program participant tracking or referral systems 4
- ☐ Electronic client ID card 5
- ☐ Electronic system for recording service (e.g., the meal) was received 6
- ☐ Financial systems for billing and/or making payments for services 7
- ☐ Cost-centered accounting system 8
- ☐ Geographic Information Systems (GIS) 9
- ☐ Other automated system 10
- ☐ No automated systems 0
- ☐ Don't know ..... d

HARD CHECK: If D1 = NO AUTOMATED SYSTEMS and any other category is selected. **No automated systems cannot be selected along with other response options.**
HARD CHECK: If D1 = DON'T KNOW and any other category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

D2. Which of the following types of program performance data does your AAA currently collect either directly or through your individual services providers?

Select all that apply

- ☐ Nutrition program service reports/program performance data 1
- ☐ Quality assurance findings 2
- ☐ Fiscal management reports 3
- ☐ Client assessments of service 4
- ☐ Client outcomes 5
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: If D2 = NONE OF THE ABOVE, no other category should be selected. **None of the above cannot be selected along with other response options.**
HARD CHECK: If D2 = DON'T KNOW and any other category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

D3. How does your AAA currently use Elderly Nutrition Program performance data?

Select all that apply

- ☐ To justify funding requests 1
- ☐ To manage the Elderly Nutrition Program 2
- ☐ To administer vendor contracts 3
- ☐ To provide information to stakeholders (governing board, advocacy organizations, local government, etc.) 4
- ☐ For program planning 5
- ☐ Do not use performance data 0
- ☐ Don't know ..... d

HARD CHECK: If D3 = DO NOT USE PERFORMANCE DATA, and any other category is selected, **Do not use performance data cannot be selected along with other response options.**
HARD CHECK: If D3 = DON'T KNOW and any other category is be selected, **Don't know cannot be selected along with other response options.**

SECTION E. SELF-DIRECTED CARE & PRIVATE PAY/FEE-FOR-SERVICE

The next question is about self-directed care. Self-directed care is defined as programs and services in which clients can choose to select, manage and dismiss their workers. Self-directed care may also be referred to as "consumer-directed care."

REQUIRED
ALL

E1. Does your AAA currently include nutrition services as part of any self-directed care programs for older adults?

- ❍ Yes 1
- ❍ No 0
- ❍ AAA does not offer self-directed care programs 2
- ❍ Don't know ..... d

REQUIRED
ALL

E2. Currently, does your AAA have policies that permit, encourage, or prohibit the operations of private pay/fee-for-service nutrition programs for older adults offered by your service providers (or for your organization if you provide direct service)?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

E3. On a scale from 1 to 5, how much does your AAA currently encourage or discourage service providers to operate private pay/fee-for-service nutrition programs for older adults?

- ❍ Strongly encourage 1
- ❍ Encourage 2
- ❍ Neither encourage nor discourage 3
- ❍ Discourage 4
- ❍ Prohibit 5
- ❍ Don't know ..... d

SECTION F. ACCESS TO SERVICES

REQUIRED
ALL

F1a. Is your AAA responsible for prioritizing clients (i.e., using characteristics to base decisions for serving some individuals before others when resources are limited) for the elderly nutrition service programs you provide?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

F1b. Does your AAA have specific prioritization criteria (i.e., characteristics to base decisions on for serving some individuals before others when resources are limited) for the elderly nutrition service programs you provide or administer through your local service providers?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

F1c. Did your AAA (either directly or through local nutrition providers) have to prioritize who received congregate or home-delivered nutrition services during the past year?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF F1b OR F1c = YES

F2. Which of the following criteria (do you/did you) use for prioritization?

Select all that apply for each column

Characteristic	Congregate Nutrition Prioritization Criteria	Home-Delivered Nutrition Prioritization Criteria
a. ADL cut-off	1 ☐	2 ☐
b. IADL cut-off	1 ☐	2 ☐
c. Homebound	1 ☐	2 ☐
d. Food insecure/hungry	1 ☐	2 ☐
e. Nutrition Risk Assessment	1 ☐	2 ☐
f. Poor housing/lack kitchen access	1 ☐	2 ☐
g. Low income	1 ☐	2 ☐
h. Lack of informal/family support	1 ☐	2 ☐
i. Racial/ethnic minority	1 ☐	2 ☐
j. Geographic isolation	1 ☐	2 ☐
k. Social isolation	1 ☐	2 ☐
l. Chronic health condition	1 ☐	2 ☐
m. Advanced age	1 ☐	2 ☐
n. Dementia/cognitive impairment	1 ☐	2 ☐
o. Limited English proficiency	1 ☐	2 ☐
p. Adult day care participation	1 ☐	2 ☐
q. Long-term need for service	1 ☐	2 ☐
r. Other	1 ☐	2 ☐
s. Do not prioritize for this type of service	1 ☐	2 ☐

HARD CHECK: If F2 = DO NOT PRIORITIZE FOR THIS TYPE OF SERVICE and any other category is be selected, **Do not prioritize for this type of service cannot be selected along with other response options.**

REQUIRED
IF F1b OR F1c = YES

F2.1 Who established the prioritization criteria?

- ❍ My organization, the AAA 1
- ❍ SUA 2
- ❍ Other (SPECIFY) 3
- ❍ Don't know ..... d

REQUIRED
IF F1b OR F1c = YES

F2.2 How much influence did the AAA have on the prioritization criteria?

- ❍ A lot 1
- ❍ Some 2
- ❍ A little 3
- ❍ None 0
- ❍ Don't know ..... d

REQUIRED
ALL

F3. Who authorizes home-delivered nutrition services for a new client?

- ❍ AAA 1
- ❍ Local service provider 2
- ❍ Either AAA or local service provider 3
- ❍ Both AAA and local service provider 4
- ❍ Other authorizing system (SPECIFY) 5
- ❍ Don't know ..... d

REQUIRED
ALL

F4. How is the current number of meals per week for a home-delivered nutrition program participant determined?

Select all that apply

- ☐ Program participant/family request 1
- ☐ Nutrition needs assessment 2
- ☐ Prioritization criteria other than nutrition needs 3
- ☐ All program participants receive the same number of meals per week 4
- ☐ Other (SPECIFY) 5
  [ ]
- ☐ Don't know ..... d

HARD CHECK: If F4 = DON'T KNOW and any other category is selected, **Don't know cannot be selected along with other response options.**

IF F4 = All program participants receive the same number of meals per week, and any other category is selected, **All program participants receive the same number of meals per week cannot be selected along with other response options.**

REQUIRED
ALL

F6. Does your AAA currently have criteria for the termination of home-delivered nutrition services?

- ❍ Yes 1
- ❍ No, we don't have criteria 0
- ❍ Not applicable, neither the AAA nor local service provider initiates termination ..... n
- ❍ Don't know ..... d

REQUIRED
F6 = Yes

F7. What criteria are currently used by the AAA/local service provider to initiate termination of home-delivered nutrition service?

Select all that apply

- ☐ Service is time limited 1
- ☐ AAA or local service provider determines the program participant is no longer in need 2
- ☐ The program participant becomes eligible for services through another nutrition program 3
- ☐ The program participant does not adhere to rights/responsibilities (uncooperative, inappropriate behavior, not home, etc.) 4
- ☐ Other (SPECIFY) 5
  [ ]
- ☐ Don't know ..... d

HARD CHECK: If F7 = DON'T KNOW and any other category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

F8. Does your AAA track reasons for home-delivered nutrition service termination, regardless of whether or not it is initiated by the AAA or local service provider?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
F8 = Yes

F9. Which of the following reasons for home-delivered nutrition service termination is currently tracked by your AAA?

	YES	NO	DON'T KNOW
F7 = Service is time limited			
a. Time limit on service is reached	1 ❍	0 ❍	d ❍
b. Nursing home placement	1 ❍	0 ❍	d ❍
c. Death	1 ❍	0 ❍	d ❍
d. Relocation	1 ❍	0 ❍	d ❍
e. No longer in need of service (participant or AAA/local service provider determined)	1 ❍	0 ❍	d ❍
f. Participant's dissatisfaction	1 ❍	0 ❍	d ❍
g. Other (SPECIFY) ☐	1 ❍	0 ❍	d ❍

SECTION G. NUTRITION SERVICE OPERATION AND QUALITY ASSURANCE

REQUIRED
ALL

G1. Currently, which entity has <u>primary</u> responsibility for the following activities for the congregate nutrition program?

Select one per row

Role/Responsibility	STATE UNIT ON AGING	AAA	LOCAL SERVICE PROVIDER	OTHER ENTITY	NO ENTITY TAKES PRIMARY RESPONSIBILITY	ACTIVITY NOT PROVIDED	DON'T KNOW
a. Meal production (either self produced or through caterer/vendor contract)	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
b. Menu planning	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
c. Nutrition program planning/development	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
d. Nutrition program outreach	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
e. Nutrition community needs assessment	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
f. Nutrition quality assurance	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
g. Congregate site management	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
h. Nutrition screening	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
i. Nutrition individual assessment	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
j. Nutrition education	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
k. Nutrition counseling	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍

REQUIRED
ALL

G2. Currently, which entity has <u>primary</u> responsibility for the following activities for the home-delivered nutrition program?

Select one per row

Role/Responsibility	STATE UNIT ON AGING	AAA	LOCAL SERVICE PROVIDER	OTHER ENTITY	NO ENTITY TAKES PRIMARY RESPONSIBILITY	ACTIVITY NOT PROVIDED	DON'T KNOW
a. Meal production (either self produced or through caterer/vendor contract)	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
b. Menu planning	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
c. Nutrition program planning/development	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
d. Nutrition program outreach	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
e. Nutrition community needs assessment	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
f. Nutrition quality assurance	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
g. Delivery service management	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
h. Nutrition screening	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
i. Nutrition individual assessment	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
j. Nutrition education	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍
k. Nutrition counseling	1 ❍	2 ❍	3 ❍	4 ❍	5 ❍	6 ❍	d ❍

REQUIRED
G1j = AAA OR G2j = AAA

G3. Which of the following does your AAA currently use to contribute to the quality of <u>nutrition education</u>?

Select all that apply

- ☐ Require credentialed nutrition professional to conduct education 1
- ☐ Conduct a survey of program participant need 2
- ☐ Use evidence-based education programs 3
- ☐ Use cooperative extension materials 4
- ☐ Use curricula from a reliable, science-based organization (academia, government, American Heart Association, American Diabetic Association) 5
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: If G3 = NONE OF THE ABOVE No other category should be selected. **None of the above cannot be selected along with other response options.**
HARD CHECK: If G3 = DON'T KNOW No other category should be selected. **Don't know cannot be selected along with other response options.**

REQUIRED
G1k = AAA OR G2k = AAA

G4. Which of the following does your AAA currently use to contribute to the quality of <u>nutrition counseling</u>?

Select all that apply

- ☐ Require credentialed nutrition professional to conduct the counseling 1
- ☐ Require use of protocols approved by a respected source such as the American Dietetic Association, Patient Education Association, or Association of Diabetic Educators 2
- ☐ Require credentialed non-nutrition professionals (e.g., nurses, diabetes educators, etc.) to conduct the counseling 3
- ☐ Require evidence-based method to conduct the counseling 4
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: If G4 = NONE OF THE ABOVE and any other category is selected, **None of the above cannot be selected along with other response options.**
HARD CHECK: If G4 = DON'T KNOW and any other category is selected. **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

G5. Which of the following does your AAA currently use to contribute to the nutrient quality of meals?

Select all that apply

- ☐ Computer-assisted menu analysis 1
- ☐ Meal patterns 2
- ☐ Use of dietician or state credentialed nutrition professional 3
- ☐ State Unit on Aging guidance 4
- ☐ Older Americans Act guidance 5
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: If G5 = NONE OF THE ABOVE and any other category is be selected, **None of the above cannot be selected along with other response options.**
HARD CHECK: If G5 = DON'T KNOW and any other category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

G6. Which of the following does your AAA currently use to contribute to the overall food service quality provided by the AAA or service providers, caterers, or vendors?

Select all that apply

- ☐ Food service license/safety inspections 1
- ☐ Training of staff 2
- ☐ Survey of program participants 3
- ☐ Program participant feedback mechanism (comment box/card, complaint mechanism, etc.) 4
- ☐ Regularly scheduled site visits either to production location and/or service location 5
- ☐ Visits to home of home-delivered nutrition clients 6
- ☐ Program participant advisory or menu committees 7
- ☐ Food quality specifications 8
- ☐ Use of dietician or state credentialed nutrition professional 9
- ☐ State Unit on Aging guidance 10
- ☐ Older Americans Act guidance 11
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: If G6 = NONE OF THE ABOVE and any other category is selected, **None of the above cannot be selected along with other response options.**
HARD CHECK: If G6 = DON'T KNOW and any other category is selected, **Don't know cannot be selected along with other response options.**

SECTION H. EMERGENCY PLANNING

REQUIRED

ALL

H1. Does the AAA currently have an emergency plan that includes providing nutrition services?

Select all that apply

- ☐ Yes, for short-term emergencies 1
- ☐ Yes, for long-term emergencies 2
- ☐ No 0

HARD CHECK: If H1 = "No," and any other category is selected, **No cannot be selected along with other response options.**

REQUIRED

ALL

H2. Has your organization experienced a disaster (natural or manmade) in the past 3 years?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED

IF H1 = 1 OR 2 AND H2 = YES

H3. During the disaster did you organization initiate an emergency plan?

- ❍ Yes 1
- ❍ No 0
- ❍ Did not have an emergency plan at the time 2
- ❍ Don't know ..... d

REQUIRED

IF H3 = YES

H4. Please rate the effectiveness of the emergency plan.

- ❍ Very effective 1
- ❍ Effective 2
- ❍ Somewhat effective 3
- ❍ Not very effective 4
- ❍ Not effective 5
- ❍ Don't know ..... d

SECTION I. PARTNERSHIP DEVELOPMENT

REQUIRED
ALL

I1. Please select all of your partners for the Elderly Nutrition Program during your most recently completed fiscal year. Partners are organizations or groups in which you may jointly engage in some of the following activities: fundraising, shared resources, advocacy, strategic planning, public education, referrals, senior activities, service delivery, shared outreach, targeting special populations, training or technical assistance, or volunteer recruitment or retention.

Select all that apply

- ☐ Hospitals, nursing facilities, including discharge planning and emergency room care 1
- ☐ Transportation (public services – county/municipal) 2
- ☐ Medicare 3
- ☐ Medicaid (Non-waiver) 4
- ☐ Medicaid Waiver 5
- ☐ Veterans Affairs 6
- ☐ Social Security 7
- ☐ Public housing and related services, including senior housing 8
- ☐ Homeless shelters 9
- ☐ SNAP (Food Stamps)/SNAP Ed (Food Stamp Nutrition Education) 10
- ☐ Senior farmers market 11
- ☐ Other food and nutrition programs (e.g., Emergency food service programs including food banks and pantries, Commodity Supplemental Nutrition Program) 12
- ☐ Title VI (Native American) program 13
- ☐ Other Older Americans Act programs 14
- ☐ Aging and Disability Resource Center 15
- ☐ Non OAA funded Meals on Wheels 16
- ☐ Community health centers 17
- ☐ Public health services 18
- ☐ City or county social services agency 19
- ☐ City or county regional planning office 20
- ☐ Elder Abuse Prevention programs or Adult Protective Services (APS) 21
- ☐ Legal services for older adults 22
- ☐ Energy assistance (LIHEAP) 23
- ☐ Churches, synagogues, mosques, faith-based organizations 24
- ☐ College or university 25
- ☐ Volunteer bureaus/organizations 26
- ☐ Civic organization 27
- ☐ Local business (SPECIFY THE TYPE) 28

  [ ]
- ☐ Other (SPECIFY) 29

  [ ]
- ☐ Do not have any partners 30
- ☐ Don't know ..... d

PROGRAMMER DISPLAY BOX I2

IF GT 5 SELECTIONS FOR J1, CONTINUE TO I2. ELSE, GO TO I3.

HARD CHECK: If I1 = DO NOT HAVE ANY PARTNERS and any other category is selected, Do not have any partners cannot be selected along with other response options.

HARD CHECK: If I1 = DON'T KNOW and any other category is selected, Don't know cannot be selected along with other response options.

REQUIRED
I1 GT 5 SELECTIONS

I2. Please select the <u>five most important Elderly Nutrition Program partners you had during your most recently completed fiscal year</u>.

Select only five

PROGRAMMER DISPLAY BOX I2

PROGRAMMER: DISPLAY ALL CHECKED SELECTIONS FROM I1. IF RESPONDENT CHECKED "Local business" or "Other," ALSO DISPLAY TEXT IN "Specify" FIELD.

HARD CHECK: IF RESPONDENT CHECKS FEWER THAN FIVE SELECTIONS FROM LIST, SHOW VALIDATION MESSAGE, **You have selected fewer than five partners. Please select your five most important partners.**
HARD CHECK: IF RESPONDENT CHECKS MORE THAN FIVE SELECTIONS FROM LIST, SHOW VALIDATION MESSAGE, **You have selected more than five partners. Please select your five most important partners.**

REQUIRED
ALL

I3. For each partnership listed, please indicate which activities you <u>jointly</u> engaged in for the Elderly Nutrition Program during your most recently completed fiscal year.

PROGRAMMER DISPLAY BOX I3

If MORE THAN 5 SELECTIONS FOR I1, FILL PARTNERSHIP NAME WITH CHECKED SELECTIONS FROM I2. ELSE, FILL PARTNERSHIP NAMES FROM I1.

Select all that apply for each column

	[Partnership 1 Name]	[Partnership 2 Name]	[Partnership 3 Name]	[Partnership 4 Name]	[Partnership 5 Name]
a. Fundraising	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Shared resources	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Advocacy	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. Strategic planning	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
e. Public education	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
f. Referrals	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
g. Senior activities	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
h. Service delivery	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
i. Shared outreach	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
j. Targeting special populations	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
k. Training/technical assistance	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
l. Volunteer recruitment or retention	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
m. None of the above	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

PROGRAMMER SKIP BOX I3

IF I3 DOES NOT INCLUDE “Title VI (Native American) program” and A3 = YES, THEN ASK I4. ELSE, SKIP TO SECTION J.

HARD CHECK: IF I3 = NONE OF THE ABOVE, and any other category is selected, **None of the above cannot be selected along with other response options.**

REQUIRED
I3 NE “Title VI (Native American) program” AND A3 = YES

I4. What are the major areas in which your AAA collaborated with Title VI programs during your most recently completed fiscal year?

Select all that apply

- ☐ Fundraising 1
- ☐ Shared resources 2
- ☐ Advocacy 3
- ☐ Strategic planning 4
- ☐ Public education 5
- ☐ Referrals 6
- ☐ Senior activities 7
- ☐ Service delivery 8
- ☐ Meal production 9
- ☐ Shared outreach 10
- ☐ Targeting special populations 11
- ☐ Training/technical assistance 12
- ☐ Volunteer recruitment or retention 13
- ☐ Other (SPECIFY) 14

  [ ]
- ☐ Don’t collaborate with Title VI programs 15
- ☐ Don’t know ..... d

HARD CHECK: IF I4 = DON’T COLLABORATE WITH TITLE VI PROGRAMS, and any other category is selected, **Don’t collaborate with Title VI programs cannot be selected along with other response options.**
HARD CHECK: IF I4 = DON’T KNOW, and any other category is selected, **Don’t know cannot be selected along with other response options.**

SECTION J. MEDICAID WAIVER PROGRAMS FOR THE ELDERLY

REQUIRED
ALL

J1. Does your AAA or your parent organization currently authorize or receive payment for services from the state's Medicaid Waiver programs for the elderly?

- ❍ Yes, AAA authorizes or receives payment for services from the state's Medicaid Waiver programs for the elderly 1
- ❍ Yes, parent organization authorizes or receives payment for services from the state's Medicaid Waiver programs for the elderly 2
- ❍ No 0
- ❍ Don't know ..... d

SECTION K. WAITING LISTS

REQUIRED
ALL

K1. Does your AAA or another organization currently maintain waiting lists for the congregate nutrition or home-delivered nutrition programs that are funded in whole or part with OAA funds?

	Select one response for each row		
	MAINTAINS WAITING LIST FOR CONGREGATE NUTRITION PROGRAM		
	YES	NO	DON'T KNOW
a. State Unit on Aging	1 ❍	0 ❍	d ❍
b. Area Agency on Aging	1 ❍	0 ❍	d ❍
c. Local Service Provider	1 ❍	0 ❍	d ❍

	Select one response for each row		
	MAINTAINS WAITING LIST FOR HOME-DELIVERED NUTRITION PROGRAM		
	YES	NO	DON'T KNOW
a. State Unit on Aging	1 ❍	0 ❍	d ❍
b. Area Agency on Aging	1 ❍	0 ❍	d ❍
c. Local Service Provider	1 ❍	0 ❍	d ❍

PROGRAMMER SKIP BOX K1

IF ALL K1 a-c = NO, DK (for congregate and home-delivered), SKIP TO K9

REQUIRED
ANY K1a-c = Yes

K2. What is the current waiting list policy in the PSA for congregate nutrition and home-delivered nutrition?

Select one per column

	Congregate Nutrition	Home-Delivered Nutrition
a. The waiting list contains everyone who requested service without screening for service eligibility or need, ordered by date of request	1 ❍	2 ❍
b. The waiting list contains everyone who is screened eligible for services on a first-come first-served basis	1 ❍	2 ❍
c. The waiting list contains everyone who is screened eligible and in priority order (by priority criteria)	1 ❍	2 ❍
d. Policy varies across the PSA	1 ❍	2 ❍
e. Other (SPECIFY) ☐	1 ❍	2 ❍
f. There is no waiting list policy	1 ❍	2 ❍
g. Don't know	d ❍	d ❍

PROGRAMMER SKIP BOX K2

IF ALL K1a-c = NO OR DON'T KNOW FOR CONGREGATE NUTRITION, SKIP TO K6

REQUIRED
ANY K1a-c = YES FOR CONGREGATE NUTRITION

K3. How many people are currently on the waiting list in your PSA for the <u>congregate nutrition</u> program?

☐ People (0-9999)

☐ Don't know ..... d

SOFT CHECK: IF LT 1 **You have indicated that your PSA currently has 0 people on the waiting list. Is this correct?**
SOFT CHECK: IF GT 1000 **You have indicated that your PSA currently has more than 1000 people on the waiting list. Is this correct?**
HARD CHECK: IF GT 5000 **The number of people on the waiting list cannot be greater than 5000.**
HARD CHECK: If K3 = DK AND number is entered. **Don't know cannot be selected if a number is entered.**

PROGRAMMER SKIP BOX K3
IF K3=0 OR DK, THEN SKIP TO K5

REQUIRED
ANY K1a-c = YES FOR CONGREGATE NUTRITION

K4. What is the longest time a person has been on the current congregate nutrition program waiting list in your PSA?

[ ] Days/Weeks/Months/Years [DROP DOWN BOX]

☐ Don't know ..... d

PROGRAMMER BOX K4
USE LIMIT OF 10 YEARS IN ANY TYPE OF UNIT (DAYS, WEEKS, MONTHS, YEARS)

SOFT CHECK: IF GT 5 YEARS **You have indicated that the longest time a person has been on the current waiting list is more than 5 years. Is this correct?**
HARD CHECK: IF GT 10 YEARS **The longest time a person has been on the current waiting list cannot be greater than 10 years.**
HARD CHECK: IF NUMBER FIELD IS FILLED BUT DROP DOWN IS NOT SELECTED, SHOW VALIDATION MESSAGE **Please select days, weeks, months or years from the drop down menu.**
HARD CHECK: IF K4 = DK AND number is entered. **Don't know cannot be selected along with other response options.**

REQUIRED
ANY K1a-c = YES FOR CONGREGATE NUTRITION

K5. On average, how often is the waiting list for the congregate nutrition program checked for duplicates and those no longer eligible or in need and then updated?

❍ Weekly 1

❍ Monthly 2

❍ Quarterly 3

❍ Semi-annually 4

❍ Yearly 5

❍ Never 0

❍ Other (SPECIFY) 6

[ ]

❍ Don't know ..... d

REQUIRED
ANY K1a-c = YES FOR HOME-DELIVERED NUTRITION

K6. How many people are currently on the waiting list for the <u>home-delivered nutrition</u> program in your PSA?

☐ People (0-9999)

☐ Don't know ..... d

SOFT CHECK: IF LT 1; **You have indicated that your PSA currently has 0 people on the waiting list. Is this correct?**
SOFT CHECK: IF GT 1000; **You have indicated that your PSA currently has more than 1000 people on the waiting list. Is this correct?**
HARD CHECK: IF GT 5000; **The number of people on the waiting list cannot be greater than 5000.**
HARD CHECK: IF K6 = DK AND number is entered. **Don't know cannot be selected along with other response options.**

PROGRAMMER SKIP BOX K6

IF K6=0 OR DK, THEN SKIP TO K8

REQUIRED
ANY K1a-c = YES FOR HOME-DELIVERED NUTRITION

K7. What is the longest time a person has been on the current <u>home-delivered nutrition</u> program waiting list in your PSA?

☐ Days/Weeks/Months/Years [DROP DOWN BOX]

☐ Don't know ..... d

PROGRAMMER BOX K7

USE LIMIT OF 10 YEARS IN ANY TYPE OF UNIT (DAYS, WEEKS, MONTHS, YEARS)

SOFT CHECK: IF GT 5 YEARS **You have indicated that the longest time a person has been on the current waiting list is more than 5 years. Is this correct?**
HARD CHECK: IF GT 10 YEARS **The longest time a person has been on the current waiting list cannot be greater than 10 years.**
HARD CHECK: HARD CHECK: IF NUMBER FIELD IS FILLED BUT DROP DOWN IS NOT SELECTED, SHOW VALIDATION MESSAGE **Please select days, weeks, months or years from the drop down menu.**
HARD CHECK: IF K7 = DK AND number is entered. **Don't know cannot be selected along with other response options.**

REQUIRED
ANY K1a-c = YES FOR HOME-DELIVERED NUTRITION

K8. On average, how often is the waiting list for the home-delivered nutrition program checked for duplicates and those no longer eligible or in need and then updated?

- ❍ Weekly 1
- ❍ Monthly 2
- ❍ Quarterly 3
- ❍ Semiannually 4
- ❍ Yearly 5
- ❍ Never 6
- ❍ Other (SPECIFY) 7

  [ ]
- ❍ Don't know ..... d

REQUIRED
ALL

K9. For which of the following OAA services does the AAA or its service providers currently maintain a waiting list?

Select all that apply

- ☐ Transportation 1
- ☐ Case management 2
- ☐ Personal care 3
- ☐ Chore services 4
- ☐ Homemaker assistance 5
- ☐ Legal services 6
- ☐ Adult day care 7
- ☐ Evidence-based disease prevention or health promotion program 8
- ☐ Family caregiver respite 9
- ☐ Family caregiver counseling 10
- ☐ Family caregiver support group 11
- ☐ Family caregiver training 12
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: IF K9 = NONE OF THE ABOVE and any other category is selected, **None of the above cannot be selected along with other response options.**
HARD CHECK: IF K9 = DON'T KNOW and any other category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
K9 = AT LEAST 2 RESPONSE OPTIONS CHOSEN

K10. Please select the service that currently has the longest waiting list in the PSA (Planning and Service Area).

- ❍ Transportation 1
- ❍ Case management 2
- ❍ Personal care 3
- ❍ Chore services 4
- ❍ Homemaker assistance 5
- ❍ Legal services 6
- ❍ Adult day care 7
- ❍ Evidence-based disease prevention or health promotion program 8
- ❍ Family caregiver respite 9
- ❍ Family caregiver counseling 10
- ❍ Family caregiver support group 11
- ❍ Family caregiver training 12
- ❍ Don't know ..... d

PROGRAMMER BOX K10
IF K9 = AT LEAST 2 RESPONSE OPTIONS CHOSEN, ASK K10.

REQUIRED
K9 = ANY ANSWER CATEGORY EXCEPT "NONE OF THE ABOVE" AND "DON'T KNOW" OR K10 = ANY EXCEPT "DON'T KNOW"

K11. How many people are currently on this waiting list?

☐ People (0-9999)

☐ Don't know ..... d

SOFT CHECK: IF LT 1 **You have indicated that there are currently 0 people on the waiting list. Is this correct?**
SOFT CHECK: IF GT 1000 **You have indicated that there are more than 1000 people on the waiting list. Is this correct?**
HARD CHECK: IF GT 5000 **The number of people on the waiting list cannot be greater than 5000.**
HARD CHECK: IF K11 = DK AND number is entered. **Don't know cannot be selected along with other response options.**

REQUIRED
K9 = ANY ANSWER CATEGORY EXCEPT “NONE OF THE ABOVE” AND “DON’T KNOW” OR K10 = ANY EXCEPT “DON’T KNOW”

K12. What is the longest a person has been on this current waiting list?

☐ Days/Weeks/Months/Years [DROP DOWN BOX]

☐ Don’t know ..... d

PROGRAMMER BOX K12

USE LIMIT OF 10 YEARS IN ANY TYPE OF UNIT (DAYS, WEEKS, MONTHS, YEARS)

SOFT CHECK: IF GT 5 YEARS **You have indicated that the longest time a person has been on the current waiting list is more than 5 years. Is this correct?**
HARD CHECK: IF NUMBER FIELD IS FILLED BUT DROP DOWN IS NOT SELECTED, SHOW VALIDATION MESSAGE **Please select days, weeks, months or years from the drop down menu.**
HARD CHECK: IF K12 = DK AND number is entered. **Don’t know cannot be selected if a number is entered.**

SECTION L: REFERRALS AND NEEDS ASSESSMENTS

REQUIRED
ALL

L1. Has a community needs assessment that included a nutrition needs component been conducted in your PSA in the past 5 years?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

L2.1 Does your AAA currently have a formal process (performed by the AAA or through local service providers) for assessing service needs (both nutrition and non-nutrition) for Elderly Nutrition Program participants (e.g., transportation, SNAP, housing, etc.)?

	Nutrition Needs			Non-Nutrition Needs		
	YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
a. Congregate nutrition	1 ❍	0 ❍	d ❍	1 ❍	0 ❍	d ❍
b. Home-delivered nutrition	1 ❍	0 ❍	d ❍	1 ❍	0 ❍	d ❍

REQUIRED
IF L2.1 = DON'T KNOW FOR NUTRITION NEEDS AND NON-NUTRITION NEEDS, SKIP TO L3.

L2.2 How often are Elderly Nutrition Program participants re-assessed for service needs (both nutrition and non-nutrition services)?

Select all that apply for each column	
Congregate nutrition program participants	**Home-delivered nutrition program participants**
1 ☐ No policy (frequency determined by staff)	1 ☐ No policy (frequency determined by staff)
2 ☐ At least yearly (1 or more assessments per year)	2 ☐ At least yearly (1 or more assessments per year)
3 ☐ Less than once per year	3 ☐ Less than once per year
4 ☐ After acute care episode (hospital, ER visit)	4 ☐ After acute care episode (hospital, ER visit)
5 ☐ Other (SPECIFY) _____	5 ☐ Other (SPECIFY) _____
d ☐ Don't know	d ☐ Don't know

HARD CHECK: If L2.2 = DON'T KNOW and any other category is be selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

L3. Not including the Nutrition Screening Initiative (NSI) DETERMINE checklist, does your AAA currently have a formal process (performed by the AAA or through service providers) for assessing nutrition service needs for non-nutrition program participants?

- ❍ Yes, participants receive a separate nutrition needs assessment 1
- ❍ Yes, participants receive a general needs assessment that includes nutrition 2
- ❍ No, participants are not formally assessed for nutrition service needs 0
- ❍ Don't know ..... d

REQUIRED
ALL

L4. Currently, which of the following services does your AAA (directly or through nutrition service providers) actively assist congregate or home-delivered nutrition participants to access? Active assistance involves more than providing reading materials and brochures.

Select all that apply for each column

Service	Congregate Nutrition Program	Home-Delivered Nutrition Program
a. Medicaid Waiver programs	1 ☐	2 ☐
b. Medicaid (non-waiver)	1 ☐	2 ☐
c. Medicare Parts A or B	1 ☐	2 ☐
d. Medicare Part D	1 ☐	2 ☐
e. Housing programs	1 ☐	2 ☐
f. Transportation services	1 ☐	2 ☐
g. Low Income Home Energy Assistance Program (LIHEAP)	1 ☐	2 ☐
h. Supplemental Security Income	1 ☐	2 ☐
i. Other supportive services (chore, homemaker)	1 ☐	2 ☐
j. SNAP (Food Stamps)	1 ☐	2 ☐
k. Other food or nutrition services (food pantry)	1 ☐	2 ☐
l. Veterans Affairs services	1 ☐	2 ☐
m. Adult Protective Services	1 ☐	2 ☐
n. Evidence-based health promotion and disease prevention programs	1 ☐	2 ☐
o. Other	1 ☐	2 ☐
p. Do not provide this type of assistance	1 ☐	2 ☐

HARD CHECK: IF L4p = CONGREGATE AND Any L4a-o = CONGREGATE, **Do not provide this type of assistance cannot be selected along with other response options.**
HARD CHECK: IF L4p = HOME DELIVERED AND Any L4a-o = HOME DELIVERED, **Do not provide this type of assistance cannot be selected along with other response options.**

REQUIRED
ALL

L5. Please rank the top 5 referral sources for the congregate nutrition and home-delivered nutrition programs during your most recently completed fiscal year.

Referral Source	*Rank top 5 referral sources in each column* Congregate Nutrition Referrals	Home-Delivered Nutrition Referrals
a. Family/friends		
b. Hospital/health care facility/discharge planner		
c. Nursing homes		
d. Physician		
e. Case management system		
f. Aging and Disability Resource Center		
g. Information and Assistance system		
h. Medicaid Waiver		
i. Other food or nutrition program		
j. Faith-based organizations		
k. Self		
l. Other		
m. Cannot rank referral sources	1 ☐	2 ☐

PROGRAMMER BOX L5

RANGE FOR L5a-k IS (1-5). EACH NUMBER (1-5) CAN ONLY BE ENTERED ONCE IN EACH COLUMN.

HARD CHECK: If L5 = CANNOT RANK REFERRAL SOURCES AND number is entered. **Cannot rank referral sources cannot be selected if ranks are entered.**

PROGRAMMER SKIP BOX L5

CHECK B1b: IF NUTRITION COUNSELING = NO OR DK, SKIP TO CHECK BEFORE L9

REQUIRED
B1b= YES

L6. How many congregate nutrition locations in the PSA currently provide nutrition counseling to eligible program participants? The nutrition counseling may be offered by your AAA or coordinated with a local service provider.

☐ Locations (0-999)

☐ Don't know ..... d

SOFT CHECK: IF LT 1; **You have indicated that 0 congregate nutrition locations in the PSA currently provide nutrition counseling. Is this correct?**
HARD CHECK: IF GT 500; **The number of congregate nutrition locations in the PSA that currently provide nutrition counseling cannot be greater than 500.**
HARD CHECK: If L6 = DK AND number is entered. **Don't know cannot be selected if a number is entered.**
HARD CHECK: IF L6 GT NUMBER OF CONGREGATE NUTRITION LOCATIONS IN B5, **Please enter a number that does not exceed the total number of congregate nutrition locations in the PSA.**

REQUIRED
B1b = Yes

L7. Currently, what is the availability of nutrition counseling for home-delivered nutrition program participants? The nutrition counseling may be offered by your AAA or coordinated with a local service provider.

❍ Available throughout the entire PSA 1

❍ Available in a portion of the PSA 2

❍ Not available in the PSA 3

❍ Don't know ..... d

REQUIRED
B1b = Yes

L8. How is the current need for <u>nutrition counseling</u> determined?

Select all that apply

- ☐ Nutrition needs assessment 1
- ☐ Nutrition Screening Initiative (NSI) score 2
- ☐ Presence of nutrition related chronic disease 3
- ☐ Food insecurity assessment 4
- ☐ Health care provider orders or recommendation 5
- ☐ Other criteria (SPECIFY) 6

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF L8 = DON'T KNOW No other category should be selected. **Don't know cannot be selected along with other response options.**

PROGRAMMER SKIP BOX L8
CHECK B1a: IF NUTRITION EDUCATION = NO OR DK, SKIP TO SECTION M

REQUIRED
B1a = Yes

L9. How many congregate nutrition locations in the PSA currently provide <u>nutrition education</u> to eligible program participants?

[ ] Locations (0-999)

- ☐ Don't know ..... d

SOFT CHECK: IF LT 1; **You have indicated that 0 congregate nutrition locations in the PSA currently provide nutrition education. Is this correct?**
HARD CHECK: IF GT 500; **The number of congregate nutrition locations in the PSA that currently provide nutrition education cannot be greater than 500.**
HARD CHECK: IF L9 = DK AND number is entered. **Don't know cannot be selected if a number is entered.**
HARD CHECK: IF L9 GT NUMBER OF CONGREGATE NUTRITION LOCATIONS IN B5, **Please enter a number that does not exceed the total number of congregate nutrition locations in the PSA.**

REQUIRED
B1a = YES

L10. Currently, what is the availability of <u>nutrition education</u> for home-delivered nutrition program participants? The nutrition education may be offered by your AAA or coordinated with a local service provider.

- ❍ Available throughout the entire PSA 1
- ❍ Available in a portion of the PSA 2
- ❍ Not available in the PSA 3
- ❍ Don't know ..... d

REQUIRED
B1a = Yes

L11. According to your current AAA policy, how often are nutrition education services provided to program participants in your PSA?

		Congregate Nutrition Program Participants	Home-Delivered Nutrition Program Participants
a.	No AAA policy (frequency determined by local service provider)	1 ❍	2 ❍
b.	Yearly (1 session per year)	1 ❍	2 ❍
c.	Twice per year (2 sessions per year)	1 ❍	2 ❍
d.	Quarterly (4 sessions per year)	1 ❍	2 ❍
e.	Monthly (12 sessions per year)	1 ❍	2 ❍
f.	More than monthly (12+ sessions per year)	1 ❍	2 ❍
g.	Nutrition education is not available	1 ❍	2 ❍
h.	Other	1 ❍	2 ❍
i.	Don't know	d ❍	d ❍

SECTION M. FOOD SAFETY

REQUIRED
ALL

M1. Does your AAA currently require congregate and home-delivered nutrition production facilities to have a food service license?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

M2. Are the food service personnel for the Elderly Nutrition Program in your PSA currently required to have food safety and sanitation training?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

M3. Does your AAA currently follow policies for reporting food borne illnesses and food recalls? The policies could have been created by your AAA, the State Unit on Aging, a state or local health department, or some other entity.

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

M4. To which of the following entities are individual service providers currently required to report food borne illness incidents in the Elderly Nutrition Program?

Select all that apply

- ☐ AAA 1
- ☐ State Unit on Aging 2
- ☐ State or local department of health 3
- ☐ Other (SPECIFY) 4
  [ ]
- ☐ No requirement to report food borne illness 5
- ☐ Don't know ..... d

HARD CHECK: IF M4 = NO REQUIREMENT TO REPORT FOOD BORNE ILLNESS and any other category is selected, **No requirement to report food borne illness cannot be selected along with other response options.**
HARD CHECK: IF M4 = DON'T KNOW and any other category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

M5. <u>In the past 3 years</u>, how many different times was the food served in the <u>congregate nutrition program</u> associated with an outbreak of food borne illness?

[ ] TIMES (0-99)

- ☐ Don't know ..... d

SOFT CHECK: IF GT 50; **You have indicated that food served in the congregate nutrition program was associated with an outbreak of food borne illness more than 50 times in the last 3 years. Is this correct?**
HARD CHECK: IF M5 = DK AND number is entered. **Don't know cannot be selected if a number is entered.**

PROGRAMMER SKIP BOX M5
IF M5 = 0 OR DK, SKIP TO M7.

REQUIRED
M5 GT 0

M6. In total, how many congregate nutrition program participants got sick in the past 3 years?

☐ CONGREGATE NUTRITION PROGRAM PARTICIPANTS (0-9999)

☐ Don't know ..... d

SOFT CHECK: IF GT 1000 **You have indicated that more than 1000 congregate nutrition program participants got sick in the past 3 years. Is this correct?**
HARD CHECK: IF M6 = DK AND number is entered. **Don't know cannot be selected if a number is entered.**

REQUIRED
ALL

M7. <u>In the past 3 years</u>, how many different times was food served in the <u>home-delivered nutrition program</u> associated with an outbreak of food borne illness?

☐ TIMES (0-99)

☐ Don't know ..... d

SOFT CHECK: IF GT 50 **You have indicated that food served in the home-delivered nutrition program was associated with an outbreak of food borne illness more than 50 times in the last 3 years. Is this correct?**
HARD CHECK: IF M = DK AND number is entered. **Don't know cannot be selected if a number is entered.**

PROGRAMMER SKIP BOX M7
IF M7 = 0 OR DK, SKIP TO SECTION N

REQUIRED
M7 GT 0

M8. In total, how many home-delivered nutrition program participants got sick in the past 3 years?

☐ HOME-DELIVERED NUTRITION PROGRAM PARTICIPANTS (0-9999)

☐ Don't know ..... d

SOFT CHECK: IF GT 1000 **You have indicated that more than 1000 home-delivered nutrition program participants got sick in the past 3 years. Is this correct?**
HARD CHECK: IF M8 = DK AND number is entered. **Don't know cannot be selected if a number is entered.**

SECTION N. CONTACT INFORMATION

REQUIRED
ALL

N1. Please provide contact information for the person who completed this questionnaire.

Contact First Name

Contact Last Name

Title or Role in AAA

Length of time in current position (years)

Email Address

Telephone Number

HARD CHECK: IF TELEPHONE IS LT OR GT 10 DIGITS, SHOW VALIDATION, **Please enter a valid telephone number.**
HARD CHECK: IF EMAIL ADDRESS DOES NOT CONTAIN “@” and “.” SHOW VALIDATION MESSAGE, **Please provide a valid email address in the format of myname@xyz.com.**

Please use the space below if you would like to provide any additional information or comments.

THANK YOU FOR COMPLETING THIS SURVEY. WE VALUE YOUR PARTICIPATION.

MATHEMATICA Policy Research

2011 National Evaluation of Title III-C Nutrition Services
Local Service Provider (LSP) Survey

Fax Back Form

A. ORGANIZATIONAL STRUCTURE

1. What was the end date of your most recently completed fiscal year?

|__|__| / |__|__| / |__|__|__|__|
Month Day Year

2. During your most recently completed fiscal year, what was the total, unduplicated number of people who received <u>any service</u> through your organization?

|__|__|__|,|__|__|__| PEOPLE RECEIVED <u>ANY SERVICE</u>

d ☐ Don't know

3. During your most recently completed fiscal year, what was the total, unduplicated number of people who received the following funded in whole or in part by the Older Americans Act (OAA)?

	Older Adults
a. Congregate nutrition services for older adults?	|__|__|,|__|__|__| d ☐ Don't know
b. Home-delivered nutrition services for older adults? ..	|__|__|,|__|__|__| d ☐ Don't know

B. SOCIALIZATION ACTIVITIES

1. During you most recent fiscal year, how many of your congregate nutrition sites offered social activities (through your organization or another organization) in addition to the meal?

|__|__|__| NUMBER OF CONGREGATE SITES

d ☐ Don't know

2. In a typical week, about how many hours of social activities are available at all congregate sites combined?

|__|__|__| NUMBER OF HOURS/WEEK

d ☐ Don't know

C. STAFF AND VOLUNTEERS

1. During your most recently completed fiscal year, including yourself, how many full-time equivalent <u>employees</u> did your organization have?

|___|,|___|___|___| NUMBER OF FULL-TIME EQUIVALENT EMPLOYEES

d ☐ Don't know

2. During your most recently completed fiscal year, including yourself, how many full-time equivalent <u>employees</u> worked on the nutrition program (congregate and home-delivered) funded in whole or in part by the OAA?

|___|___|___| NUMBER OF FULL-TIME EQUIVALENT EMPLOYEES

d ☐ Don't know

3. During your most recently completed fiscal year, how many full-time equivalent employees who worked on the nutrition program (congregate and home-delivered) funded in whole or in part by the OAA were dieticians or state credentialed nutrition professionals?

|___| NUMBER OF FULL-TIME EQUIVALENT DIETICIANS OR STATE CREDENTIALED NUTRITION PROFESSIONALS

d ☐ Don't know

4. During your most recently completed fiscal year, how many <u>individual volunteers</u> worked on the nutrition program (congregate and home-delivered) at your LSP?

Please count each volunteer only once.

	Number
a. Number of volunteers who work exclusively for the congregate nutrition program	|___|___|,|___|___|___| d ☐ Don't know
b. Number of volunteers who work exclusively for the home-delivered nutrition program	|___|___|,|___|___|___| d ☐ Don't know
c. Number of volunteers who work for both the congregate and home-delivered nutrition program ...	|___|___|,|___|___|___| d ☐ Don't know

5. During your most recently completed fiscal year, in total, how many <u>volunteer hours</u> did the nutrition program at your LSP directly receive?

a. |__|,|__|__|__|,|__|__|__|

NUMBER OF HOURS FOR THE CONGREGATE NUTRITION PROGRAM

d ☐ Don't know → GO TO QUESTION 5C

b. |__|,|__|__|__|,|__|__|__|

NUMBER OF HOURS FOR THE HOME-DELIVERED NUTRITION PROGRAM

d ☐ Don't know

c. |__|,|__|__|__|,|__|__|__|

NUMBER OF HOURS FOR CONGREGATE AND HOME-DELIVERED NUTRITION PROGRAMS

d ☐ Don't know

D. TARGETING

1. In the table below, please record the number of your LSP's program participants that fell into each of the following racial or ethnic categories for both congregate and home-delivered nutrition programs during your most recently completed fiscal year. Also indicate whether each category is a target population for your LSP.

Racial or Ethnic Category	Number in Congregate Nutrition Program	Don't know	Number in Home-Delivered Nutrition Program	Don't know	Is this a target population? Yes	No	Don't know
a. American Indian or Alaska Native (alone)	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
b. Asian (alone)	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
c. Black or African American (alone).	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
d. Native Hawaiian or other Pacific Islander (alone).....	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
e. White (alone)	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
f. Person reporting 2 or more races..	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
g. Other *(Specify)* ..... _____	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
h. Hispanic (Total)	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐

2. In the table below, please record the number of your LSP's program participants that fell into each of the categories listed below for both congregate and home-delivered nutrition programs during your most recently completed fiscal year. Also indicate whether each category is a target population for your LSP.

Categories:	Number in Home-Delivered Nutrition Program	Don't know	Number in Congregate Nutrition Program	Don't know	Is this a target population? Yes	No	Don't know
a. Impairments in 3 or more Activities of Daily Living.....	|__|__|,|__|__|__|	d ☐			1 ☐	0 ☐	d ☐
b. Impairments in 1-2 Activities of Daily Living	|__|__|,|__|__|__|	d ☐			1 ☐	0 ☐	d ☐
c. Living alone	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
d. Rural residents	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
e. Living below the federal poverty level	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
f. Female.....	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
g. 60-74 years old.....	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
h. 75-84 years old.....	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐
i. 85+ years old.....	|__|__|,|__|__|__|	d ☐	|__|__|,|__|__|__|	d ☐	1 ☐	0 ☐	d ☐

E. PROGRAM RESOURCES

The next questions concern the total expenditures incurred by your LSP during your most recently completed fiscal year. Total expenditures include service, administrative, and overhead expenditures.

During your most recently completed fiscal year...

1. ...what were the total expenditures for your organization?

$ |__|__|__|,|__|__|__|,|__|__|__|

d ☐ Don't know

2. ...what were the total expenditures for the Elderly Nutrition Program? This includes expenditures from funds received from the AAA plus expenditures from any additional sources of funds for the elderly nutrition program.

$ |__|__|__|,|__|__|__|,|__|__|__|

d ☐ Don't know

3. ...what were the total expenditures for the congregate nutrition program?

$ |__|__|__|,|__|__|__|,|__|__|__|

d ☐ Don't know

4. ...what were the total expenditures for the home-delivered nutrition program?

$ |___|___|___|,|___|___|___|,|___|___|___|

d ☐ Don't know

5. For each of the following funding sources, please indicate how much your LSP spent for congregate nutrition expenditures and home-delivered nutrition expenditures during your most recently completed fiscal year.

Funding Sources	Congregate Nutrition Expenditures	Don't know	Home-Delivered Nutrition Expenditures	Don't know
Area Agency on Aging.....	$_____	d ☐	$_____	d ☐
Other direct federal sources (not through AAA or state) (i.e. grants from USDA, Veterans Affairs, HUD, etc.).....	$_____	d ☐	$_____	d ☐
Other direct state sources.....	$_____	d ☐	$_____	d ☐
Other local sources (Including county, city, and other local public sources)	$_____	d ☐	$_____	d ☐
Private Sources				
a. Non-profit organization (e.g., United Way, 501 3-c)	$_____	d ☐	$_____	d ☐
b. Private for-profit (e.g., food industry)	$_____	d ☐	$_____	d ☐
c. Participant contributions.....	$_____	d ☐	$_____	d ☐
d. Program income other than participant contributions	$_____	d ☐	$_____	d ☐
e. Other private sources.....	$_____	d ☐	$_____	d ☐
Other *(Specify)* _____	$_____	d ☐	$_____	d ☐

OMB:
EXPIRATION DATE:

MATHEMATICA Policy Research

2011 National Evaluation of Title III-C Nutrition Services Local Service Provider Survey

INTRODUCTION

Thank you for helping us with the National Evaluation of Title III-C Elderly Nutrition Services. This study will examine how effectively and efficiently the Elderly Nutrition Program helps to keep older Americans healthy and active in their homes and communities. Results of the study will be used to support program planning and guide program practices at various levels of the aging network.

This survey asks about your organization's characteristics and objectives, staffing, use of technology, program decision processes, and measures used to coordinate with internal staff and other organizations. The survey takes approximately 60 minutes to complete.

- If you have any questions regarding the study or completing the local service provider survey, please contact Rhoda Cohen at 1-800-232-8024 or email: rcohen@mathematica-mpr.com
- The information you provide will be used only for statistical purposes. In accordance with the Confidential Information Protection and Statistical Efficiency Act of 2002, your responses will not be disclosed in identifiable form without your consent.
- Participation is completely voluntary. We thank you for your cooperation and participation in this very important study.
- If you do not have exact information available to answer certain questions, your best estimate will be fine.
- After hitting the submit button, it may take a few seconds for the next page of the survey to load. Please be patient and your responses will be accepted.
- Please be aware that after using the "Review my answers" link to go back to a previous question of the survey, you will need to continue through the survey again from that point forward.

SECTION A. ORGANIZATIONAL STRUCTURE

REQUIRED
ALL

A1. Which of the following services does your organization provide to older adults or their caregivers through a grant or contract with the Area Agency on Aging?

Select all that apply

- ☐ Congregate nutrition services 1
- ☐ Home-delivered nutrition service 2
- ☐ Nutrition screening and assessment 3
- ☐ Nutrition education 4
- ☐ Nutrition counseling 5
- ☐ Social activities 6
- ☐ Health promotion and disease prevention activities 7
- ☐ Other non-nutrition services 8
- ☐ Don't know ..... d

SOFT CHECK: IF A1 DNE CONGREGATE NUTRITION SERVICES, SHOW VALIDATION **Your response indicates that your organization does not provide congregate nutrition services. Is this correct?**
SOFT CHECK: IF A1 DNE HOME-DELIVERED NUTRITION SERVICES, SHOW VALIDATION **Your response indicates that your organization does not provide home-delivered nutrition services. Is this correct?**
HARD CHECK: IF A1 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**
HARD CHECK: IF A1 DNE CONGREGATE NUTRITION SERVICES AND A1 DNE HOME-DELIVERED NUTRITION SERVICES, SHOW VALIDATION **Your response must include congregate nutrition services or home-delivered nutrition services. If you believe you have received this survey in error, please contact please contact Rhoda Cohen at 1-800-232-8024 or email: rcohen@mathematica-mpr.com**

REQUIRED
IF A1 INCLUDES "OTHER NON-NUTRITION SERVICES." ELSE SKIP TO A3.

A2. Which other non-nutrition services does your organization provide through a grant or contract with the Area Agency on Aging?

Select all that apply

- ☐ Housing 1
- ☐ Chore/housekeeping 2
- ☐ Grocery assistance 3
- ☐ Personal care 4
- ☐ Home health 5
- ☐ Transportation 6
- ☐ Case management 7
- ☐ Other *(Please Specify)* 8

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF A2 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

A3. Which of the following populations does your organization currently serve through all its programs and services?

Select all that apply

- ☐ Adults 60 years and older 1
- ☐ Adults with physical disabilities regardless of age 2
- ☐ Adults with mental retardation or developmental disability regardless of age 3
- ☐ Children with physical disabilities 4
- ☐ Children with mental retardation or developmental disability 5
- ☐ Family caregivers 6
- ☐ Don't know ..... d

HARD CHECK: IF A3 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

A4. Is your organization currently a standalone organization or is it part of another organization?

- ❍ Standalone organization 1
- ❍ Part of another organization 2
- ❍ Don't know ..... d

REQUIRED
ALL

A6. Which of the following best describes the current management structure of your organization?

- ❍ A not-for-profit agency (non-governmental) 1
- ❍ For profit 2
- ❍ A division of city or county government 3
- ❍ Part of a council of governments or regional planning and development agency 4
- ❍ A Tribal Government entity 5
- ❍ Educational institution 6
- ❍ Other *(Please Specify)* 7

  [ ]
- ❍ Don't know ..... d

REQUIRED
IF A6 DNE "A TRIBAL GOVERNMENT ENTITY"

A7. Is your service area for nutrition near an Older American Act Title VI program for Older Native Americans?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

A8. Is your organization a faith-based organization?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO A11.

A9. Please describe the areas included in your congregate nutrition service area:

Select all that apply

- ☐ Urban area 1
- ☐ Suburban area 2
- ☐ Rural area 3
- ☐ Frontier area 4
- ☐ Don't know ..... d

HARD CHECK: IF A9 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES

A10. Which of the following best describes the current boundaries of your congregate nutrition service area?

- ❍ Single county 1
- ❍ Multi-county 2
- ❍ Single city/Metro area 3
- ❍ Multiple city/Metro area 4
- ❍ Other *(Please Specify)* 5

  [ ]
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES. ELSE SKIP TO B1.

A11. Please describe the areas included in your home-delivered nutrition service area:

Select all that apply

- ☐ Urban area 1
- ☐ Suburban area 2
- ☐ Rural area 3
- ☐ Don't know ..... d

HARD CHECK: IF A11 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES

A12. Which of the following best describes the current boundaries of your home-delivered nutrition service area?

- ❍ Single county 1
- ❍ Multi-county 2
- ❍ Single city/Metro area 3
- ❍ Multiple city/Metro area 4
- ❍ Other *(Please Specify)* 5

  [ ]
- ❍ Don't know ..... d

SECTION B. AGING AND DISABILITY RESOURCE CENTER (ADRC)

REQUIRED
ALL

B1. Currently, is there an Aging and Disability Resource Center (ADRC) in your service area? In your state, the ADRC is known as [FILL ADRC NAME (to the public)].

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF B1 = YES. ELSE SKIP TO C1.

B2. Does your organization receive referrals for nutrition services from the ADRC?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF B1 = YES

B3. Does your organization refer nutrition clients to the ADRC for non-nutrition needs?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

SECTION C. STAFF AND VOLUNTEERS

REQUIRED
ALL

C1. What kinds of tasks are assigned to volunteers for your elderly nutrition services program?

Select all that apply

- ☐ Meal production (e.g., prepare or cook food) 1
- ☐ Congregate site meal delivery (e.g., serve meals), [PROGRAMMER: SHOW ONLY IF A1 INCLUDES CONGREGATE NUTRITION] 2
- ☐ Congregate site work, non-production (e.g., hostess, table setting, clean-up, re-stock, cashier), [PROGRAMMER: SHOW ONLY IF A1 INCLUDES CONGREGATE NUTRITION] 3
- ☐ Home-delivered meal delivery [PROGRAMMER: SHOW ONLY IF A1 INCLUDES HOME-DELIVERED NUTRITION] 4
- ☐ Nutrition education or counseling 5
- ☐ Nutrition program management or administration (fund-raising, accounting, human resources) 6
- ☐ Other *(Please Specify)* 7

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF C1 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

C2. Who are your typical volunteers?

Select all that apply

- ☐ Older adults 1
- ☐ Client family members/friends 2
- ☐ Students 3
- ☐ Faith-based organization members 4
- ☐ Civic organization members 5
- ☐ Local business employees 6
- ☐ General public 7
- ☐ Other *(Please Specify)* 8

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF C2 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO CHECK BEFORE C4

C3. Would your organization continue to provide congregate nutrition services if you had no volunteers?

- ❍ Yes, and at the current level of service provision 1
- ❍ Yes, but at a reduced level of service provision (e.g., close some sites, reduce the number of days of service, reduced number of people served) 2
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME DELIVERED NUTRITION SERVICES. ELSE SKIP TO D1

C4. Would your organization continue to provide home-delivered nutrition services if you had no volunteers?

- ❍ Yes, and at the current level of service provision 1
- ❍ Yes, but at a reduced level of service provision (e.g., reduce service area, reduced frequency of delivery, reduce number of meals per person, reduce number of people served) 2
- ❍ No 0
- ❍ Don't know ..... d

SECTION D. TECHNOLOGY AND DATA

REQUIRED
ALL

D1. Which of the following electronic systems does your organization currently use?

Select all that apply

- ☐ Computer-assisted menu planning and analysis 1
- ☐ Software to track inventory or order food 2
- ☐ Delivery systems for home-delivered nutrition (e.g., route mapping software) 3
- ☐ Program participant tracking or referral systems 4
- ☐ Electronic client ID card 5
- ☐ Electronic system for recording service (e.g., the meal) as received 6
- ☐ Financial systems for billing and/or making payments for services 7
- ☐ Cost-centered accounting system 8
- ☐ Geographic Information Systems (GIS) 9
- ☐ Other automated system 10
- ☐ No automated systems 0
- ☐ Don't know ..... d

HARD CHECK: IF D1 = NO AUTOMATED SYSTEMS AND ANY OTHER ANSWER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **No automated systems cannot be selected along with other response options.**
HARD CHECK: IF D1 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

SECTION E. PROGRAM RESOURCES

REQUIRED
ALL

E1. How many of each of the following are rented, owned, or donated for use in your Elderly Nutrition Program?

Note: Please enter 0 if you do not have any of a particular item.

RESOURCE	# RENTED	# OWNED	# DONATED
a. Kitchen			
Don't know	d ❍	d ❍	d ❍
b. Off-site storage (food/supplies)			
Don't know	d ❍	d ❍	d ❍
c. Delivery vehicles			
Don't know	d ❍	d ❍	d ❍
d. Vehicle garage/parking facility			
Don't know	d ❍	d ❍	d ❍
e. Congregate site			
Don't know	d ❍	d ❍	d ❍

PROGRAMMER: RANGE FOR E1a-e IS (0-99)

SOFT CHECK: IF GT 25, **You indicated more than 25 [resources] are [rented, owned, donated]. Is that correct?**
HARD CHECK: IF E1a-e = DON'T KNOW AND NUMBER FIELD IS FILLED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO E3.

E2. Is your organization responsible for at least some utilities (e.g., electricity) at your congregate nutrition sites?

- ❍ Yes, all sites 1
- ❍ Yes, some sites 2
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

E3. Does your organization pay for at least some utilities (e.g., electricity) at your production sites?

- ❍ Yes, all sites 1
- ❍ Yes, some sites 2
- ❍ No 0
- ❍ Not applicable, we don't have a production site ..... n
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME DELIVERED NUTRITION SERVICES. ELSE SKIP TO E6

E4. How are home-delivered meals delivered to program participants' homes?

Select all that apply

- ☐ Drivers use their own vehicles 1
- ☐ Vehicles are provided by our organization 2
- ☐ Other *(Please Specify)* 3

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF E4 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME DELIVERED NUTRITION SERVICES.

E5. Does your organization reimburse home-delivered nutrition program drivers for gas or mileage when using their own vehicles?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d
- ❍ Not applicable (i.e., drivers do not use their own vehicles) ..... n

REQUIRED
ALL

E6. Does your organization provide stipends or other monetary rewards to volunteers (other than gas or mileage)?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME DELIVERED NUTRITION SERVICES.

E7. Has your organization reduced or stopped reimbursement of program drivers for gas/mileage when using their own vehicle within the last 3 years?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d
- ❍ Not applicable (i.e., drivers do not use their own vehicles) ..... n

REQUIRED
ALL

E8. Has your organization reduced or stopped providing stipends or other monetary rewards to volunteers within the last 3 years?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

SECTION F. ACCESS TO SERVICES

REQUIRED
ALL

F1a. Is your organization responsible for prioritizing clients (i.e., using characteristics to base decisions for serving some individuals before others when resources are limited) for the elderly nutrition service programs you provide?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
ALL

F1b. Does your organization have specific prioritization criteria (i.e., characteristics to base decisions on for serving some individuals before others when resources are limited) for the elderly nutrition service programs you provide?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d
- ❍ Not applicable ..... n

REQUIRED
ALL

F1c. Did your organization have to prioritize who received services during the past year?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d
- ❍ Not applicable ..... n

REQUIRED
IF F1b or F1c = YES AND A1 INCLUDES CONGREGATE NUTRITION AND HOME-DELIVERED NUTRITION. ELSE SKIP TO F3

F2. Which of the following criteria do you currently use for prioritization?

CHARACTERISTIC	CONGREGATE NUTRITION PRIORITIZATION CRITERIA	HOME-DELIVERED NUTRITION PRIORITIZATION CRITERIA
a. ADL cut-off	1 ☐	2 ☐
b. IADL cut-off	1 ☐	2 ☐
c. Lack of informal/family support	1 ☐	2 ☐
d. Geographic isolation	1 ☐	2 ☐
e. Social isolation	1 ☐	2 ☐
f. Chronic health condition	1 ☐	2 ☐
g. Poor housing/lack kitchen access	1 ☐	2 ☐
h. Homebound	1 ☐	2 ☐
i. Racial/ethnic minority	1 ☐	2 ☐
j. Advanced age	1 ☐	2 ☐
k. Low Income	1 ☐	2 ☐
l. Limited English Proficiency	1 ☐	2 ☐
m. Dementia/Cognitive Impairment	1 ☐	2 ☐
n. Food insecure/hungry	1 ☐	2 ☐
o. Nutrition Risk Assessment	1 ☐	2 ☐
p. Adult day care participation	1 ☐	2 ☐
q. Long-term need for service	1 ☐	2 ☐
r. Other	1 ☐	2 ☐
s. Do not prioritize for this type of service	1 ☐	2 ☐

HARD CHECK: IF NO ANSWER CATEGORY IS CHECKED IN A COLUMN, **At least one response is required in each column.**
HARD CHECK: IF DO NOT PRIORITIZE FOR THIS TYPE OF SERVICE AND ANY OTHER RESPONSE IS CHECKED, **Do not prioritize for this type of service cannot be selected with other response options.**

REQUIRED
IF F1b or F1c = YES AND A1 INCLUDES CONGREGATE NUTRITION BUT NOT HOME-DELIVERED NUTRITION. ELSE SKIP TO F3

F2.1 Which of the following criteria do you currently use for prioritization?

CHARACTERISTIC	CONGREGATE NUTRITION PRIORITIZATION CRITERIA
a. ADL cut-off	1 ☐
b. IADL cut-off	1 ☐
c. Lack of informal/family support	1 ☐
d. Geographic isolation	1 ☐
e. Social isolation	1 ☐
f. Chronic health condition	1 ☐
g. Poor housing/lack kitchen access	1 ☐
h. Homebound	1 ☐
i. Racial/ethnic minority	1 ☐
j. Advanced age	1 ☐
k. Low Income	1 ☐
l. Limited English Proficiency	1 ☐
m. Dementia/Cognitive Impairment	1 ☐
n. Food insecure/hungry	1 ☐
o. Nutrition Risk Assessment	1 ☐
p. Adult day care participation	1 ☐
q. Long-term need for service	1 ☐
r. Other	1 ☐
s. Do not prioritize for this type of service	1 ☐

HARD CHECK: IF NO ANSWER CATEGORY IS CHECKED, **At least one response is required.**
HARD CHECK: IF DO NOT PRIORITIZE FOR THIS TYPE OF SERVICE AND ANY OTHER RESPONSE IS CHECKED, **Do not prioritize for this type of service cannot be selected with other response options.**

REQUIRED
IF F1b or F1c = YES AND A1 INCLUDES HOME-DELIVERED NUTRITION BUT NOT CONGREGATE NUTRITION. ELSE SKIP TO F3

F2.2 Which of the following criteria do you currently use for prioritization?

CHARACTERISTIC	HOME-DELIVERED NUTRITION PRIORITIZATION CRITERIA
a. ADL cut-off	2 ☐
b. IADL cut-off	2 ☐
c. Lack of informal/family support	2 ☐
d. Geographic isolation	2 ☐
e. Social isolation	2 ☐
f. Chronic health condition	2 ☐
g. Poor housing/lack kitchen access	2 ☐
h. Homebound	2 ☐
i. Racial/ethnic minority	2 ☐
j. Advanced age	2 ☐
k. Low Income	2 ☐
l. Limited English Proficiency	2 ☐
m. Dementia/Cognitive Impairment	2 ☐
n. Food insecure/hungry	2 ☐
o. Nutrition Risk Assessment	2 ☐
p. Adult day care participation	2 ☐
q. Long-term need for service	2 ☐
r. Other	2 ☐
s. Do not prioritize for this type of service	1 ☐

HARD CHECK: IF NO ANSWER CATEGORY IS CHECKED, **At least one response is required.**
HARD CHECK: IF DO NOT PRIORITIZE FOR THIS TYPE OF SERVICE AND ANY OTHER RESPONSE IS CHECKED, **Do not prioritize for this type of service cannot be selected with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES

F3. What method is used by participants to access congregate nutrition services?

Select all that apply

- ☐ Pre-approval mechanism 1
- ☐ Participants sign-up ahead/make a reservation 2
- ☐ First come, first served at site 3
- ☐ Other *(Please Specify)* 4

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF F3 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO F5

F4. Does your organization provide transportation directly or arrange transportation services such as free or low cost cabs, vans, or buses for clients of the congregate nutrition program?

Select all that apply

- ☐ Organization directly provides transportation 1
- ☐ Organization arranges transportation services 2
- ☐ Transportation available through other entity 3
- ☐ Participant arranges for their own transportation 4
- ☐ Don't know ..... d

HARD CHECK: IF F4 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES. ELSE SKIP TO G1.

F5. Who authorizes home-delivered nutrition services for a new client?

Select all that apply

- ☐ Your organization authorizes clients to receive services using funding that includes Older Americans Act funds 1
- ☐ The Area Agency on Aging authorizes clients to receive services using funding that includes OAA funds 2
- ☐ Other authorizing system *(Please Specify)* 3

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF F5 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

F6. Please identify up to three sources that provided the most referrals for the home-delivered nutrition program during your most recently completed fiscal year.

Select all that apply

- ☐ Family/Friends 1
- ☐ Hospital/health care facility/discharge planner 2
- ☐ Nursing homes 3
- ☐ Physician 4
- ☐ Case management system 5
- ☐ Aging and Disability Resource Center (ADRC) 6
- ☐ Information and Assistance system 7
- ☐ Medicaid Waiver 8
- ☐ Other food or nutrition program 9
- ☐ Faith-based organizations 10
- ☐ Self 11
- ☐ Other *(Please Specify)* 12

  [ ]
- ☐ Don't know the three sources that provided the most referrals ..... d

HARD CHECK: IF F6 = DON'T KNOW THE THREE SOURCES THAT PROVIDED THE MOST REFERRALS and any other answer category is selected, **Don't know the three sources that provided the most referrals cannot be selected along with other response options.**
SOFT CHECK: IF RESPONDENT CHECKS LT 3 SELECTIONS FROM LIST, **You have selected fewer than three sources. Is that correct?**
HARD CHECK: IF RESPONDENT CHECKS GT 3 SELECTIONS FROM LIST, **You have selected more than three sources. Please select the three sources that provided the most referrals for the home-delivered nutrition program.**

SECTION G. WAITING LISTS

REQUIRED

IF A1 INCLUDES CONGREGATE NUTRITION AND HOME-DELIVERED NUTRITION

G1. Does your organization currently maintain waiting lists for the congregate nutrition or home-delivered nutrition programs?

MAINTAINS WAITING LIST FOR CONGREGATE NUTRITION PROGRAM			MAINTAINS WAITING LIST FOR HOME-DELIVERED NUTRITION PROGRAM		
YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
1 ❍	0 ❍	d ❍	1 ❍	0 ❍	d ❍

REQUIRED

IF A1 INCLUDES CONGREGATE NUTRITION AND A1 DOES NOT INCLUDE HOME-DELIVERED NUTRITION

G1.1 Does your organization currently maintain a waiting list for the congregate nutrition program?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED

IF A1 INCLUDES HOME-DELIVERED NUTRITION AND A1 DOES NOT INCLUDE CONGREGATE NUTRITION

G1.2 Does your organization currently maintain a waiting list for the home-delivered nutrition program?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF G1 = YES FOR CONGREGATE NUTRITION AND G1 = YES FOR HOME-DELIVERED NUTRITION.

G2. What is the current waiting list policy for congregate and home-delivered nutrition?

	CONGREGATE NUTRITION	HOME-DELIVERED NUTRITION
a. The waiting list contains everyone who requested service without screening for service eligibility or need, ordered by date of request	1 ❍	1 ❍
b. The waiting list contains everyone who is screened eligible for services on a first-come first-served basis	2 ❍	2 ❍
c. The waiting list contains everyone who is screened eligible and in priority order (by priority criteria)	3 ❍	3 ❍
d. Other *(Please Specify)*	4 ❍	4 ❍
e. There is no waiting list policy	5 ❍	5 ❍
f. Don't know	d ❍	d ❍

REQUIRED
IF G1 OR G1.1 = YES FOR CONGREGATE NUTRITION AND BOTH G1 AND G1.2 NOT YES FOR HOME-DELIVERED NUTRITION.

G2.1 What is the current waiting list policy for congregate nutrition?

	CONGREGATE NUTRITION
a. The waiting list contains everyone who requested service without screening for service eligibility or need, ordered by date of request	1 ❍
b. The waiting list contains everyone who is screened eligible for services on a first-come first-served basis	2 ❍
c. The waiting list contains everyone who is screened eligible and in priority order (by priority criteria)	3 ❍
d. Other *(Please Specify)*	4 ❍
e. There is no waiting list policy	5 ❍
f. Don't know	d ❍

REQUIRED
IF G1 OR G1.2 = YES FOR HOME-DELIVERED NUTRITION AND BOTH G1 AND G1.1 NOT YES FOR CONGREGATE NUTRITION.

G2.2 What is the current waiting list policy for home-delivered nutrition?

	HOME-DELIVERED NUTRITION
a. The waiting list contains everyone who requested service without screening for service eligibility or need, ordered by date of request	1 ❍
b. The waiting list contains everyone who is screened eligible for services on a first-come first-served basis	2 ❍
c. The waiting list contains everyone who is screened eligible and in priority order (by priority criteria)	3 ❍
d. Other *(Please Specify)*	4 ❍
e. There is no waiting list policy	5 ❍
f. Don't know	d ❍

SECTION H. REFERRALS AND NEEDS ASSESSMENTS

REQUIRED

A1 INCLUDES CONGREGATE NUTRITION AND HOME DELIVERED NUTRITION

H1. Does your organization currently have a formal process for assessing service needs for Elderly Nutrition Program participants (e.g., transportation, SNAP, housing, etc.)?

Service Type	NUTRITION NEEDS			NON-NUTRITION NEEDS		
	YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
Congregate nutrition	1 ❍	0 ❍	d ❍	1 ❍	0 ❍	d ❍
Home-delivered nutrition	1 ❍	0 ❍	d ❍	1 ❍	0 ❍	d ❍

REQUIRED

A1 INCLUDES CONGREGATE NUTRITION AND A1 DOES NOT INCLUDE HOME-DELIVERED NUTRITION

H1.1 Does your organization currently have a formal process for assessing service needs for Elderly Nutrition Program participants (e.g., transportation, SNAP, housing, etc.)?

	CONGREGATE NUTRITION		
	YES	NO	DON'T KNOW
Nutrition needs	1 ❍	0 ❍	d ❍
Non-nutrition needs	1 ❍	0 ❍	d ❍

REQUIRED

A1 INCLUDES HOME-DELIVERED NUTRITION AND A1 DOES NOT INCLUDE CONGREGATE NUTRITION

H1.2 Does your organization currently have a formal process for assessing service needs for Elderly Nutrition Program participants (e.g., transportation, SNAP, housing, etc.)?

	HOME-DELIVERED NUTRITION		
	YES	NO	DON'T KNOW
Nutrition needs	1 ❍	0 ❍	d ❍
Non-nutrition needs	1 ❍	0 ❍	d ❍

REQUIRED
IF H1=YES FOR CONGREGATE NUTRITION FOR EITHER NUTRITION OR NON-NUTRITION NEEDS AND IF H1=YES FOR HOME-DELIVERED NUTRITION FOR EITHER NUTRITION OR NON-NUTRITION NEEDS

H2. How often are Elderly Nutrition Program participants re-assessed for service needs (both nutrition and non-nutrition services)?

	Select all that apply for each column	
	Congregate nutrition program participants	**Home-delivered nutrition program participants**
No policy (frequency determined by staff)	1 ☐	1 ☐
At least yearly (1 or more assessments per year)	2 ☐	2 ☐
Less than once per year	3 ☐	3 ☐
After acute care episode (hospital, ER visit)	4 ☐	4 ☐
Other *(Specify)* _____	5 ☐	5 ☐
Don't know	d ☐	d ☐

HARD CHECK: IF H2 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
(IF H1=YES FOR CONGREGATE NUTRITION FOR EITHER NUTRITION OR NON-NUTRITION NEEDS AND IF H1<>YES FOR HOME-DELIVERED NUTRITION FOR NEITHER NUTRITION NOR NON-NUTRITION NEEDS) OR (H1.1=YES FOR CONGREGATE NUTRITION FOR EITHER NUTRITION OR NON-NUTRITION NEEDS)

H2.1 How often are Elderly Nutrition Program participants re-assessed for service needs (both nutrition and non-nutrition services)?

	Select all that apply
	Congregate nutrition program participants
No policy (frequency determined by staff)	1 ☐
At least yearly (1 or more assessments per year)	2 ☐
Less than once per year	3 ☐
After acute care episode (hospital, ER visit)	4 ☐
Other *(Specify)*	5 ☐
Don't know	d ☐

HARD CHECK: IF H2.1 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
(IF H1=YES FOR HOME-DELIVERED NUTRITION FOR EITHER NUTRITION OR NON-NUTRITION NEEDS AND IF H1<>YES FOR CONGREGATE NUTRITION FOR NEITHER NUTRITION NOR NON-NUTRITION NEEDS) OR (H1.2=YES FOR HOME-DELIVERED NUTRITION FOR EITHER NUTRITION OR NON-NUTRITION NEEDS)

H2.2 How often are Elderly Nutrition Program participants re-assessed for service needs (both nutrition and non-nutrition services)?

	Select all that apply
	Home-delivered nutrition program participants
No policy (frequency determined by staff)	1 ☐
At least yearly (1 or more assessments per year)	2 ☐
Less than once per year	3 ☐
After acute care episode (hospital, ER visit)	4 ☐
Other *(Specify)*	5 ☐
Don't know	d ☐

HARD CHECK: IF H2.2 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION

H3.1 Currently, which of the following services does your organization actively assist Elderly Nutrition Program participants to access? Active assistance involves more than providing reading materials and brochures.

Select all that apply

Service	Congregate nutrition program
a. Medicaid Waiver programs	1 ☐
b. Medicaid (non-waiver)	1 ☐
c. Medicare Parts A or B	1 ☐
d. Medicare Part D	1 ☐
e. Housing programs	1 ☐
f. Transportation services	1 ☐
g. Low Income Home Energy Assistance Program (LIHEAP)	1 ☐
h. Supplemental Security Income	1 ☐
i. Other supportive services (chore, homemaker)	1 ☐
j. SNAP (Food Stamps)	1 ☐
k. Other food or nutrition services (food pantry)	1 ☐
l. Veterans Affairs services	1 ☐
m. Adult Protective Services	1 ☐
n. Evidence-based health promotion and disease prevention programs	1 ☐
o. Other	1 ☐
p. Do not provide this type of assistance	1 ☐

HARD CHECK: IF H3p = CONGREGATE AND ANY H3a-o = CONGREGATE, SHOW VALIDATION MESSAGE, **Do not provide this type of assistance cannot be selected along with other response options.**
HARD CHECK: AT LEAST ONE RESPONSE MUST BE SELECTED, **At least one response must be selected.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION

H3.2 Currently, which of the following services does your organization actively assist Elderly Nutrition Program participants to access? Active assistance involves more than providing reading materials and brochures.

Select all that apply

Service	Home-delivered nutrition program
a. Medicaid Waiver programs	1 ☐
b. Medicaid (non-waiver)	1 ☐
c. Medicare Parts A or B	1 ☐
d. Medicare Part D	1 ☐
e. Housing programs	1 ☐
f. Transportation services	1 ☐
g. Low Income Home Energy Assistance Program (LIHEAP)	1 ☐
h. Supplemental Security Income	1 ☐
i. Other supportive services (chore, homemaker)	1 ☐
j. SNAP (Food Stamps)	1 ☐
k. Other food or nutrition services (food pantry)	1 ☐
l. Veterans Affairs services	1 ☐
m. Adult Protective Services	1 ☐
n. Evidence-based health promotion and disease prevention programs	1 ☐
o. Other	1 ☐
p. Do not provide this type of assistance	1 ☐

HARD CHECK: AT LEAST ONE RESPONSE MUST BE SELECTED, **At least one response must be selected.**
HARD CHECK: I IF H3p = HOME-DELIVERED AND ANY H3a-o = HOME-DELIVERED, SHOW VALIDATION MESSAGE, **Do not provide this type of assistance cannot be selected along with other response options.**

REQUIRED
IF SUM OF SELECTIONS FROM H3.1 IS GREATER THAN 3.

H4.1 Please identify the three most common programs or services that your organization refers Elderly Nutrition Program participants.

MARK ONLY THREE

PROGRAMMER: DISPLAY ALL CHECKED SELECTIONS FROM H3.1

HARD CHECK: IF RESPONDENT DOES NOT CHECK 3 ITEMS FROM LIST, SHOW VALIDATION MESSAGE, **Please select the three most common programs or services.**

REQUIRED
IF SUM OF SELECTIONS FROM H3.2 IS GREATER THAN 3.

H4.2 Please identify the three most common programs or services that your organization refers Elderly Nutrition Program participants.

MARK ONLY THREE

PROGRAMMER: DISPLAY ALL CHECKED SELECTIONS FROM H3.2

HARD CHECK: IF RESPONDENT DOES NOT CHECK 3 ITEMS FROM LIST, SHOW VALIDATION MESSAGE, **Please select the three most common programs or services.**

REQUIRED
IF H3.1 OR H3.2 DOES NOT EQUAL DO NOT PROVIDE THIS TYPE OF ASSISTANCE

H5. Is follow-up done on active referrals?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

SECTION I. NUTRITION SERVICE OPERATION AND QUALITY ASSURANCE

REQUIRED
ALL

I1. Which of the following does your organization currently use to contribute to the <u>nutrient quality of meals</u>?

Select all that apply

- ☐ Computer-assisted menu analysis 1
- ☐ Meal patterns 2
- ☐ Use of dietician or state credentialed nutrition professional 3
- ☐ Area Agency on Aging guidance 4
- ☐ State Unit on Aging guidance 5
- ☐ Older Americans Act guidance 6
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: IF I1 = NONE OF THE ABOVE AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **None of the above cannot be selected along with other response options.**
HARD CHECK: IF I1 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

I2. Which of the following does your organization currently use to contribute to the <u>overall food service quality provided by your organization, caterers, or vendors</u>?

Select all that apply

- ☐ Food service license/safety inspections 1
- ☐ Training of staff 2
- ☐ Survey of program participants 3
- ☐ Program participant feedback mechanism (comment box/card, complaint mechanism, etc.) 4
- ☐ Regularly scheduled site visits either to production location and/or service location 5
- ☐ Visit to home of home-delivered nutrition client 6
- ☐ Program participant advisory/menu committee 7
- ☐ Food quality specifications 8
- ☐ Use of dietician or state credentialed nutrition professional 9
- ☐ Area Agency on Aging guidance 10
- ☐ State Unit on Aging guidance 11
- ☐ Older Americans Act guidance 12
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: IF I2 = NONE OF THE ABOVE AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **None of the above cannot be selected along with other response options.**
HARD CHECK: IF I2 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

SECTION J. EMERGENCY PLANNING

REQUIRED
ALL

J1. Does your organization currently have an emergency plan that includes providing nutrition services?

Select all that apply

- ☐ Yes, for short-term emergencies 1
- ☐ Yes, for long-term emergencies 2
- ☐ No 0
- ☐ Don't know ..... d

HARD CHECK: IF J1 = NO AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **No cannot be selected along with other response options.**
HARD CHECK: IF J1 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
ALL

J2. Has your organization experienced a disaster (natural or manmade) in the past 3 years?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF J1 = 1 OR 2 AND J2 = YES. ELSE, SKIP TO K1.

J3. During the disaster did your organization initiate an emergency plan?

- ❍ Yes 1
- ❍ No 0
- ❍ Did not have an emergency plan at the time 2
- ❍ Don't know ..... d

REQUIRED
IF J3 = YES

J4. Please rate the effectiveness of the emergency plan.

- ❍ Very effective 1
- ❍ Effective 2
- ❍ Somewhat effective 3
- ❍ Not very effective 4
- ❍ Not effective 5
- ❍ Don't know ..... d

SECTION K. PARTNERSHIP DEVELOPMENT

REQUIRED
ALL

K1. Please select all of your partners for the Elderly Nutrition Program during your most recently completed fiscal year. Partners are organizations or groups in which you may jointly engage in some of the following activities: fundraising, shared resources, advocacy, strategic planning, public education, referrals, senior activities, service delivery, shared outreach, targeting special populations, training or technical assistance, or volunteer recruitment or retention.

Select all that apply

- ☐ Hospitals, nursing facilities, including discharge planning and emergency room care 1
- ☐ Home health agencies 2
- ☐ Transportation (public services – county/municipal) 3
- ☐ Medicare 4
- ☐ Medicaid (Non-waiver) 5
- ☐ Medicaid Waiver 6
- ☐ Veterans Affairs 7
- ☐ Social Security 8
- ☐ Public housing and related services, including senior housing 9
- ☐ Homeless shelters 10
- ☐ SNAP (Food Stamps)/SNAP Ed (Food Stamp Nutrition Education) 11
- ☐ Senior farmers market 12
- ☐ Other food and nutrition programs (e.g., Commodity Supplemental Nutrition Program, emergency food service programs including food banks and pantries) 13
- ☐ Title VI (Native American) program 14
- ☐ Other Older Americans Act programs 15
- ☐ Aging and Disability Resource Center 16
- ☐ Non OAA funded Meals on Wheels 17
- ☐ Community health centers 18
- ☐ Public health services 19
- ☐ City or county social services agency 20
- ☐ City or county regional planning office 21
- ☐ County/city/local public service providers such as EMS, police/fire departments 22
- ☐ Elder Abuse Prevention programs or Adult Protective Services (APS) 23
- ☐ Legal services for older adults 24
- ☐ Energy assistance (LIHEAP) 25
- ☐ Churches, synagogues, mosques, faith-based organizations 26
- ☐ College or university 27
- ☐ Volunteer bureaus/organizations 28
- ☐ Civic organization 29
- ☐ Local business *(Please specify the type)* 30
- ☐ Other *(Please Specify)* 31

  [ ]

- ☐ Do not have any partners 32
- ☐ Don't know ..... d

HARD CHECK: IF K1 = DON'T KNOW and any other category is selected, **Don't know cannot be selected along with other response options.**
HARD CHECK: IF K1 = DO NOT HAVE ANY PARTNERS and any other category is selected, **Do not have any partners cannot be selected along with other response options.**

REQUIRED
IF GT 5 SELECTIONS FOR K1. ELSE, GO TO K3

K2. Please select the <u>five most important</u> Elderly Nutrition Program partners you had during your most recently completed fiscal year.

SELECT ONLY FIVE

PROGRAMMER: DISPLAY ALL CHECKED SELECTIONS FROM K1. IF RESPONDENT CHECKED "Local business" or "Other", ALSO DISPLAY TEXT IN "Specify" FIELD.

HARD CHECK: IF RESPONDENT CHECKS GT FIVE SELECTIONS FROM LIST, SHOW VALIDATION MESSAGE, **You have selected more than five partners. Please select your five most important partners.**
HARD CHECK: IF RESPONDENT CHECKS LT FIVE SELECTIONS FROM LIST, SHOW VALIDATION MESSAGE, **You have selected less than five partners. Please select your five most important partners.**

REQUIRED
ALL

K3. For each partnership listed, please indicate which activities you <u>jointly</u> engaged in for the Elderly Nutrition Program during your most recently completed fiscal year.

PROGRAMMER: IF MORE THAN 5 SELECTIONS FOR K1, FILL PARTNERSHIP NAME WITH CHECKED SELECTIONS FROM K2. ELSE, FILL PARTNERSHIP NAMES FROM K1 [MAY BE LESS THAN 5].

	[Partnership 1 Name]	[Partnership 2 Name]	[Partnership 3 Name]	[Partnership 4 Name]	[Partnership 5 Name]
a. Fundraising	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Shared resources	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Advocacy	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. Strategic planning	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
e. Public education	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
f. Referrals	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
g. Senior activities	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
h. Service delivery	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
i. Shared outreach	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
j. Targeting special populations	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
k. Training/technical assistance	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
l. Volunteer recruitment or retention	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
m. None of the above	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

HARD CHECK: IF K3 = NONE OF THE ABOVE, and any other category is selected, **None of the above cannot be selected along with other response options.**

REQUIRED
IF PARTNERSHIPS LISTED FOR K3 NE "Title VI (Native American) program" OR IF K1 = DK OR DO NOT HAVE ANY PARTNERS AND A7 = YES.

K4. What are the major areas in which your organization collaborated with Title VI programs during your most recently completed fiscal year?

Select all that apply

- ☐ Fundraising 1
- ☐ Shared resources 2
- ☐ Advocacy 3
- ☐ Strategic planning 4
- ☐ Public education 5
- ☐ Referrals 6
- ☐ Senior activities 7
- ☐ Service delivery 8
- ☐ Meal production 9
- ☐ Shared outreach 10
- ☐ Targeting special populations 11
- ☐ Training/technical assistance 12
- ☐ Volunteer recruitment or retention 13
- ☐ Other *(Please Specify)* 14

  [ ]

- ☐ Don't collaborate with Title VI programs 15
- ☐ Don't know ..... d

HARD CHECK: IF K4 = DON'T COLLABORATE WITH TITLE VI PROGRAMS AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **Don't collaborate with Title VI programs cannot be selected with other response options.**
HARD CHECK: IF K4 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

SECTION L. PRIVATE PAY/FEE-FOR-SERVICE AND MEDICAID WAIVER

The next series of questions are about private pay/fee-for-service and Medicaid Waiver participation.

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO L6.

L1. Does your organization have a private pay/fee-for-service meal program in the congregate nutrition program?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF L1 = YES. ELSE SKIP TO L6.

L2. How is the private pay/fee-for-service program's meal price calculated in the congregate nutrition program?

- ❍ Cost-reimbursement 1
- ❍ Fair market value 2
- ❍ Other 3
- ❍ Don't know ..... d

REQUIRED
IF L1 = YES

L3. What is the average price of the private pay/fee-for-service lunch meal in the congregate nutrition program?

$ [ ] PRICE OF PRIVATE PAY MEAL ***(0-99.99)***

☐ Don't know ..... d

SOFT CHECK: IF L3 GT 10.00, SHOW VALIDATION, **You indicated an average price over $10. Is this correct?**
HARD CHECK: IF L3 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF L1 = YES

L4. Are OAA clients in the congregate nutrition program offered the same meal as private pay/fee-for-service customers?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF L1 = YES

L5. Is the private pay/fee-for-service meal offered at the same site as the congregate meal?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES. ELSE SKIP TO L8.

L6. Does your organization have a private pay/fee-for-service meal program in the home-delivered nutrition program?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

REQUIRED
IF L6 = YES.

L7. How is the private pay/fee-for-service program's meal price calculated in the home-delivered nutrition program?

- ❍ Cost-reimbursement 1
- ❍ Fair market value 2
- ❍ Other 3
- ❍ Don't know ..... d

REQUIRED
IF L6 = YES

L7a. What is the average price of the private pay/fee-for-service meal in the home-delivered nutrition program?

$ [ ] PRICE OF PRIVATE PAY MEAL (0-99.99)

☐ Don't know ..... d

SOFT CHECK: IF L7a GT 10.00, SHOW VALIDATION, **You indicated an average price over $10. Is this correct?**
HARD CHECK: IF L7a = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF L6 = YES

L7b. Are OAA clients in the home-delivered nutrition program offered the same meal as private pay/fee-for-service customers?

❍ Yes 1

❍ No 0

❍ Don't know ..... d

REQUIRED
ALL

L8. Is your organization a provider of Medicaid nutrition services to the elderly?

Select all that apply

☐ Yes, we are a provider of Medicaid Waiver nutrition services to the elderly 1

☐ Yes, we are a provider of non-waiver Medicaid nutrition services to the elderly 2

☐ No, we do not provide Medicaid Waiver or non-waiver nutrition services to the elderly 0

☐ Don't know ..... d

HARD CHECK: IF L8 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**
HARD CHECK: IF L8 = NO and any other answer category is selected, **No cannot be selected along with other response options.**

SECTION M. NUTRITION EDUCATION AND NUTRITION COUNSELING

The next series of questions are about nutrition education and nutrition counseling services that your organization may provide.

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICE

M1. How many congregate nutrition sites operated by your organization currently provide <u>nutrition education (i.e., presented in a group setting)</u> to eligible program participants? The nutrition education may be offered by your organization or coordinated with another organization.

☐ SITES (0-999)

☐ Don't know ..... d

SOFT CHECK: IF M1 GT 200, You indicated that more than 200 congregate nutrition sites operated by your organization currently provide nutrition education. Is that correct?
HARD CHECK: IF M1 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICE

M2. Currently, what is the availability of <u>nutrition education</u> for home-delivered nutrition program participants? The nutrition education may be offered by your organization or coordinated with another organization.

❍ Available throughout your service area..... 1

❍ Available in a portion of your service area..... 2

❍ Not available in your service area 3

❍ Don't know ..... d

REQUIRED
IF M1 GE 1

M3. How often is nutrition education provided to program participants by your organization or coordinated with another organization?

	CONGREGATE NUTRITION PROGRAM PARTICIPANTS
a. Yearly (1 session per year)	1 ❍
b. Twice per year (2 sessions per year)	1 ❍
c. Quarterly (4 sessions per year)	1 ❍
d. Monthly (12 sessions per year)	1 ❍
e. More than monthly (12+ sessions per year)	1 ❍
f. Other	1 ❍
g. Don't know	d ❍

REQUIRED
IF M2 = 1 OR 2

M3.1 How often is nutrition education provided to program participants by your organization or coordinated with another organization?

	HOME-DELIVERED NUTRITION PROGRAM PARTICIPANTS
a. Yearly (1 session per year)	2 ❍
b. Twice per year (2 sessions per year)	2 ❍
c. Quarterly (4 sessions per year)	2 ❍
d. Monthly (12 sessions per year)	2 ❍
e. More than monthly (12+ sessions per year)	2 ❍
f. Other	2 ❍
g. Don't know	d ❍

REQUIRED
IF M1 GE 1 OR M2 = 1 OR 2

M4. Which of the following does your organization currently use to contribute to the quality of <u>nutrition education</u>?

Select all that apply

- ☐ Use credentialed nutrition professional to conduct education 1
- ☐ Conduct a survey of program participant need 2
- ☐ Use evidence-based education programs 3
- ☐ Use cooperative extension materials 4
- ☐ Use curricula from a reliable, science-based organization (academia, government, American Heart Association, American Diabetic Association) 5
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: IF M4 = NONE OF THE ABOVE AND ANY OTHER ANSWER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **None of the above cannot be selected along with other response options.**
HARD CHECK: IF M4 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICE

M5. How many of your congregate nutrition sites currently provide <u>nutrition counseling</u> (i.e. working one-on-one with an individual to provide support for dietary issues) to eligible program participants? The nutrition counseling may be offered by your organization or coordinated with another organization.

☐ SITES (0-999)

- ☐ Don't know ..... d

SOFT CHECK: IF M1 GT 200, You indicated that more than 200 congregate nutrition sites operated by your organization currently provide nutrition counseling. Is that correct?
HARD CHECK: IF M5 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICE

M6. Currently, what is the availability of <u>nutrition counseling</u> for home-delivered nutrition program participants? The nutrition counseling may be offered by your organization or coordinated with another organization.

- ❍ Available throughout your service area 1
- ❍ Available in a portion of your service area 2
- ❍ Not available in your service area 3
- ❍ Don't know ..... d

REQUIRED
IF M5 GT 0 OR M6 = AVAILABLE THROUGHOUT YOUR SERVICE AREA OR AVAILABLE IN A PORTION OF YOUR SERVICE AREA. ELSE, SKIP TO SECTION N.

M7. How is the current need for <u>nutrition counseling</u> determined?

Select all that apply

- ☐ Nutrition needs assessment 1
- ☐ Nutrition Screening Initiative (NSI) score 2
- ☐ Presence of nutrition related chronic disease 3
- ☐ Food insecurity assessment 4
- ☐ Other criteria 5
- ☐ Don't know ..... d

HARD CHECK: IF M7 = DK AND OTHER CATEGORY IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
IF M5 GT 0 OR M6 = AVAILABLE THROUGHOUT YOUR SERVICE AREA OR AVAILABLE IN A PORTION OF YOUR SERVICE AREA.

M8. Which of the following does your organization currently use to contribute to the quality of nutrition counseling?

Select all that apply

- ☐ Use credentialed nutrition professional to conduct the counseling..... 1
- ☐ Use credentialed non-nutrition professionals to conduct the counseling (e.g., nurses, diabetes educators, etc.)..... 2
- ☐ Use protocols approved by a respected source such as the American Dietetic Association, Patient Education Association, or Association of Diabetic Educators..... 3
- ☐ None of the above..... 4
- ☐ Don't know ..... d

HARD CHECK: IF M8 = NONE OF THE ABOVE AND ANY OTHER ANSWER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **None of the above cannot be selected along with other response options.**
HARD CHECK: IF M8 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF M5 GT 0 OR M6 = AVAILABLE THROUGHOUT YOUR SERVICE AREA OR AVAILABLE IN A PORTION OF YOUR SERVICE AREA.

M9. How frequently is the need for nutrition counseling assessed with Elderly Nutrition Program participants?

Select all that apply

- ☐ At program enrollment/entry only..... 1
- ☐ On a regular basis (e.g., annually) *(Please Specify)* 2

  [ ]
- ☐ When staff notice a change in the participant..... 3
- ☐ Program participant/caregiver/family request 4
- ☐ Healthcare professional request 5
- ☐ Other *(Please Specify)*..... 6

  [ ]
- ☐ Don't know ..... d

HARD CHECK: IF M9 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF M5 GT 0 OR M6 = AVAILABLE THROUGHOUT YOUR SERVICE AREA OR AVAILABLE IN A PORTION OF YOUR SERVICE AREA.

M10. Does your organization have a formal mechanism for following-up with program participants who have had nutrition counseling?

- ❍ Yes 1
- ❍ No 0
- ❍ Don't know ..... d

SECTION N. TITLE III-C ELDERLY NUTRITION PROGRAM CONGREGATE NUTRITION CHARACTERISTICS AND OPERATIONS

The next series of questions are about the characteristics and operations of the congregate nutrition program operated by your organization.

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO O1.

N1. For how many years has your organization offered congregate nutrition services?

☐ YEARS ***(0-99)***

☐ Don't know ..... d

SOFT CHECK: IF N1 GT 50 SHOW VALIDATION MESSAGE, **You indicated your organization has offered congregate nutrition services for more than 50 years. Is that correct?**
HARD CHECK: IF N1 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N2. How many different congregate nutrition sites does your organization currently operate?

☐ NUMBER OF CONGREGATE NUTRITION SITES ***(0-999)***

☐ Don't know ..... d

SOFT CHECK: IF N2 = 0, SHOW VALIDATION MESSAGE, **You have indicated that your organization currently operates 0 congregate nutrition sites. Is this correct?**
SOFT CHECK: **I**F GT 100, SHOW VALIDATION MESSAGE, **You have indicated that your organization operates more than 100 congregate nutrition sites. Is this correct?**
HARD CHECK: IF N2 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N3. How many different congregate nutrition sites offer meals…

	NUMBER OF CONGREGATE NUTRITION SITES	DON'T KNOW
a. More than 5 days per week	☐ *(0-999)*	d ❍
b. Only 5 days per week	☐ *(0-999)*	d ❍
c. Only 4 days per week	☐ *(0-999)*	d ❍
d. Only 3 days per week	☐ *(0-999)*	d ❍
e. Only 2 days per week	☐ *(0-999)*	d ❍
f. Only 1 day per week	☐ *(0-999)*	d ❍

SOFT CHECK: IF GT 100, SHOW VALIDATION MESSAGE, **You have indicated that your organization operates more than 100 congregate nutrition sites that offer meals [more than 5 days per week, only 5 days per week, only 4 days per week, only 3 days per week, only 2 days per week, only 1 day per week]. Is this correct?**
HARD CHECK: IF SUM OF N3a-f GT NUMBER OF CONGREGATE NUTRITION SITES FROM N2 AND N2 DNE DK, SHOW VALIDATION MESSAGE, **The total cannot be more than the number of sites your organization operates.**
HARD CHECK: IF N3a-f = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N4. How many different congregate nutrition sites offer…

	NUMBER OF CONGREGATE NUTRITION SITES	DON'T KNOW
a. Breakfast	☐☐☐ *(0-999)*	d ❍
b. Lunch	☐☐☐ *(0-999)*	d ❍
c. Dinner	☐☐☐ *(0-999)*	d ❍

SOFT CHECK: IF GT 100, SHOW VALIDATION MESSAGE, **You have indicated that more than 100 congregate nutrition sites offer [breakfast, lunch, dinner]. Is this correct?**
HARD CHECK: IF ANY INDIVIDUAL ROW N4a-c GT NUMBER OF CONGREGATE NUTRITION SITES FROM N2, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of sites your organization operates.**
HARD CHECK: IF N4a-c = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N5. How many different congregate nutrition sites offer meals on weekends?

☐☐☐ NUMBER OF CONGREGATE NUTRITION SITES *(0-999)*

☐ Don't know ..... d

SOFT CHECK: IF GT 100, SHOW VALIDATION MESSAGE, **You have indicated that more than 100 congregate nutrition sites offer meals on weekends. Is this correct?**
HARD CHECK: IF N5 GT NUMBER OF CONGREGATE NUTRITION SITES FROM N2, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of sites your organization operates.**
HARD CHECK: IF N5 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N6. How many different congregate nutrition sites meet the Americans with Disabilities Act standards for accessible design?

☐ NUMBER OF CONGREGATE NUTRITION SITES ***(0-999)***

☐ Don't know ..... d

SOFT CHECK: IF GT 100, SHOW VALIDATION MESSAGE, **You have indicated more than 100 different congregate nutrition sites meet the American with Disabilities Act standards for accessible design. Is this correct?**
HARD CHECK: IF N6 GT NUMBER OF CONGREGATE NUTRITION SITES FROM N2, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of sites your organization operates.**
HARD CHECK: IF N6 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N7. How many total individuals <u>can</u> your organization serve at one lunch meal in the congregate nutrition program? Please include all congregate nutrition sites and calculate the maximum number of lunches that can be served in one sitting if all sites are open and operating.

☐ MAXIMUM NUMBER OF INDIVIDUALS ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF N7 GT 5000 SHOW VALIDATION MESSAGE, **You indicated that your organization can serve more than 5,000 individuals at one lunch meal. Is this correct?**
HARD CHECK: IF N7 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N7a. How many individuals <u>can</u> your largest congregate nutrition site serve at one lunch meal?

☐ MAXIMUM NUMBER OF INDIVIDUALS ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF GT 500, SHOW VALIDATION MESSAGE, **You indicated your largest congregate nutrition site can serve more than 500 people at one lunch meal. Is this correct?**
HARD CHECK: IF N7a GT NUMBER OF INDIVIDUALS FROM N7, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of individuals your organization can serve.**
HARD CHECK: IF N7a = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N7b. How many individuals <u>can</u> your smallest congregate nutrition site serve at one lunch meal?

☐ MAXIMUM NUMBER OF INDIVIDUALS ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF GT 100, SHOW VALIDATION MESSAGE, **You indicated your smallest congregate nutrition site can serve more than 100 people at one lunch meal. Is this correct?**
HARD CHECK: IF N7b GT NUMBER OF INDIVIDUALS FROM N7, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of individuals your organization can serve.**
HARD CHECK: IF N7b GT NUMBER OF INDIVIDUALS FROM N7a, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of individuals your largest congregate nutrition site can serve.**
HARD CHECK: IF N7b = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N8. How many <u>total lunches</u> did your organization serve last week?

☐ NUMBER OF LUNCHES ***(0-99999)***

☐ Don't know ..... d

SOFT CHECK: IF GT 5000, SHOW VALIDATION MESSAGE, **You indicated your organization served more than 5,000 meals last week. Is this correct?**
HARD CHECK: IF N8 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N9. How many of your agency's congregate nutrition sites have closed, opened, reduced or expanded in the last 3 years?

	NUMBER OF SITES	DON'T KNOW
a. Number of sites that have closed	☐ ***(0-999)***	d ❍
b. Number of sites that have reduced service (fewer days open, fewer meals served)	☐ ***(0-999)***	d ❍
c. Number of sites that have opened	☐ ***(0-999)***	d ❍
d. Number of sites that have expanded service (more days open, more meals served)	☐ ***(0-999)***	d ❍

SOFT CHECK: IF any N9 GT 100 SHOW VALIDATION MESSAGE, **You have indicated that more than 100 [sites that have closed, sites that have reduced service, sites that have opened, sites that have expanded service]. Is this correct?**
HARD CHECK: IF N9 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N10. Which of the following methods are used for meal production in your congregate nutrition sites?

	YES	NO	DON'T KNOW
a. Central kitchen	1 ❍	0 ❍	d ❍
b. On-site production	1 ❍	0 ❍	d ❍
c. Catering/vendor contract	1 ❍	0 ❍	d ❍
d. Restaurant vouchers	1 ❍	0 ❍	d ❍

HARD CHECK: ONE RESPONSE MUST BE SELECTED IN EACH ROW, **One response must be selected in each row.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N11. Which of the following best describes the menu provided by your congregate nutrition program?

- ❍ Set menu that does not offer the participant any choice of food items ... 1
- ❍ Choice of different complete meal options (ex. Meal A or Meal B) 2
- ❍ A choice of different food items within the meal (ex. Choice of entrée, choice of vegetables, fruit, dessert, salad bar)..... 3
- ❍ Don't know..... d

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N12. Are any sites that offer congregate nutrition services operated for specific populations, religious, cultural or ethnic groups (e.g., Somali, Chinese, Buddhist, or Orthodox Jewish communities)?

- ❍ Yes..... 1
- ❍ No 0
- ❍ Don't know..... d

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N13. Which of the following special or therapeutic diets does your organization offer in the congregate nutriton program?

Select all that apply

- ☐ Diabetic 1
- ☐ Low sodium/salt 2
- ☐ Modified texture 3
- ☐ Vegetarian 4
- ☐ Kosher 5
- ☐ Halal 6
- ☐ Do not offer special or therapeutic diets 7
- ☐ Other *(Please Specify)* 8

  [ ]

- ☐ Don't know ..... d

HARD CHECK: IF N13 = Do not offer special or therapeutic diets AND ANY OTHER ANSWER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **Do not offer special or therapeutic diets cannot be selected along with other response options.**
HARD CHECK: IF N13 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES.

N14. What is the recommended contribution for congregate nutrition program participants for a single meal?

[ ] RECOMMENDED CONTRIBUTION ***(0-9.99)***

- ☐ No dollar amount is recommended 0
- ☐ Don't know ..... d

SOFT CHECK: IF N14 GT 5.00, SHOW VALIDATION, **You indicated the recommended contribution for congregate nutrition program participants is more than $5 for a single meal. Is that correct?**
HARD CHECK: IF N14 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**
HARD CHECK: IF N14 = DK AND NUMBER IS ENTERED SHOW VALIDATION MESSAGE, Don't know cannot be selected if a number is entered.
HARD CHECK: IF N14 = NO DOLLAR AMOUNT IS RECOMMENDED AND NUMBER IS ENTERED SHOW VALIDATION MESSAGE, No dollar amount is recommended cannot be selected if a number is entered.

REQUIRED
IF G1 OR G1.1 = YES FOR CONGREGATE NUTRITION PROGRAM

N15. How many people are currently on the waiting list for the congregate nutrition program?

☐ PEOPLE ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF LT 1, SHOW VALIDATION MESSAGE, **You have indicated that there are currently 0 people on the waiting list. Is this correct?**
SOFT CHECK: IF GT 1000, SHOW VALIDATION MESSAGE, **You have indicated that there are currently more than 1000 people on the waiting list. Is this correct?**
HARD CHECK: IF N15 = DK AND NUMBER IS ENTERED SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
IF N15 GE 1

N16. What is the longest time a person has been on the current congregate nutrition program waiting list in your service area?

☐ DAYS/WEEKS/MONTHS/YEARS [DROP DOWN BOX]

☐ Don't know ..... d

SOFT CHECK: IF GT 5 YEARS, SHOW VALIDATION MESSAGE, **You have indicated that the longest time a person has been on the current waiting list is more than 5 years. Is this correct?**
HARD CHECK: IF LT 1 DAY OR GT 10 YEARS, SHOW VALIDATION MESSAGE, **The length of time on the waiting list must be between 1 day and 10 years.**
HARD CHECK: IF NUMBER FIELD IS FILLED BUT DROP DOWN IS NOT SELECTED, SHOW VALIDATION MESSAGE, **Please select days, weeks, months or years from the drop down menu.**
HARD CHECK: IF N16 = DK AND NUMBER IS ENTERED SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF G1 OR G1.1 = YES FOR CONGREGATE NUTRITION PROGRAM

N17. On average, how often is the waiting list for the congregate nutrition program checked for duplicates and those no longer eligible or in need and then updated?

- ❍ Weekly 1
- ❍ Monthly 2
- ❍ Quarterly 3
- ❍ Semi-annually 4
- ❍ Yearly 5
- ❍ Never 0
- ❍ Other (*Please Specify*) 6

  [ ]
- ❍ Don't know ..... d

SECTION O. TITLE III-C ELDERLY NUTRITION PROGRAM HOME-DELIVERED NUTRITION CHARACTERISTICS AND OPERATIONS

The next series of questions are about the characteristics and operations of the home-delivered nutrition program operated by your organization.

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES. ELSE SKIP TO SECTION P.

O1. For how many years has your organization offered home-delivered nutrition services?

☐ YEARS ***(0-99)***

☐ Don't know ..... d

SOFT CHECK: IF O1 GT 50 SHOW VALIDATION MESSAGE, **You indicated your organization has offered home-delivered nutrition services for more than 50 years. Is that correct?**
HARD CHECK: IF O1 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O2. Which meals does your organization provide in home-delivered nutrition services?

Select all that apply

☐ Breakfast 1

☐ Lunch 2

☐ Dinner 3

☐ Don't know ..... d

HARD CHECK: IF O2 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O3. How many clients can your organization provide meals to through home-delivered nutrition services for a single meal?

☐ MAXIMUM NUMBER OF CLIENTS ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF O3 GT 1,000 SHOW VALIDATION MESSAGE, **You indicated that your organization can provide meals to more than 1000 clients for a single meal. Is this correct?**
HARD CHECK: IF O3 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be** selected **if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O3a. On an average day when your organization makes deliveries, how many clients receive meals through home-delivered nutrition services for a single meal?

☐ NUMBER OF CLIENTS SERVED ON AN AVERAGE DAY ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF O3a GT 1,000 SHOW VALIDATION MESSAGE, You indicated that on an average day, more than 1000 clients receive meals through home-delivered nutrition services for a single meal**. Is this correct?**
HARD CHECK: IF O3a GT NUMBER OF INDIVIDUALS FROM O3, SHOW VALIDATION MESSAGE, **Please enter a number that does not exceed the number of individuals your organization can serve.**
HARD CHECK: IF O3a = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O4. How many days per week are meal deliveries made to clients' homes?

☐ NUMBER OF DAYS PER WEEK ***(0-7)***

☐ Don't know ..... d

HARD CHECK: IF O4 GT 7, SHOW VALIDATION MESSAGE, **The number of days per week cannot be greater than seven.**
HARD CHECK: IF O4 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O4a. How many meals are usually provided to a client at each visit?

☐ NUMBER OF MEALS PROVIDED AT ONE VISIT ***(1-99)***

☐ Don't know ..... d

SOFT CHECK: IF O4a GT 5 SHOW VALIDATION MESSAGE, **You indicated that clients receive more than 5 meals each visit. Is this correct?**
HARD CHECK: IF O4a LT 1 OR GT 10, SHOW VALIDATION MESSAGE, **Please enter a number between 1 and 10.**
HARD CHECK: IF O4a = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O4b. Are meal deliveries made to clients' homes on the weekends?

❍ Yes..... 1

❍ No 0

❍ Don't know..... d

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O5. How many of the following types of meals were delivered in your most recently completed week in the home-delivered nutrition program?

	NUMBER OF MEALS	DON'T KNOW
a. Hot meals	☐ *(0-9999)*	d ❍
b. Frozen meals	☐ *(0-9999)*	d ❍
c. Cold meals	☐ *(0-9999)*	d ❍
d. Shelf stable meals	☐ *(0-9999)*	d ❍
e. Combination	☐ *(0-9999)*	d ❍
f. Other *(Please Specify)* ☐	☐ *(0-9999)*	d ❍

SOFT CHECK: IF any O5 GT 1000 SHOW VALIDATION MESSAGE, You have entered more than 1000 [hot meals, frozen meals, cold meals, shelf stable meals, combination, other meals]. Is this correct?
HARD CHECK: IF O5a-f = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O6. What is the total mileage on the longest route for which your organization provides home-delivered nutrition services?

☐ MILES *(0-999)*

☐ Don't know ..... d

SOFT CHECK: IF O6 GT 300, SHOW VALIDATION MESSAGE, **You indicated your longest route is over 300 miles. Is this correct?**
HARD CHECK: IF O6 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O6a. What is the total mileage on the shortest route for which your organization provides home-delivered nutrition services?

☐ MILES ***(0-999)***

☐ Don't know ..... d

SOFT CHECK: IF O6a GT 100, SHOW VALIDATION MESSAGE, **You indicated your shortest route is over 100 miles. Is this correct?**
HARD CHECK: IF O6a = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**
HARD CHECK: IF O6a GT MILES FROM O6 AND O6 DNE DON'T KNOW, **Please enter a number that does not exceed the total mileage on the longest route.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O7. Have you increased or started using frozen meals in your home-delivered nutrition program <u>in the past 3 years</u>?

❍ Yes..... 1

❍ No 0

❍ Don't know ..... d

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O8. Which of the following changes has your agency's home-delivered nutrition program experienced <u>in the past 3 years</u>?

Select all that apply

- ☐ Service area has been reduced 1
- ☐ Frequency of meal delivery has been reduced 2
- ☐ Number of meals delivered per customer has been reduced 3
- ☐ Service area has been expanded 4
- ☐ Frequency of meal delivery has been increased 5
- ☐ Number of meals served per customer has been increased 6
- ☐ None of the above 0
- ☐ Don't know ..... d

HARD CHECK: IF O8 = NONE OF THE ABOVE AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **None of the above cannot be selected along with other response options.**
HARD CHECK: IF O8 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O9. Which of the following methods are used for meal production in your home-delivered nutrition program?

	YES	NO	DON'T KNOW
a. Central kitchen	1 ❍	0 ❍	d ❍
b. On-site production (e.g., CM site)	1 ❍	0 ❍	d ❍
c. Catering/vendor contract including restaurants	1 ❍	0 ❍	d ❍

HARD CHECK: ONE RESPONSE MUST BE SELECTED IN EACH ROW, **One response must be selected in each row.**

REQUIRED

IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O10. Which of the following best describes the menu provided by your home-delivered nutrition program?

- ❍ Set menu that does not offer the participant any choice of food items.....1
- ❍ Choice of different complete meal options (ex. Meal A or Meal B).....2
- ❍ A choice of different food items within the meal (ex. Choice of entrée, choice of vegetables, fruit, dessert).....3
- ❍ Don't know .....d

REQUIRED

IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O11. Which of the following special or therapeutic diets does your organization offer in the home-delivered nutriton program?

Select all that apply

- ☐ Diabetic 1
- ☐ Low sodium/salt 2
- ☐ Modified texture.....3
- ☐ Vegetarian.....4
- ☐ Kosher.....5
- ☐ Halal.....6
- ☐ Other *(Please Specify)*.....7

  [ ]
- ☐ Do not offer special or therapeutic diets 0
- ☐ Don't know .....d

HARD CHECK: IF O11 = DO NOT OFFER SPECIAL OR THERAPEUTIC DIETS and any other answer category is selected, **Do not offer special or therapeutic diets cannot be selected along with other response options.**

HARD CHECK: IF O11 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES.

O12. What is the recommended contribution for home-delivered nutrition program participants?

	RECOMMENDED CONTRIBUTION ***(0-9.99)***
☐	No dollar amount is recommended 0
☐	Don't know ..... d

SOFT CHECK: IF O12 GT 5.00, SHOW VALIDATION, **You indicated the recommended contribution is greater than $5.00. Is that correct?**
HARD CHECK: IF O12 = DON'T KNOW and any other answer category is selected, **Don't know cannot be selected along with other response options.**
HARD CHECK: IF O12 = DK AND NUMBER IS ENTERED SHOW VALIDATION MESSAGE, Don't know cannot be selected if a number is entered.
HARD CHECK: IF O12 = NO DOLLAR AMOUNT IS RECOMMENDED AND NUMBER IS ENTERED SHOW VALIDATION MESSAGE, No dollar amount is recommended cannot be selected if a number is entered.

REQUIRED
IF G1 OR G1.2 = YES FOR HOME-DELIVERED NUTRITION PROGRAM

O13. How many people are currently on the waiting list for the home-delivered nutrition program in your service area?

	PEOPLE ***(0-9999)***
☐	Don't know ..... d

SOFT CHECK: IF LT 1, SHOW VALIDATION MESSAGE, **You have indicated that there are currently 0 people on the waiting list. Is this correct?**
SOFT CHECK: IF GT 1000, SHOW VALIDATION MESSAGE, **You have indicated that there are currently more than 1000 people on the waiting list. Is this correct?**
HARD CHECK: IF O13 = DK AND NUMBER IS ENTERED SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF O13 GE 1.

O14. What is the longest time a person has been on the current home-delivered nutrition program waiting list in your service area?

[ ] DAYS/WEEKS/MONTHS/YEARS [DROP DOWN BOX]

☐ Don't know ..... d

SOFT CHECK: IF GT 5 YEARS, SHOW VALIDATION MESSAGE, **You have indicated that the longest time a person has been on the current waiting list is more than 5 years. Is this correct?**
HARD CHECK: IF LT 1 DAY OR GT 10 YEARS, SHOW VALIDATION MESSAGE, **The length of time on the waiting list must be between 1 day and 10 years.**
HARD CHECK: IF NUMBER FIELD IS FILLED BUT DROP DOWN IS NOT SELECTED, SHOW VALIDATION MESSAGE, **Please select days, weeks, months or years from the drop down menu.**
HARD CHECK: IF O14 = DK AND NUMBER IS ENTERED SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF G1 OR G1.2 = YES FOR HOME-DELIVERED NUTRITION PROGRAM

O15. On average, how often is the waiting list for the home-delivered nutrition program checked for duplicates and those no longer eligible or in need and then updated?

❍ Weekly 1

❍ Monthly 2

❍ Quarterly 3

❍ Semi-annually 4

❍ Yearly 5

❍ Never 0

❍ Other *(Please Specify)* 6

[ ]

❍ Don't know ..... d

SECTION P. FOOD SAFETY

REQUIRED
ALL

P1. Does your organization or caterer currently have a food service license for its production facilities?

- ❍ Yes.....1
- ❍ No.....0
- ❍ Don't know.....d

REQUIRED
ALL

P2. Are the food service personnel for the Elderly Nutrition Program in your service area currently required to have food safety and sanitation training?

- ❍ Yes.....1
- ❍ No.....0
- ❍ Don't know.....d

REQUIRED
ALL

P3. To which of the following entities is your organization currently required to report food borne illness incidents in the Elderly Nutrition Program?

Select all that apply

- ☐ AAA.....1
- ☐ State Unit on Aging.....2
- ☐ State or Local Department of Health.....3
- ☐ Other.....4
- ☐ No requirement to report food borne illness.....0
- ☐ Don't know.....d

HARD CHECK: IF P3 = No requirement to report food borne illness AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **No requirement to report food borne illness cannot be selected along with other response options.**
HARD CHECK: IF P3 = DK AND ANY OTHER CATEGORY IS SELECTED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected along with other response options.**

REQUIRED
IF A1 INCLUDES CONGREGATE NUTRITION SERVICES. ELSE SKIP TO P6.

P4. **<u>In the past 3 years</u>, how many different times was the food served in the congregate nutrition program associated with an outbreak of food borne illness?**

☐ TIMES ***(0-99)***

☐ Don't know ..... d

SOFT CHECK: IF GT 10, SHOW VALIDATION MESSAGE, **You have indicated that food served in the congregate nutrition program was associated with an outbreak of food borne illness more than 10 times in the past 3 years. Is this correct?**
HARD CHECK: IF P4 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF P4 GT 0

P5. **In total, how many congregate nutrition program participants got sick in the past 3 years?**

☐ CONGREGATE NUTRITION PROGRAM PARTICIPANTS ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF GT 100, SHOW VALIDATION MESSAGE, **You have indicated that more than 100 congregate nutrition program participants got sick in the past 3 years. Is this correct?**
HARD CHECK: IF P4 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF A1 INCLUDES HOME-DELIVERED NUTRITION SERVICES. ELSE SKIP TO Q1.

P6. **<u>In the past 3 years</u>, how many different times was food served in the home-delivered nutrition program associated with an outbreak of food borne illness?**

☐ TIMES ***(0-99)***

☐ Don't know ..... d

SOFT CHECK: IF GT 10, SHOW VALIDATION MESSAGE, **You have indicated that food served in the home-delivered nutrition program was associated with an outbreak of food borne illness more than 10 times in the past 3 years. Is this correct?**
HARD CHECK: IF P6 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

REQUIRED
IF P6 GT 0

P7. **In total, how many home-delivered nutrition program participants got sick in the past 3 years?**

☐ HOME-DELIVERED NUTRITION PROGRAM PARTICIPANTS ***(0-9999)***

☐ Don't know ..... d

SOFT CHECK: IF GT 100, SHOW VALIDATION MESSAGE, **You have indicated that more than 100 home-delivered nutrition program participants got sick in the past 3 years. Is this correct?**
HARD CHECK: IF P7 = DK AND NUMBER IS ENTERED, SHOW VALIDATION MESSAGE, **Don't know cannot be selected if a number is entered.**

SECTION Q. CONTACT INFORMATION

Q1. Please provide contact information for the person who completed this questionnaire.

REQUIRED
ALL

Contact First Name	
Contact Last Name	
Title or Role in local service provider organization	
Email Address	
Telephone Number	

HARD CHECK: IF TELEPHONE IS LT OR GT 10 DIGITS, SHOW VALIDATION, **Please enter a valid telephone number.**

THANK YOU FOR COMPLETING THIS SURVEY. WE VALUE YOUR PARTICIPATION.