

**Please Print the Following Information:**

Facility Name \_\_\_\_\_  
Admission Date \_\_\_\_\_ Region \_\_\_\_\_ SP ID# \_\_\_\_\_  
Round \_\_\_\_\_ Target Interviewer \_\_\_\_\_ Target PSU \_\_\_\_\_

**MEDICARE  
CURRENT BENEFICIARY SURVEY  
FACILITY SCREENER**

Good (morning/afternoon). My name is\_\_\_\_\_. I am from Westat, a survey research company in Rockville, MD. We are conducting the Medicare Current Beneficiary Survey for the Centers for Medicare and Medicaid Services (CMS), part of the United States Department of Health and Human Services. We are studying a sample of people eligible for Medicare who live in community and facility settings.

I am contacting you to confirm information that a person in our sample has moved to (FACILITY NAME).

Q1. Does (SP) currently live at (FACILITY NAME)?

- YES ..... 1 (Q3)
- NO ..... 2 (Q2)
- DK ..... 3 (Ask to speak to  
..... someone who  
..... would know  
..... admission  
..... information)

Q2. Since (LAST INTERVIEW DATE/JANUARY 1, (CURRENT YEAR), has (SP) lived (here/there)?

- YES ..... 1 (INSTR1)
- NO ..... 2 (CLOSING 3)
- DK ..... 3 (Ask to speak to  
..... someone who  
..... would know  
..... admission  
..... information)

INSTR1. IF SUPPLEMENTAL SAMPLE, GO TO Q4.  
OTHERWISE, CONTINUE.



Q6. What type of facility/place is this?  
**USE CATEGORIES AS PROBES IF NECESSARY.**  
 (Is this a .....)

- |  |    |      |
|--|----|------|
| CONTINUING CARE RETIREMENT COMMUNITY (CCRC)                    | 1  | (Q7) |
| RETIREMENT COMMUNITY   | 2  | (Q7) |
| ADULT/GROUP HOME   | 3  | (Q8) |
| NURSING HOME/UNIT WITHIN A CCRC OR RETIREMENT CENTER           | 4  | (Q9) |
| HOSPITAL-BASED SNF UNIT  | 5  | (Q9) |
| ASSISTED LIVING FACILITY                                       | 6  | (Q9) |
| BOARD AND CARE HOME  | 7  | (Q9) |
| DOMICILIARY CARE HOME  | 8  | (Q9) |
| PERSONAL CARE HOME   | 9  | (Q9) |
| REST HOME/RETIREMENT HOME                                      | 10 | (Q9) |
| MENTAL HEALTH CENTER/PsYCHIATRIC SETTING                       | 11 | (Q9) |
| INSTITUTION FOR THE MENTALLY RETARDED/DEVELOPMENTALLY DISABLED | 12 | (Q9) |
| REHABILITATION FACILITY  | 13 | (Q9) |
| OTHER LONG-TERM CARE FACILITY (SPECIFY)                        | 14 | (Q9) |

\_\_\_\_\_ 15 (CLOSING 2)  
 PRIVATE RESIDENCE.....

Q7. What is the name of the specific place within (FACILITY NAME) where (SP) was residing on or around [ADMISSION DATE/JANUARY 1, (CURRENT YEAR)]?

\_\_\_\_\_ (Q9)  
**SPECIFIC PLACE NAME**

Q8. Are residents placed in this facility by an agency of state, county, or local government?

- |           |   |       |
|-----------|---|-------|
| YES ..... | 1 | (Q10) |
| NO .....  | 2 | (Q9)  |

Q9. What is the name of the facility administrator?

\_\_\_\_\_ (CLOSING 1)  
**FACILITY ADMINISTRATOR'S NAME**

Q10. Please give me the name, address, and telephone number of the person who is responsible for the oversight of (SP's) care.

ADDRESS

NAME: \_\_\_\_\_

PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

(CLOSING 1)

CLOSING 1

Thank you very much for your time. I will mail some information to (you/your facility administrator/NAME IN Q9) explaining the study in detail.

CLOSING 2

TELEPHONE SCREENER:

Thank you very much for your time. A professional interviewer will contact (you/SP) within the next few weeks to arrange for an interview.

IN PERSON SCREENER:

Thank you very much for your time. We will contact (you/SP) to arrange an interview. CONTACT YOUR SUPERVISOR FOR PROCEDURES.

CLOSING 3

Thank you very much for your time.

We will contact you if there are additional questions.