Appendix C

REV.OAHMP Client Program Questionnaire

(Baseline and Post-Modification)

Older Adults Home Modification Program
Client Program Questionnaire[1]

Study ID			Visit	Today's Date (mm/dd/yyyy)	Form Completed By:	
Site ID	Field Team ID	Client ID			Name	Job Title
			☐ Baseline ☐ Follow-Up			*(dropdown menu: OT, OTA, CAPS, other [Specify])Include Program Manager as option at followup*

(At baseline) **Note: THIS FORM SHOULD ONLY BE COMPLETED BY AN OT/OTA/CAPS.**

(Baseline: If client eligibility form is not complete): **WARNING: DO NOT ENTER DATA INTO THIS FORM UNTIL YOU HAVE COMPLETED THE CLIENT ELIGIBILITY FORM.**

OMB Control No. 2528-0335, expiration date 5/31/25. This form is designed to provide HUD with information about the effectiveness of its Older Adults Home Modification Grant Program is. The information the client provides is voluntary. The client's home can be enrolled in the program whether they decide to participate in the evaluation or not. The public reporting burden for collection of this information is estimated to be 6 minutes per response. HUD may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number.

*Grantee Instructions: Administer this questionnaire only to a **client you have enrolled in the OAHM Program, i.e., the beneficiary receiving direct services from your program who has been identified as the client by the licensed occupational therapist (OT), or a licensed OT Assistant (OTA) or Certified Aging-in-Place Specialist (CAPS) whose work is overseen by a licensed OT**. Make sure this client's information has been correctly entered into Item 9 of the Client Eligibility Documentation Form. For each question, do not give "not answered" as an answer choice. Instead, gently probe for answers and record "not answered" as a last resort.*

Section A: ACTIVITIES OF DAILY LIVING (Source: National Health and Aging Trends Survey [NHATS], Round 12, 2024)

Read Verbatim:

"The next few questions are about your ability to do everyday activities without help. By help, I mean either the help of another person, including the people who live with you, or the help of special equipment."

Check only one answer per question.

	No	Yes	Can't Do/ Don't Do	Don't Know	Refused
A.1 Do you have any problem eating without the help of another person or special equipment?	☐	☐	☐	☐	☐
A.2 Do you have any problem getting in or out of bed without help?	☐	☐	☐	☐	☐
A.3 Do you have any problem getting in or out of chairs without help?	☐	☐	☐	☐	☐
A.4 Do you have any problem walking around inside without help?	☐	☐	☐	☐	☐
A.5 Do you have any problem going outside without the help of another person or special equipment?	☐	☐	☐	☐	☐

[1] Code for this document: Black font=Question asked of the person being interviewed; *Blue italics* = Instruction for the interviewer; "**Black bold in quotes**"=Script for interviewer; *yellow highlighted italics*: Instruction for REDCap programmer.

A.6 Do you have any problem dressing without help?	☐	☐	☐	☐	☐
A.7 Do you have any problem bathing without help?	☐	☐	☐	☐	☐
A.8 Do you have any problem getting to the bathroom or using the toilet?	☐	☐	☐	☐	☐
If any of the 8 questions were not answered, try to obtain answers.					

Section B: INSTRUMENTAL ACTIVITIES OF DAILY LIVING (Source: National Health and Aging Trends Survey (NHATS), Round 12, 2024, pp. 536-537)

Check only one answer per question.

IF CLIENT DOES NOT DO, BUT IS ABLE TO DO AN ACTIVITY, SELECT "YES" FOR THE ACTIVITY

	Yes	No	Can't Do/ Don't Do	Don't Know	Refused
B.1 Are you able to prepare meals without help?	☐	☐	☐	☐	☐
B.2 Are you able to do laundry without help?	☐	☐	☐	☐	☐
B.3 Are you able to do light housework such as washing dishes?	☐	☐	☐	☐	☐
B.4 Are you able to shop for groceries without help?	☐	☐	☐	☐	☐
B.5 Are you able to manage money, such as keeping track of bills and handling cash?	☐	☐	☐	☐	☐
B.6 Are you able to take medicine without help?	☐	☐	☐	☐	☐
B.7 Are you able to make telephone calls without help?	☐	☐	☐	☐	☐
If any of the 7 questions were not answered, try to obtain answers.					

Section C: Falls Efficacy Scale (Tinetti et al., 1990) *CARD A - Falls Scale*

Hand the client Answer Card A. **"On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you can do the following activities without falling? Please give me a number on a scale of 1 to 10."**

For each question, enter the number between 1 and 10 the person answers or points to on Card C. Enter "0" if the client doesn't answer the question..

Question	Answer *(range 0-10)*
C.1 How confident are you taking a bath or shower without falling	
C.2 How confident are you about reaching into cabinets or closets without falling	
C.3 How confident are you walking around the house without falling	
C.4 How confident are you preparing meals, that don't require carrying heavy or hot objects, without falling	
C.5 How confident are you getting in and out of bed without falling	
C.6 How confident are you answering the door or telephone without falling	
C.7 How confident are you getting in and out of chairs without falling	
C.8 How confident are you getting dressed and undressed without falling	
C.9 How confident are you with personal grooming (for example, washing your face) without falling	

C.10 How confident are you getting on and off the toilet without falling	
If any of questions C.1 through C.10 were not answered, try to obtain answers. Enter "0" if the client still declines to answer.	

Section D: Falls and Non-Fall Injuries in the Past Year

Read Verbatim: **"A fall is when your body goes to the ground without being pushed." (CMS HOS)**

D.1 In the past 12 months, how many times have you fallen? BRFSS 2020 CFAL.01	Number of times *(REDCap: Range 0-75.If answer=0, go to D.6.* *Enter 76 if the person fell more than 75 times* ☐ Not answered *(Go to D.6)*
D.2 How many of these falls occurred while you were inside your home or on your property (for example, in your yard or your driveway)?	☐ None *(Go to D.6)* ☐ Number of falls *(This number must be ≤ number provided in D.1)* *(Go to D.2a)* ☐ Not answered *(Go to D.6)*
D.3 Can you please list the approximate date(s) that you fell inside your home or on your property in the past year?	*Record all dates; month and year are sufficient if client doesn't remember exact date.* *(open ended response listing dates)* ☐ Not answered
D.3.a Where in your home or on your property did you fall? *Check all that apply*	☐ Bathroom ☐ Kitchen ☐ Living room ☐ Dining room ☐ Bedroom ☐ Other room (Specify):_ ☐ My driveway ☐ My yard ☐ Other outdoor location on my property (Specify):_____
D.4 What was/were the main reason(s) you fell inside your home or on your property? *Do not read answer choices to client. Check all that client mentions.*	☐ You tripped or stumbled or slipped ☐ You were not paying attention ☐ You had nothing to hold on to ☐ You blacked out or fainted ☐ You lost your balance ☐ You hurried too much ☐ You had an issue with your hearing ☐ You were exercising ☐ You had an issue with your vision ☐ The lighting was poor ☐ You were getting up after sitting/lying down ☐ You were walking up/down stairs ☐ You had slow reactions or reflexes ☐ You had weakness or numbness in one or both legs ☐ You had a problem with medicine ☐ You drank too much alcohol ☐ You had a problem using a walker, cane or other aid that helps you get around ☐ You had a problem with shoes, sandals, or socks ☐ You had a health condition ☐ Another reason not yet mentioned Specify:_____

	☐ Not answered
D.5 "How many of these falls caused an injury that limited your regular activities for at least a day or caused you to go to see a doctor? BRFSS 2020 CFAL.02	☐ None ☐ Number of falls _____ [76 = 76 or more] ☐ Don't know/Not sure ☐ Refused to answer
D.6 In the past 12 months, have you had a non-fall injury in your home or on your property? *If client answers yes - ask what type of injury and enter the number of times the injury occurred.*	☐ None *(End Interview)* ☐ Burn ☐ Cut ☐ Struck by /dropped object (e.g., pot, chair, door) ☐ Other. Please describe: _____ ☐ Not answered
D.6a Where in your home or on your property did the injury occur? *Check all that apply*	☐ Bathroom ☐ Kitchen ☐ Living room ☐ Dining room ☐ Bedroom ☐ Other room (Specify)" _____ ☐ My driveway ☐ My yard ☐ Other outdoor location on my property (Specify):_____ ☐ Not answered
D.7 "How many of these non-fall injuries limited your regular activities for at least a day or caused you to go to see a doctor? BRFSS 2020 CFAL.02	☐ None ☐ Number of injuries _____ [76 = 76 or more] ☐ Don't know/Not sure ☐ Refused to answer

CLIENT PROGRAM QUESTIONNAIRE ANSWER CARDS

PROGRAM QUESTIONNAIRE ANSWER CARD A

Scale of 1 to 10:

1--------2--------3--------4--------5--------6--------7--------8--------9--------10

Very Confident

Not Confident At All