

AGENCY ID: _____
AGENCY NAME: _____
PATIENT ID: _____
PATIENT NAME: _____

FORM ___ OF ___

**MEDICAL EXPENDITURE SURVEY
MEDICAL PROVIDER SURVEY**

**HOME CARE PROVIDER BOOKLET
FOR NON-HEALTH CARE PROVIDERS**

PANEL 1 - YEAR 1

1. During calendar year 1996, what was the (first/next) month during which your records show that services were provided in (PATIENT NAME)'s home?

MONTH: _____

2. I need to know which type or types of persons provided services at (PATIENT NAME)'s home during (MONTH) and either the number of hours or the number of visits for each type.

HOURS: VISITS:

_____	OR	_____

EXPLAIN IF NECESSARY: By type of person I mean a housekeeper, therapist, nurse aide, yard worker, and so forth.

3. I need a description of the services provided during (MONTH).

- CLEANING OR YARD WORK..... 1
- TRANSPORTATION 2
- SHOPPING 3
- EMOTIONAL SUPPORT PERSON OR
ONE-ON-ONE BUDDY..... 4
- SUPPORT GROUPS 5
- CHILD CARE 6
- OTHER (SPECIFY):
_____ 7

4. What were the charges for the services provided to (PATIENT NAME) during (MONTH)?

TOTAL CHARGES: \$_____.

5a. Who paid your organization for the charges during (MONTH)?
CHECK ALL THAT APPLY

Patient or patient's family \$_____.

Medicare \$_____.

5b. ASK FOR EACH SOURCE OF PAYMENT CHECKED:
How much did (SOURCE OF PAYMENT) pay?

Medicaid \$_____.

Private Insurance \$_____.

VA \$_____.

CHAMPVA/CHAMPUS \$_____.

OTHER (SPECIFY):
_____ \$_____.

6. IF NOT VOLUNTEERED, ASK: And what was the total of all payments received for (MONTH)?
[IF NOT AVAILABLE, COMPUTE.]

TOTAL PAYMENTS: \$_____.

BOX 1
DO TOTAL PAYMENTS (Q6) EQUAL TOTAL CHARGES (Q4)?
YES..... 1 (Q8)
NO 2 (Q7)

7. It appears that the total payments were (less than/more than) total charges. What is the reason for that discrepancy? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]

PAYMENTS LESS THAN CHARGES:		YES	NO
Adjustment or discount			
Medicare or Medicaid limit or adjustment.....	1		2
Contractual arrangement with insurer or managed care organization ...	1		2
Courtesy discount.....	1		2
Insurance write-off.....	1		2
Other (Specify:) 1		2
Expecting additional payment			
Patient or Patient's Family.....	1		2
Medicare.....	1		2
Medicaid.....	1		2
Private Insurance.....	1		2
VA.....	1		2
CHAMPVA/CHAMPUS.....	1		2
Other (Specify:) 1		2
Charity care or sliding scale.....	1		2
Bad debt.....	1		2
PAYMENTS MORE THAN CHARGES:			
Medicare or Medicaid adjustment.....	1		2
Other (Specify:) 1		2

8. Have we covered all of the months your organization provided services to (PATIENT NAME) during the calendar year 1996?

YES, ALL MONTHS COVERED 1 (Q9)
 NO, NEED TO COVER ADDITIONAL MONTHS)..... 2 (Q1-NEXT EVENT FORM)

9. REVIEW NUMBER OF MONTHS OF HOME CARE SERVICE REPORTED BY HOUSEHOLD. IF FEWER MONTHS OF SERVICE ARE REPORTED BY THE HOME CARE ORGANIZATION, PROBE TO EXPLAIN THE DIFFERENCE.

NO DIFFERENCE OR PROVIDER REPORTED MORE MONTHS OF HOME CARE SERVICE THAN HOUSEHOLD..... 1 (Q10)

PROVIDER RECORDED FEWER VISITS:..... 2
 PROBE: (PATIENT NAME) reported (NUMBER) months of home care service. Do you have any information in your records that would explain this discrepancy?

10. GO TO NEXT PATIENT FOR THIS PROVIDER. IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.