

PATIENT LABEL

FORM ___ OF ___

**MEDICAL EXPENDITURE SURVEY
MEDICAL PROVIDER COMPONENT**

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

FOR

REFERENCE YEAR 2005



D1. During calendar year 2005, what was the (first/next) month during which your records show that services were provided in (PATIENT NAME)'s home?

MONTH: _____ YEAR: 2005

D2. 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.

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

OFFICE USE ONLY	TYPE OF PERSON	HOURS/MINUTES:	VISITS:	
_	_____	____ / ____	OR ____	_ _ _
_	_____	____ / ____	OR ____	OFFICE
_	_____	____ / ____	OR ____	USE
_	_____	____ / ____	OR ____	ONLY
_	_____	____ / ____	OR ____	
_	_____	____ / ____	OR ____	
_	_____	____ / ____	OR ____	
_	_____	____ / ____	OR ____	

D3. I need a description of the services provided during (MONTH).

	<u>YES</u>	<u>NO</u>
CLEANING OR YARD WORK	1	2
TRANSPORTATION	1	2
SHOPPING.....	1	2
EMOTIONAL SUPPORT PERSON OR		
ONE-ON-ONE BUDDY	1	2
SUPPORT GROUPS.....	1	2
CHILD CARE	1	2
OTHER (SPECIFY):		
_____	1	2

C2. What were the charges for the services provided to (PATIENT NAME) during (MONTH)?

TOTAL CHARGES: \$_____.

C3. NOT ASKED THIS VERSION

| 1 |
OFFICE USE
ONLY

C4a. Who paid your organization for the charges during (MONTH)?

a. Patient or patient's family \$_____.

b. Medicare \$_____.

C4b. ASK FOR EACH SOURCE OF PAYMENT MENTIONED: How much did (SOURCE OF PAYMENT) pay?

c. Medicaid \$_____.

d. Private Insurance \$_____.

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

e. VA \$_____.

f. TRICARE/CHAMPVA/
CHAMPUS \$_____.

g. Worker's Comp \$_____.

h. OTHER (SPECIFY):
_____ \$_____.

C5. 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 (C5) EQUAL TOTAL CHARGES (C2)?
YES 1 (D4)
NO 2 (C6)

C6. It appears that the total payments were (less than/ more than) the total charges. What is the reason for that difference? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]

PAYMENTS LESS THAN CHARGES: YES NO

Adjustment or discount

- a. Medicare limit or adjustment..... 1 2
- b. Medicaid limit or adjustment..... 1 2
- c. Contractual arrangement with insurer or managed care organization..... 1 2
- d. Courtesy discount..... 1 2
- e. Insurance write-off..... 1 2
- f. Worker's Comp limit or adjustment..... 1 2
- g. Eligible veteran..... 1 2
- h. Other (Specify:)..... 1 2

Expecting additional payment

- i. Patient or Patient's Family..... 1 2
- j. Medicare..... 1 2
- k. Medicaid..... 1 2
- l. Private Insurance..... 1 2
- m. VA..... 1 2
- n. TRICARE/CHAMPVA/CHAMPUS..... 1 2
- o. WORKER'S COMP..... 1 2
- p. Other (Specify:)..... 1 2
- q. **Charity care or sliding scale**..... 1 2
- r. **Bad debt**..... 1 2

PAYMENTS MORE THAN CHARGES:

- s. Medicare adjustment..... 1 2
- t. Medicaid adjustment..... 1 2
- u. Private insurance adjustment..... 1 2
- v. Other (Specify:)..... 1 2

D4. Have we covered all of the months your organization provided services to (PATIENT NAME) during the calendar year 2005?

YES, ALL MONTHS COVERED..... 1 (D5)
 NO, NEED TO COVER
 ADDITIONAL MONTH(S)..... 2 (D1-NEXT EVENT FORM)

D5. 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 (D6)

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?

D6. GO TO NEXT PATIENT FOR THIS PROVIDER.
 IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.