Protocol Special Instructions

The instructions appearing below have been provided for your convenience in completing the data protocol more accurately. They should be used in conjunction with the instructions which appear on the front of each protocol.

1. Barthel Index totals are derived by substituting values from the Barthel Index Scoring Sheet (p. 57 of the demonstration manual) to the corresponding responses of each item of the Index. In the past, most errors on Barthel scores have been attributable to this step in the computation. Please be careful in computing total Barthel scores.

2. PULSES Profile Scale totals are derived directly from totaling responses to each letter of the scale. Please recheck all additions to insure accuracy in reporting scores.

3. Skip patterns are included so that clients will only be required to answer questions pertinent to them. It was brought to your attention that these skip patterns have not been followed correctly. It is imperative that the skip patterns appearing throughout the protocol are handled properly.

4. On page 22 of the protocol it asks that the number of hours a client spends sleeping, in bed awake, etc. be estimated. The hours should always total 24.

5. Unknown dollar amounts as responses to #G.2 on p. 29 have occurred too frequently in past protocols. To remedy this, we ask that you make every attempt to procure clients' medical expenses. Where this is impossible, estimated medical figures are acceptable.

6. The list of numbers appearing on p. 6, C.1, refers to actual grades. Select the highest grade completed by client and place in the space provided to the right.

7. Please refer to the demonstration manual when the instructions so indicate. Many of the changes made in the questionnaire are explained in more detail in the manual.

ANSWER FORM FOR SECTION 130 DEMONSTRATION REPORTS

INSTRUCTIONS:

1. This answer form has been extensively revised. There are a sufficient number of spaces provided for each answer. Please write your answers in the spaces provided and not in the margins. The numbers in the margins are for the keypunchers. In addition, be careful in following the skip patterns.

2. Please consult the manual before administering the questionnaire. The manual contains instructions and comments which will assist in answering some of the questions you might have.

3. Be sure to leave blank only those questions which do not pertain to your clients. For example, clients who are not employed would not answer questions 8-12 in the employment section.

4. It is extremely important that you right justify certain answers. For example, if a client is No. 14, the numbers 1 and 4 should appear in the 2 far right spaces designated for client I.D. number. Also, the first digit should correspond to the code listed for your project. Thus, Berkeley's client No. 14 should appear in the questionnaire as:

   1 0 0 1 4

5. We have added a nonapplicable code for many questions. It always appears as either an "8" or an "88". However, if a nonapplicable code does not appear in the list of codes, DO NOT USE IT for that question. This should be a "skip" and left blank.

6. PLEASE NOTE special instructions which appear in all CAPS.

7. Unanswered questions will appear as zeros to the computer. Please be certain to answer all questions which pertain to your clients.

8. Please do not use fractions. Round up or down to the nearest whole number.

Date: _____

PLEASE DO NOT WRITE HERE

CARD 1

I. Demographic Information

A. Client I.D. [| | | | |] 1-5

First digit codes:

1=Berkeley 2=New York
4=Salt Lake 5=San Antonio 6=Seattle

B. Anniversary Date [| |] Mo. [| |] Yr. 6-9

C. Form Administered [ ] 10

1=New 2=1st Follow-up 3=2nd Follow-up
4=3rd Follow-up

D. Client's Status [ ] 11

1=Active 2-Inactive 3=Closure

E. Client's Year of Birth [| |] Yr. 12-13

F. Client's Sex [ ] 14

1=Male 2=Female

G. Client's Race [ ] 15

1=White 2-Black 3=Hispanic (Spanish-speaking: includes Mexican, Cuban, Puerto Rican, Spanish, etc.)

4=American Indian

5=Other (specify)_____ (e.g., Asian, Eskimo, etc.)

H. Type of Housing [ ] 16

1=Owned home (self or family) 4=Rented apt. condominium, trailer

2=Rented home 5=Rented room

3=Owned apt., condominium trailer 6=Institution (nursing home, intermediate care facility, hospital, other institution) (If 6, skip to N)

I. Does client live alone? [ ] 17

1=Yes (skip to Section II) 2=No (continue)

PLEASE DO NOT WRITE HERE

J. Are there related persons presently sharing household with client? ☐ 18

1=Yes (continue) 2=No (skip to L)

K. If yes, what is the relationship and number of client's related household members?

1. Spouse present? 1=Yes 2-No ☐ 19

2. Adults over age 18 present? 1=Yes 2=No ☐ 20

If yes, number ☐☐ 21-22

3. Children under 18 yrs. present? 1=Yes 2=No ☐ 23

If yes, number ☐☐ 24-25

4. Parents present? 1=Yes 2=No ☐ 26

If yes, number ☐☐ 27-28

29-31 blank

L. Are there unrelated persons sharing household with client? ☐ 32

1=Yes (continue) 2=No (skip to Section II)

M. If yes, number of unrelated household members: ☐☐ 33-34

ANSWER QUESTIONS N THROUGH S ONLY IF CODE "6", INSTITUTION, WAS SELECTED FOR QUESTION I.F. (TYPE OF HOUSING). SEE p. 4 OF DEMONSTRATION MANUAL FOR COMMENT PERTAINING TO THIS SECTION.

N. If client could be discharged, is there a residence where client could live? ☐ 35

1=Yes (continue) 2=No (skip to Section II)
9=Don't know (skip to Section II)

O. Would client live alone? ☐ 36

1=Yes (skip to Section II) 2=No (continue)

PLEASE DO NOT WRITE HERE

P. Would there be related persons sharing household with client? ☐ 37

1=Yes (continue) 2=No (skip to R)

Q. If yes, what is the relationship and number of related household members who would be living with client?

1. Spouse present? 1=Yes 2=No ☐ 38

2. Adults over age 18 present? 1=Yes 2=No ☐ 39

If yes, number ☐ 40-41

3. Children under 18 present? 1=Yes 2=No ☐ 42

If yes, number ☐☐ 43-44

45-47 blank

4. Parents present? 1=Yes 2=No ☐ 48

If yes, number ☐☐ 49-50

51-53 blank

R. Would there be unrelated persons sharing household with client? ☐ 54

1=Yes (continue) 2=No (skip to Section II)

S. Number of unrelated household members: ☐☐ 55-56

PLEASE DO NOT WRITE HERE

II. Income, Insurance, Education and Employment Data

A. Income

1. Is the client's family able to contribute toward

   a. the client's maintenance in home ☐ 57

   b. the client's maintenance out of home (in institution) ☐ 58

   c. the costs of such goods and services that may be necessary to complete the rehabilitation plan ☐ 59

   1 = Yes 2 = No 9 = Don't know

2. Including client income, what are the largest three sources of household income?

   01 = Money wages and salary
   02 = Income from self-employment
   03 = Social Security Disability Insurance
   04 = Supplemental Security Income
   05 = Old Age Survivors Insurance
   06 = Unemployment, Veterans, private pensions, workmen's compensation, etc.
   07 = Other (dividends, interest, rental income, etc.)
   08 = Aid to Families with Dependent Children
   09 = Railroad Retirement and Disability Benefits
   88 = Nonapplicable
   99 = Don't know

   Largest ☐☐ 60-61
   2nd Largest ☐☐ 62-63
   3rd Largest ☐☐ 64-65

   See p. 6 of demonstration manual for comment.

3. Including client income, what is the gross household income per year? $ ☐☐☐☐☐. 66-70

   If household income is unknown, enter "99999" (don't know)

4. Does client receive any income other than from family members? ☐ 71

   1 = Yes (continue) 2 = No (skip to B)
   9 = Don't know (skip to B)

PLEASE DO NOT WRITE HERE

5. What is the largest single source of client's income? ☐☐ 72-73

01 = Money wages and salary
02 = Income from self-employment
03 = Social Security Disability Insurance
04 = Supplemental Security Income
05 = Old Age Survivors Insurance
06 = Unemployment, Veterans, private pensions, workmen's compensation, etc.
07 = Other (dividends, interest, rental income, etc.)
08 = Aid to Families with Dependent Children
09 = Railroad Retirement and Disability Benefits
88 = Nonapplicable
99 = Don't know

Largest single source

See p. 7 of demonstration manual for comment.

6. What is client's gross income per year? $☐☐☐☐☐. 74-78

If client's income is unknown, enter "99999" (don't know)

B. Insurance

1. Is client covered by any private health plan or health insurance? ☐ 79

1 = Yes (continue) 2 = No (skip to C) 9 = Don't know (skip to C)

2. If yes, what are you covered by? (Write in name)

_____ 80 = 1 CARD 2 Duplicate 1-5

3. Does client's insurance exclude any condition or any service needs relating to his/her disability? ☐ 6

1 = Yes 2 = No 9 = Don't know

If yes, explain _____

_____

_____

See p. 7 of demonstration manual for comment.

PLEASE DO NOT WRITE HERE

7-9 blank

C. Education ☐☐ 10-11

1. Highest grade completed:

01	09	17
02	10	18=M.A./M.S.
03	11	19
04	12=High school grad.	20=Ph.D.
05	13	21=Ungraded (special
06	14=A.A.	education)
07	15	88=Never attended
08	16=B.A./B.S.	99=Don't know

2. Is client in school now? ☐ 12

1=Yes 2=No

3. Has client's disability limited the client's ability to attend school in any way? ☐ 13

1=Yes 2=No (skip to 5) 9=Don't know (skip to 5)

4. How did it limit client's schooling? Did client:

a. have to interrupt schooling several times due to hospitalization, illness, emotional reaction to disability, etc. ☐ 14

b. have to limit the number of hours taken? ☐ 15

c. leave school permanently or not attend school because of disability? ☐ 16

1=Yes 2=No 9=Don't know

PLEASE DO NOT WRITE HERE

5. How old was client when finished school? ☐☐ 17-18

(Enter "99" if age is unknown)

6. Would client like to attend school at this point if special assistance or arrangements were made? ☐ 19

1=Yes, 8=Nonapplicable } (continue) 2=No, 9=Don't Know } (skip to D)

7. What kinds of special assistance or arrangements does/would client need to be able to attend school or obtain educational services, is this assistance available, and, if so, who provides this assistance? (If answer to "Does client need" is "No", response to "Is this available" and "Who provides" should be "Non-applicable".) 20 Blank

	Does client need	Is this Available	Who provides	
a. Help from others to get ready for school	☐	☐	☐	21-23
b. Transportation (need adapted vehicles or others to drive)	☐	☐	☐	24-26
c. Special devices or equipment (e.g., tape recorder, typewriter, TTY)	☐	☐	☐	27-29
				30-32 (blank)
d. Flexible schedule	☐	☐	☐	33-35
e. Reduced schedule	☐	☐	☐	36-38
f. External accessibility (accessible buildings)*	☐	☐	☐	39-41
g. Internal accessibility*	☐	☐	☐	42-44
h. Regular assistance for school tasks	☐	☐	☐	45-47
i. Attendant help	☐	☐	☐	48-50
j. Other (specify) _____	☐	☐	☐	51-53
k. Doesn't need help	☐			54

Does client need: 1=Yes 2=No 9=Don't know
Is this available: 1=Yes 2=No 8=Nonapplicable 9=Don't know
Who provides: 1=VR, 2=Welfare, 3=School, 4=Self/Family/Friend, 5=Other (specify)_____, 6=Project, 8=Nonapplicable, 9=Don't know.

*See p. 10 of demonstration manual for comment.

PLEASE DO NOT WRITE HERE

55 Blank

D. Employment

1. Client's present employment status: ☐ 56

   1=Employed--paying job (skip to 8)
   2=Employed--sheltered workshop work
   3=Retired due to age
   4=No longer working due to disability
   5=Student--not working
   6=Not working--looking, can't find job
   7=Not working--can't afford to lose benefits of SSI or other programs
   8=Not working--not looking

   (Continue)

2. Has client ever worked (for wages)? ☐ 57

   1=Yes (continue) 2=No (skip to 7) 9=Don't know (skip to 7)

3. How many years ago did client work (full-time or part-time)? ☐☐ 58-59

4. About how many years did client work? ☐☐ 60-61

5. About how many hours a week did client usually work? ☐ 62

   1=at least 35 hours (skip to 7)
   2=less than 35 hours (continue)
   9=don't know (continue)

6. Did client work part-time as a result of his/her disability? ☐ 63

   1=Yes (continue) 2=No (continue) 9=Don't know (continue)

7. Would client like to work (for wages) at this point if services, special arrangements, or other adjustments were made? ☐ 64

   1=Yes (skip to 13) 2=No (skip to Section III 9= Don't know (skip to Section III)

PLEASE DO NOT WRITE HERE

ANSWER QUESTIONS 8-12 ONLY IF CLIENT IS EMPLOYED

8. About how many years has client worked? ☐☐ 65-66

9. How many hours a week does client usually work? ☐☐ 67-68

10. What is client's present occupation:

_____ 69-73

11. Is this the client's usual occupation? ☐ 74

1 = Yes (skip to 13) 2 = No (continue)
9 = Don't know (continue)

See p. 32 of demonstration manual for comment.

12. What is client's usual occupation?

_____ 75-79

(Write in, e.g., clerk, taxi driver, machinist, etc.)

PLEASE DO NOT WRITE HERE

80=2
CARD 3
Duplicate 1-5

13. If client works/would like to work, which of the following types of help are needed, is this help available, and, if so, who provides this help?
If answer to "Does client need" is No then responses to "Is this available" and "Who provides" should be "nonapplicable."

	Does client need	Is this available	Who provides	
a. Help from others to get ready for work	☐	☐	☐	6-8
b. Transportation (need adapted vehicles or others to drive	☐	☐	☐	9-11
c. Special equipment (e.g., TTY) or furniture at work	☐	☐	☐	12-14
d. Flexible work schedule	☐	☐	☐	15-17
e. Reduced work schedule	☐	☐	☐	18-20
f. Special training or education	☐	☐	☐	21-23
g. Light work only	☐	☐	☐	24-26
h. External accessibility (accessible buildings)*	☐	☐	☐	27-29
i. Internal accessibility*	☐	☐	☐	30-32
j. Regular assistance in work tasks	☐	☐	☐	33-35
k. Attendant help	☐	☐	☐	36-38
l. Other (specify) _____	☐	☐	☐	39-41
m. Doesn't need help	☐			42

Does client need: 1=Yes 2=No 9=Don't know
Is this available: 1=Yes 2=No
8=Nonapplicable 9=Don't know
Who provides: 1=VR, 2=Welfare, 3=Employer
4=Self/Family/Friend, 5=Other (specify)_____
6=Project, 8=Nonapplicable
9=Don't know

*See p. 13 of demonstration manual for comment.

PLEASE DO NOT WRITE HERE

III. Data on the Character of the Client's Medical Condition

A. What is client's primary disability diagnosis? ☐☐☐ 43-45

_____

(Use R-300 codes)

B. Date of onset of primary disability (month and year): ☐☐ ☐☐ 46-49

Mo. Yr.

C. Client's secondary disability diagnosis?

_____ ☐☐☐ 50-52

D. Status of condition according to reviewer's evaluation of information given in the record: ☐ 53

1=improving, 2=stable, 3=worsening, 4=fluctuating

E. Does client report any medical complications? ☐ 54

1 = Yes 2 = No 9 = Don't know

F. Sensory Deprivation and Communication Ability

The peripheral senses indicate that:

1. Hearing is impaired	☐	55
2. Vision is impaired	☐	56
3. Listening (understanding) is impaired	☐	57
4. Speaking (content) is impaired	☐	58
5. Speech (intelligibility) is impaired	☐	59
		60 Blank
6. Reading ability is impaired	☐	61
7. Writing ability is impaired	☐	62

1 = Yes 2 = No 9 = Don't know

See pp. 14-15 of demonstration manual for comment.

G. Client's Active Motion of Limbs

1. Right upper limb	☐	63
2. Left upper limb	☐	64
3. Right lower limb	☐	65
4. Left lower limb	☐	66

1=Null function, 2=Partial function,
3=Adequate function, 9=Don't know

See p. 15 of demonstration manual for comment.

PLEASE DO NOT WRITE HERE

H. Limiting Conditions: Is client's functioning limited by any of the following:

	Right Limbs Upper/Lower	Left Limbs Upper/Lower	
1. Weakness	☐☐	☐☐	67-70
2. Pain	☐☐	☐☐	71-74
3. Inflammation	☐☐	☐☐	75-78

79 Blank
80=3
CARD 4
Duplicate 1-5

4. Contracture	☐☐	☐☐	6-9
5. Skin ulcer	☐☐	☐☐	10-13
6. Ataxia	☐☐	☐☐	14-17
7. Spasticity	☐☐	☐☐	18-21
8. Rigidity	☐☐	☐☐	22-25
9. Sensory loss	☐☐	☐☐	26-29
10. Abnormal length (amputation, etc.)	☐☐	☐☐	30-33

1=Yes 2=No 9=Don't know

See page 16 of demonstration manual for definitions.

I. If client has problems with falling, balance, bumps into things (non-blind), what is the apparent cause? ☐ 34

1=environmental condition (architectural barriers, include trauma)
2=physiological disturbance (dizziness, reactions to medication, etc.)
3=other (specify) _____
8=nonapplicable
9=don't know

J. How often does client see a doctor, nurse, or physical therapist to check on condition of health or to receive treatments? ☐ 35

1=at least daily
2=at least weekly
3=at least monthly
4=at least quarterly
5=at least semiannually
8=nonapplicable
9=don't know

PLEASE DO NOT WRITE HERE

IV. Severity Scales

A. Functional Profile (PULSES)[1/]

1. P (Physical condition, including diseases of the viscera [cardiovascular, gastrointestinal, urological, and endocrine] and neurological disorders): ☐ 36

   1 = Medical problems sufficiently stable that medical or nursing monitoring is not required more often than 3 month intervals.
   2 = Medical or nurse monitoring is needed more often than 3 month intervals, but not each week.
   3 = Medical problems are sufficiently unstable as to require medical and/or nursing attention at least weekly.
   4 = Medical problems require intensive medical and/or nursing attention at least daily (excluding personal care assistance only).

2. U (Self-care activities dependent mainly upon upper limb function): ☐ 37

   1 = Independent in self-care without impairment of upper limbs.
   2 = Independent in self-care with some impairment of upper limbs.
   3 = Dependent upon assistance or supervision in self-care with or without impairment of upper limbs.
   4 = Dependent totally in self-care with marked impairment of upper limbs.

3. L (Mobility activities dependent mainly upon lower limb function): ☐ 38

   1 = Independent in mobility without impairment of lower limbs.
   2 = Independent in mobility with some impairment of lower limbs, such as needing ambulatory aids, a brace or prosthesis, or else fully independent in a wheelchair without significant architectural or environmental barriers.
   3 = Dependent upon assistance or supervision in mobility with or without impairment of lower limbs, or else partly independent in a wheelchair, or else there are significant architectural or environmental barriers.
   4 = Dependent totally in mobility with marked impairment of lower limbs.

[1/] See pages 25-31 of the demonstration manual for Criteria for Determining Client's Function Level with Respect to PULSES Profile Scale.

PLEASE DO NOT WRITE HERE

4. S (Sensory components relating to communication [speech and hearing] and vision): ☐ 39

1 = Independent in communication and vision without impairment.
2 = Independent in communication and vision with some impairment such as mild dysarthria, mild aphasia, or need for eyeglasses or hearing aid, or needing regular medication.
3 = Dependent upon assistance, or interpreter or supervision in communication or vision.
4 = Dependent totally in communication or vision.

5. E (Excretory functions [bladder and bowel]): ☐ 40

1 = Complete voluntary control of bladder and bowel sphincters.
2 = Control of sphincters allows normal social activities despite urgency or need for catheter, appliance, suppositories, etc. Able to care for needs without assistance.
3 = Dependent upon assistance in sphincter management or else has accidents occasionally.
4 = Incontinent of bladder or bowel sphincters.

6. S (Consider intellectual and emotional adaptability, support from family unit, and financial ability): ☐ 41

1 = Able to fulfill social role(s) and perform customary tasks.
2 = Must make some modification in usual role(s) or performance of customary tasks.
3 = Dependent upon assistance, supervision, or encouragement due to any of the above.
4 = Dependent upon long-term institutional care (chronic hospital, nursing home, etc.) excluding time-limited hopsitalization for specific evaluation, treatment or active rehabilitation.

7. Total PULSES score: ☐☐ 42-43

PLEASE DO NOT WRITE HERE

ANSWER QUESTIONS 1-45 ONLY IF CLIENT IS NOT IN AN INSTITUTION. QUESTIONS WHICH MAY REQUIRE ESTIMATES ARE TO BE COMPLETED BY COUNSELOR STAFF WITH CLIENT'S SUGGESTIONS TAKEN INTO CONSIDERATION.

V. Client's Limitations on Functioning in Substantive Areas

A. Management and Homemaking Activities

1. Does client need assistance in household financial management? (Include paying bills, balancing checkbook, etc.) ☐ 44

   1 = Yes (continue) 2 = No (skip to 10)

2. Does client receive assistance in household financial management? ☐ 45

   1 = Yes (skip to 4) 2 = No (continue)

3. How many hours per week (including weekends) is assistance in financial management needed? ☐☐☐ 46-48

   SKIP TO 10

4. How many hours per week (including weekends) does client receive assistance in financial management? ☐☐☐ 49-51

5. Who usually helps client perform this function? ☐ 52

   1 = Unpaid help (skip to 8)
   2 = Paid help (continue)

6. Who pays? ☐ 53

   1 = Self/family
   2 = VR
   3 = Medicaid
   4 = Medicare
   5 = Welfare
   6 = Private Insurance
   7 = Other (specify) _____
   8 = Project

7. How much does this cost per month? $☐☐☐. 54-56

PLEASE DO NOT WRITE HERE

8. Is additional assistance in financial management needed? ☐ 57

   1 = Yes (continue) 2 = No (skip to 10)

9. How many hours per week (including weekends) is additional assistance needed? ☐☐☐ 58-60

10. Does client need assistance to conduct necessary personal business activities? (Include arranging daily schedule, securing adequate living quarters, etc.) ☐ 61

    1 = Yes (continue) 2 = No (skip to 19)

11. Does client receive assistance to conduct necessary personal business activities? ☐ 62

    1 = Yes (skip to 13) 2 = No (continue)

12. How many hours per week (including weekends) is assistance needed? ☐☐☐ 63-65

    SKIP TO 19

13. How many hours per week (including weekends) does client receive assistance? ☐☐☐ 66-68

14. Who usually helps client perform this function? ☐ 69

    1 = Unpaid help (skip to 17)
    2 = Paid help (continue)

15. Who pays? ☐ 70

    1 = Self/family
    2 = VR
    3 = Medicaid
    4 = Medicare
    5 = Welfare
    6 = Private Insurance
    7 = Other (specify) _____
    8 = Project

16. How much does this cost per month? $☐☐☐. 71-73

17. Is additional assistance needed in this area? ☐ 74

    1 = Yes 2 = No (skip to 19)

PLEASE DO NOT WRITE HERE

18. How many hours per week (including weekends) is additional assistance needed? [ ][ ][ ] 75-77

19. Does client need assistance in preparing meals and/or housekeeping? [ ] 78

1 = Yes (continue) 2 = No (skip to 28)

79 Blank
80=4
Card 5 Duplicate
1-5

20. Does client receive assistance in preparing meals and/or housekeeping? [ ] 6

1 = Yes (skip to 22) 2 = No (continue)

21. How many hours per week (including weekends) is assistance in preparing meals and/or housekeeping needed? [ ][ ][ ] 7-9

SKIP TO 28

22. How many hours per week (including weekends) does client receive assistance in preparing meals and/or housekeeping? [ ][ ][ ] 10-12

23. Who usually helps client perform this function? [ ] 13

1 = Unpaid help (skip to 26)
2 = Paid help (continue)

24. Who pays? [ ] 14

1 = Self/family
2 = VR
3 = Medicaid
4 = Medicare
5 = Welfare
6 = Private Insurance
7 = Other (specify) _____
8 = Project

25. How much does this cost per month? $[ ][ ][ ]. 15-17

26. Is additional assistance in preparing meals and/or housekeeping needed? [ ] 18

1 = Yes 2 = No (skip to 28)

PLEASE DO NOT WRITE HERE

27. How many hours per week (including weekends) is additional assistance required? ☐☐☐ 19-21

28. Does client need attendant care? (Include assistance in getting in/out of bed, dressing, toileting, etc.) ☐ 22

1 = Yes (continue) 2 = No (skip to 37)

29. Does client receive attendant care? ☐ 23

1 = Yes (skip to 31) 2 = No (continue)

30. How many hours per week (including weekends) is attendant care needed? ☐☐☐ 24-26

SKIP TO 37

31. How many hours per week (including weekends) does client receive attendant care? ☐☐☐ 27-29

32. Who usually helps client perform this function? ☐ 30

1 = Unpaid help (skip to 35)
2 = Paid help (continue)

33. Who pays? ☐ 31

1 = Self/family
2 = VR
3 = Medicaid
4 = Medicare
5 = Welfare
6 = Private Insurance
7 = Other (specify) _____
8 = Project

34. How much does this cost per month? $☐☐☐. 32-34

35. Is additional attendant care needed? ☐ 35

1 = Yes (continue) 2 = No (skip to 37)

36. About how many hours per week is additional assistance required? (include weekends) ☐☐☐ 36-38

37. Does client need assistance to shop for groceries and other things? ☐ 39

1 = Yes (continue) 2 = No (skip to 46)

PLEASE DO NOT WRITE HERE

38. Does client receive assistance to shop for groceries and other things? ☐ 40

1 = Yes (skip to 40) 2 = No (continue)

39. How many hours per week (including weekends) is assistance needed? ☐☐☐ 41-43

SKIP TO 46

40. How many hours per week is assistance in shopping received? (include weekends) ☐☐☐ 44-46

41. Who usually helps client perform this function? ☐ 47

1 = Unpaid help (skip to 44)
2 = Paid help (continue)

42. Who pays? ☐ 48

1 = Self/family
2 = VR
3 = Medicaid
4 = Medicare
5 = Welfare
6 = Private Insurance
7 = Other (specify) _____
8 = Project

43. How much does this cost per month? $☐☐☐. 49-51

44. Is additional assistance in shopping for groceries and other things needed? ☐ 52

1 = Yes (continue) 2 = No (skip to 46)

45. About how many hours per week is additional assistance required? ☐☐☐ 53-55

FOR EVERYONE

46. Since client's disability, has any member of his/ her family quit working, changed jobs, or left school in order to help take care of client? ☐ 56

1 = Yes 2 = No 9 = Don't Know

PLEASE DO NOT WRITE HERE

B. Transportation

1. Does client have a transportation problem? ☐ 57

1 = Yes
2 = No (skip to 3)
8 = Nonapplicable [homebound, unable to travel, hasn't tried to travel](skip to 3)

2. Is that problem:

a. getting out of the home . . . . . ☐ 58
b. getting in/out of autos . . . . . ☐ 59
c. getting in/out of trains, buses, other mass transit . ☐ 60
d. traveling near distances for routine purposes (grocery shopping, medical appointments, etc.). . . . ☐ 61
e. traveling far distances but within the urban area (recreational, social, etc.) . . . . . ☐ 62
f. traveling to other cities . . . . . ☐ 63
g. other (specify) _____ . . . . . ☐ 64

1 = Yes 2 = No 9 = Don't Know

3. Which of the following does client use and how often?

	Transportation Used	How Often	
a. Walk	☐	☐	65-66
b. Wheelchair	☐	☐	67-68
c. Drive self -- regular or adapted auto	☐	☐	69-70
d. Motorized (or self-propelled) vehicles for disabled other than auto (drive self)	☐	☐	71-72 Blank 73-74
e. Relative or friend drives	☐	☐	75-76
f. Regular public transportation (bus, subway, taxi)	☐	☐	77-78
			79 Blank 80=5 Card 6 Duplicate 1-5
g. Adapted buses, minibuses for disabled	☐	☐	6-7
h. Transportation arranged by agency	☐	☐	8-9
i. Doesn't travel (homebound)	☐		10

PLEASE DO NOT WRITE HERE

Transportation used: 1 = Yes 2 = No 9 = Don't Know
How often used: 1 = daily
2 = several times a week
3 = about once a week
4 = 1-3 times a month
5 = less than once a month
8 = nonapplicable
9 = don't know

4. In an average week, about how many times did client travel outside the home? (If client doesn't travel outside the home, enter "88" (nonapplicable). ☐☐ 11-12

C. Social Interaction

1. With whom does client most frequently relate his/her problems? ☐ 13

1 = Family Member
2 = Friend
3 = Agency Person
4 = No One
9 = Don't Know

2. During the past month, which of the following social activities did client engage in and how often?

	Engaged In	How Often	
a. Friends/relatives visited client	☐	☐	14-15
b. Client visited friends/relatives	☐	☐	16-17
c. Attended church, synagogue or other religious center	☐	☐	18-19
d. Group meetings for disabled	☐	☐	20-21
e. Other group meetings, such as PTA, lodges, etc.	☐	☐	22-23
f. Public entertainment	☐	☐	24-25
g. School or vocational training	☐	☐	26-27
h. Shopping	☐	☐	28-29
i. Volunteer work	☐	☐	30-31
j. Wage or workshop work	☐	☐	32-33
k. Other (specify) _____	☐	☐	34-35

Engaged in: 1 = Yes 2 = No 9 = Don't Know
How often: 1 = once
2 = twice
3 = three times
4 = four or more times
8 = nonapplicable
9 = don't know

PLEASE DO NOT WRITE HERE

3. In a typical day, estimate the time spent (hours):

a. In bed asleep		36-37
b. In bed awake		38-39
c. Inside home, not in bed		40-41
d. Outside home, within 2 blocks		42-43
e. Outside home, more than 2 blocks away		44-45
Total 24 hrs.		

If client is homebound or does not travel outside the home (d and/or e above), enter 88. However, do not include the "88(s)" when totaling hours. As a result, hours will always total 24.

D. Architectural Barriers

1. Does client have architectural barriers in the home? ☐ 46

1 = Yes (continue)
2 = No (skip to 4)
9 = Don't Know (skip to 4)

2. What is needed to eliminate the barriers in the home?

a. Elevators	☐	47
b. Ramps	☐	48
c. Wider doorways	☐	49
d. Household appliances	☐	50
e. Cannot modify, should move to ground floor	☐	51
f. Other (specify) _____	☐	52

1 = Yes 2 = No 9 = Don't Know

3. What is made difficult due to the house barriers?

a. Getting in/out of residence	☐	53
b. Moving from room to room	☐	54
c. Going from the threshold to the street.	☐	55
d. Doing homemaking activities (cooking, etc.)	☐	56
e. Bathing	☐	57
f. Toilet	☐	58
g. Grooming (shaving, combing hair, etc.	☐	59
h. Other (specify) _____	☐	60

1 = Yes 2 = No 9 = Don't Know

4. If client's situation would improve if client moved, what is the main reason he/she has not? ☐ 61

1 = needed physical assistance to relocate
2 = cost of moving too high
3 = cost of living too high in new location
4 = too difficult to make arrangements for housing, jobs., etc., in new location

(codes continued on following page)

PLEASE DO NOT WRITE HERE

5 = don't know people in new location (fear of changing places)
6 = good job in present location (doesn't think could get similar job elsewhere)
7 = other (specify) _____
8 = nonapplicable
9 = don't know
(Choose major reason only)

E. Equipment Usage

1. Which of the following special equipment does client have, which equipment is needed as a result of the client's disability, and does the client use the equipment? All responses (Have, Need, Use) are to be recorded independent of each other. See page 43 of the demonstration manual for comment.

	Does Client Have	Does Client Need	Does Client Use	
a. Helper for upper limb (e.g. splint, brace--limb is present)	☐	☐	☐	62-64
b. Helper for lower limb	☐	☐	☐	65-67
c. Artificial limbs, hands	☐	☐	☐	68-70
d. Back brace	☐	☐	☐	71-73
e. Cane, crutches, walker	☐	☐	☐	74-76
f. Transfer chair or board	☐	☐	☐	77-79
				80=6
				Card 7
				Duplicate 1-5
g. Typewriter	☐	☐	☐	6-8
h. Tape recorder	☐	☐	☐	9-11
i. Ramps	☐	☐	☐	12-14
j. Special telephone equipment (e.g TTY)	☐	☐	☐	15-17
k. Motorized wheelchair	☐	☐	☐	18-20
l. Wheelchair (manual)	☐	☐	☐	21-23
m. Trapeze or bathtub lift	☐	☐	☐	24-26
n. Hospital bed	☐	☐	☐	27-29
o. Specially equipped autos or other motorized vehicles	☐	☐	☐	30-32
p. Aids for vision (high magnification lenses, TV monitor, etc.)	☐	☐	☐	33-35
q. Seeing eye dog	☐	☐	☐	36-38
r. Hearing aids	☐	☐	☐	39-41
s. Speech aids (e.g. voice boxes, amplifiers)	☐	☐	☐	42-44
t. Respiratory aids	☐	☐	☐	45-47
u. Dentures	☐	☐	☐	48-50
v. Other (specify) _____	☐	☐	☐	51-53
w. Doesn't have/need any	☐			54

PLEASE DO NOT WRITE HERE

Does client have: 1 = Yes 2 = No 9 = Don't Know
Does client need: 1 = Yes 2 = No 8 = Nonapplicable 9 = Don't Know
Does client use: 1 = Yes 2 = No 8 = Nonapplicable 9 = Don't Know

ANSWER QUESTIONS 2-4 ONLY IF CLIENT HAS ANY OF THE EQUIPMENT IN QUESTION 1.

2. Does any of the equipment need repair? ☐ 55

1 = Yes (continue)
2 = No } skip to
9 = Don't know } Section VI

3. Any problems getting equipment repaired? ☐ 56

1 = Yes (continue)
2 = No } skip to
9 = Don't Know } Section VI

4. What is the major problem? ☐☐ 57-58

01 = Problems with manufacturer (send wrong parts, don't know which parts to order, description unclear)
02 = Inconvenient to get to place that repairs equipment
03 = Delay in getting equipment repaired too long
04 = Costs too high
05 = Sponsoring agency wouldn't pay for repairs
06 = Delay in getting sponsorship too long
07 = No place available to repair equipment
08 = Other (specify) _____
99 = Don't know

VI. Pattern of Services

ANSWER QUESTION A ONLY IF CLIENT LIVES IN INSTITUTION--SHELTERED CARE HOME, NURSING HOME, MENTAL INSTITUTION. OTHERWISE, SKIP TO B.

A. Could client live outside if:

1. Household financial management was available . . . . . ☐ 59
2. Assistance in personal business activities was available ☐ 60
3. Preparing meals and/or housekeeping and/or shopping were available . . . . . ☐ 61
4. Attendant care was available . . . . . ☐ 62
5. Counselor/Follow-Up services were available . . . . . ☐ 63
6. Anything else? (specify) _____ . . ☐ 64

1 = Yes 2 = No 9 = Don't Know

See page 45 of the demonstration manual for comment.

PLEASE DO NOT WRITE HERE

ANSWER FOR EVERYONE

B. Which of the following services have been and/or are presently being received as a direct result of client's disability? Which of the following services does the client need, irrespective of whether or not the client is or has received such services?

		Received	Needed	
1.	Surgery	☐	☐	65-66
2.	Hospitalization	☐	☐	67-68
3.	Physical therapy	☐	☐	69-70
4.	Occupational therapy	☐	☐	71-72
5.	Dental therapy	☐	☐	73-74
6.	Speech/hearing therapy	☐	☐	75-76
7.	Other medical treatment	☐	☐	77-78
				79 Blank
				80=7
				Card 8
				Duplicate 1-5
8.	Visiting nurse	☐	☐	6-7
9.	Prosthetic devices, braces, wheelchairs	☐	☐	8-9
10.	Vocational counseling	☐	☐	10-11
11.	Vocational training	☐	☐	12-13
12.	Educational costs	☐	☐	14-15
13.	Vocational placement	☐	☐	16-17
14.	Receipt of tools, equipment or licenses (for work or training)	☐	☐	18-19
15.	Psychological therapy/counseling	☐	☐	20-21
16.	Home modifications	☐	☐	22-23
17.	Social services	☐	☐	24-25
18.	Therapeutic recreation	☐	☐	26-27
19.	Sex therapy/sex education	☐	☐	28-29
20.	Family member counseling on emotional adjustment to client disability, including marital counseling	☐	☐	30-31
21.	Family member training in assistance in use of equipment, management of disability, etc.	☐	☐	32-33
22.	Other (specify) _____	☐	☐	34-35
23.	Did not receive/does not need any	☐		36

Received: 1 = Yes 2 = No 9 = Don't Know
Need: 1 = Yes 2 = No 8 = Nonapplicable 9 = Don't Know

See page 46 in the demonstration manual for comment.

PLEASE DO NOT WRITE HERE

C. Since client's disability, what programs have been contacted, were benefits received, and, if so, what type of benefits? See page 48 of the demonstration manual for comment.

	Programs Contacted	Receive Benefits	Type of Benefit	
PUBLIC				
1. Employment and job placement services	☐	☐	☐☐	37-40
2. Job training programs, e.g. WIN, JOBS, etc.	☐	☐	☐☐	41-44
3. Low cost or public housing	☐	☐	☐☐	45-48
4. Food stamps and commodities	☐	☐	☐☐	49-52
5. Medicaid	☐	☐	☐☐	53-56
6. Medicare	☐	☐	☐☐	57-60
7. Legal aid societies	☐	☐	☐☐	61-64
8. State programs for sickness and temporary disability benefits	☐	☐	☐☐	65-68
9. Div. of Developmental Disabilities	☐	☐	☐☐	69-72
10. Social services under Title XX	☐	☐	☐☐	73-76
				77-79 Blank
				80=8
				Card 9
				Duplicate 1-5
11. Vocational Rehabilitation Agency	☐	☐	☐☐	6-9
12. Other public program (specify) _____	☐	☐	☐☐	10-13
PRIVATE				
1. Medical agency or hospital	☐	☐	☐☐	14-17
2. Vocational training agency	☐	☐	☐☐	18-21
3. Mental health agency	☐	☐	☐☐	22-25
4. Employment or job placement agency	☐	☐	☐☐	26-29
5. Church or synagogue social services	☐	☐	☐☐	30-33
6. Other private program (specify) _____	☐	☐	☐☐	34-37

Contacted: 1 = Yes 2 = No 9 = Don't Know
Receive Benefits: 1 = Yes 2 = No 8 = Nonapplicable 9 = Don't Know

PLEASE DO NOT WRITE HERE

Type of Benefit: SPECIFY MAJOR BENEFIT ONLY

01 = Cash income or subsidy
02 = Job training
03 = Job placement
04 = Receipt of adapted tools, equipment or licenses
05 = Guidance and counseling
06 = Physical therapy
07 = Special equipment (wheelchair, brace, artificial limb)
08 = Training for home activities (e.g. OT)
09 = Nursing services
10 = Physician services
11 = Homemaker/housekeeping services
12 = Attendant services
13 = Surgery
14 = Dental care
16 = Other _____(specify)
88 = Nonapplicable
99 = Don't know

D. If individual has not been able to get necessary services:

1. What is that service (describe) _____

_____

_____

2. Problem getting that service:

a. Don't know where to get service . . . . . ☐ 38
b. Agency will not provide . . . . . ☐ 39
c. No agency provides this service and cost is too high for client . . . . . ☐ 40
d. Service not available in this area . . . . . ☐ 41
e. Benefit of service not great enoug to be worth pursuing . . . . . ☐ 42
f. Other (specify) _____

_____ . . ☐ 43

1 = Yes 2 = No 9 = Don't know

PLEASE DO NOT WRITE HERE

3. If agency won't provide ("b" above) why not?

_____

_____

_____

See page 50 of the demonstration manual for comment.

E. If individual has not been able to get necessary services:

1. What is that service (describe) _____

_____

_____

2. Problem getting that service:

a. Don't know where to get service	☐	44
b. Agency will not provide	☐	45
c. No agency provides this service and cost is too high for client	☐	46
d. Service not available in this area	☐	47
e. Benefit of service not great enough to be worth pursuing	☐	48
f. Other (specify) _____		
_____	☐	49

1 = Yes 2 = No 9 = Don't know

3. If agency won't provide ("b" above) why not?

_____

_____

_____

See page 50 of the demonstration manual for comment.

F. If individual has not been able to get necessary services:

1. What is that service: (describe) _____

_____

_____

PLEASE DO NOT WRITE HERE

2. Problem getting that service:

a. Don't know where to get service . . . . . ☐ 50
b. Agency will not provide . . . . . ☐ 51
c. No agency provides this service and cost is too high for client . . . . . ☐ 52
d. Service not available in this area . . . . . ☐ 53
e. Benefit of service not great enough to be worth pursuing . . . . . ☐ 54
f. Other (specify) _____

_____ ☐ 55

1 = Yes 2 = No 9 = Don't know

3. If agency won't provide ("b" above) why not?

_____

_____

_____

See page 50 of the demonstration manual for comment.

G. Medical Expenses

1. Did client have any medical expenses in the last 12 months?

1 = Yes (continue) 2 = No (skip 2-4) ☐ 56

2. What was client's total medical expenses in the last 12 months? (If client doesn't know, enter "9999" [don't know] in the spaces.) $ ☐☐☐☐☐. 57-61

3. In the last 12 months, what percentage of medical bills was paid by client/client's family? (If client only knows the amount paid, write the amount next to this question [NOT IN THE BOXES], and we will compute the percentage.) If client doesn't know the information, enter "999" in the boxes. ☐☐☐ % 62-64

PLEASE DO NOT WRITE HERE

4. Who paid the rest? ☐☐ 65-66

01 = VR
02 = Medicaid
03 = Medicare
04 = Welfare
05 = No one
06 = Insurance
07 = Friend/unrelated person
08 = Other agency (specify)_____
88 = Nonapplicable
99 = Don't know
09 = Veterans Administration

67-79 Blank
80=9

PLEASE DO NOT WRITE HERE
Card 10
Duplicate 1-5

The Barthel Index[1/]

1. Barthel: Self-Care

	Ability	How Often	
a. Drinking	☐	☐	6-7
b. Eating	☐	☐	8-9
c. Dressing upper body	☐	☐	10-11
d. Dressing lower body	☐	☐	12-13
e. Putting on brace or artificial limb	☐	☐	14-15
f. Grooming	☐	☐	16-17
g. Washing or bathing	☐	☐	18-19
h. Controlling urination (bladder continence)	☐	☐	20-21
i. Controlling bowel movements (bowel continence)	☐	☐	22-23

Ability:

1 = Cannot do at all (use for "e" above if nonapplicable)
2 = Can do with human assistance (someone else is usually present when client does this)
3 = Can do by self
9 = Don't know

How Often:

How often refers to how often per day client performs this function. Note: Clients must be able to perform the function at least with human assistance in order for the frequency portion of the scale to be applicable. If client cannot perform the function at all, enter 1 in the ability column and 8 in the how often column.

1 = less than once
2 = once or twice
3 = three or four times
4 = five or six
5 = seven or more
8 = nonapplicable

j. Weighted self-care score . . . . . ☐☐ 24-25

See p. 55 of the demonstration manual for computation instructions.

1/ See page 57 of demonstration manual for Barthel Index Scoring.

PLEASE DO NOT WRITE HERE

2. Barthel: Mobility

	Ability	How Often	
a. Getting in or out of chair	☐	☐	26-27
b. Getting on or off toilet	☐	☐	28-29
c. Getting in/out of tub/shower	☐	☐	30-31
d. Walking 50 yards on level	☐	☐	32-33
e. Walking up/down one flight of stairs . .	☐	☐	34-35
f. If not walking, propelling or pushing wheelchair*.	☐	☐	36-37

* See page 55 of demonstration manual for comment.

Ability:

1 = Cannot do at all (use for "f" above if nonapplicable)
2 = Can do with human assistance (someone else is usually present when client does this)
3 = Can do by self
9 = Don't know

How often:

How often refers to how often per day client performs this function. Note: Clients must be able to perform the function at least with human assistance in order for the frequency portion of the scale to be applicable. If client cannot perform the function at all, enter 1 in the ability column and 8 in the how often column.

1 = less than once
2 = once or twice
3 = three or four times
4 = five or six
5 = seven or more
8 = nonapplicable

g. Weighted mobility score** . . . . . ☐☐ 38-39

3. Total Weighted Barthel Score: ** ☐☐☐ 40-42

** See page 56 of the demonstration manual for comment computation instructions.

PLEASE DO NOT WRITE HERE

Functional Limitations	Ability	How Often	
1. Operating household appliances	☐	☐	43-44
2. Taking medicine	☐	☐	45-46
3. Getting in/out of bed	☐	☐	47-48
4. Sitting for more than one hour	☐	☐	49-50
5. Lifting or carrying weights of about 10 lbs.	☐	☐	51-52
6. Stooping, bending or kneeling	☐	☐	53-54
7. Reaching with both arms	☐	☐	55-56
8. Using hands and fingers	☐	☐	57-58
9. Using the telephone	☐	☐	59-60
10. Operating a TV, radio or stereo . . .	☐	☐	61-62
11. Admitting visitors to home	☐	☐	63-64

Ability:

1 = Cannot do at all
2 = Can do with some difficulty (or with assistance)
3 = Can do with no difficulty
8 = Nonapplicable (use only in No. 2 if client does not take medicine
9 = Don't know

How Often:

How often refers to how often per day client performs this function. Note: Clients must be able to perform the function at least with human assistance in order for the frequency portion of the scale to be applicable. If client cannot perform the function at all, enter 1 in the ability column and 8 in the how often column.

1 = less than once
2 = once or twice
3 = three or four times
4 = five or six times
5 = seven or more times
8 = nonapplicable

Columns
65-78 Blank

79-80 = 10