

Appendix C. Facsimile of SIPP Topical Module Questions on Disability Status

(See questionnaire on following pages.)

| Section 5 – TOPICAL MODULES (Continued) | |
|--|--|
| Part E – FUNCTIONAL LIMITATIONS AND DISABILITY | |
| <p>1. These next few questions are about ...'s health. Would you say ...'s health in general is excellent, very good, good, fair, or poor?</p> | <p>8800 1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 4 <input type="checkbox"/> Fair 5 <input type="checkbox"/> Poor</p> |
| <p><i>Mark by observation if apparent.</i></p> <p>2. Does ... use any of the following aids to get around?</p> <p>a. A cane, crutches, or a walker</p> <p>b. A wheelchair</p> | <p>8802 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>8804 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>CHECK ITEM T17 Is "Yes" marked in 2a or 2b above?</p> | <p>8806 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to 4a</i></p> |
| <p>3. Has ... used (Aid mentioned in 2a or 2b) for six months or longer?</p> | <p>8808 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>4a. Does ... have difficulty seeing the words and letters in ordinary newspaper print even when wearing glasses or contact lenses if ... usually wears them?</p> | <p>8810 1 <input type="checkbox"/> Has difficulty 2 <input type="checkbox"/> No difficulty – <i>SKIP to 5a</i></p> |
| <p>b. Is ... able to see the words and letters in ordinary newspaper at all?</p> | <p>8812 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>5a. Does ... have any difficulty hearing what is said in a normal conversation with another person (using a hearing aid if ... usually wears one)?</p> | <p>8814 1 <input type="checkbox"/> Has difficulty 2 <input type="checkbox"/> No difficulty – <i>SKIP to 6a</i></p> |
| <p>b. Is ... able to hear what is said in a normal conversation at all?</p> | <p>8816 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>6a. Because of a health condition or problem, does ... have any difficulty having his/her speech understood?</p> | <p>8818 1 <input type="checkbox"/> Has difficulty 2 <input type="checkbox"/> No difficulty – <i>SKIP to 7a</i></p> |
| <p>b. Is ... able to have his/her speech understood at all?</p> | <p>8820 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>7a. Does ... have any difficulty lifting and carrying something as heavy as 10 lbs., such as a full bag of groceries?</p> | <p>8822 1 <input type="checkbox"/> Has difficulty 2 <input type="checkbox"/> No difficulty – <i>SKIP to 8a</i></p> |
| <p>b. Is ... able to lift and carry this much weight at all?</p> | <p>8824 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>8a. Does ... have any difficulty climbing a flight of stairs without resting?</p> | <p>8826 1 <input type="checkbox"/> Has difficulty 2 <input type="checkbox"/> No difficulty – <i>SKIP to 9a</i></p> |
| <p>b. Is ... able to climb a flight of stairs without resting at all?</p> | <p>8828 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>9a. Does ... have any difficulty walking a quarter of a mile – about 3 city blocks?</p> | <p>8830 1 <input type="checkbox"/> Has difficulty 2 <input type="checkbox"/> No difficulty – <i>SKIP to 10a</i></p> |
| <p>b. Is ... able to walk a quarter of a mile at all?</p> | <p>8832 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>10a. Does ... have any difficulty using the telephone?</p> | <p>8834 1 <input type="checkbox"/> Has difficulty 2 <input type="checkbox"/> No difficulty – <i>SKIP to 11a</i></p> |
| <p>b. Is ... able to use the telephone at all?</p> | <p>8836 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |

| Section 5 – TOPICAL MODULES (Continued) | | |
|--|---|--|
| Part E – FUNCTIONAL LIMITATIONS AND DISABILITY (Continued) | | |
| <p>11a. Because of a physical or mental health condition, does . . . have difficulty doing any of the following by himself/herself (exclude the effects of temporary conditions)? If an aid is used, ask whether the person has difficulty even when using the aid.</p> <p style="text-align: center; margin-top: 20px;">FIELD REPRESENTATIVE INSTRUCTION ▶ Repeat lead-in as necessary.</p> | <p>11b. Does . . . need the help of another person with (Name of activity)?</p> <p style="text-align: center; margin-top: 10px;"><i>Mark "Yes" if person sometimes needs help or usually needs help.</i></p> | |
| <p>(1) Getting around INSIDE the home?</p> | <p>8838 1 <input type="checkbox"/> Has difficulty – ASK 11b 2 <input type="checkbox"/> No difficulty</p> | <p>8839 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>(2) Going OUTSIDE the home, for example to shop or visit a doctor's office?</p> | <p>8840 1 <input type="checkbox"/> Has difficulty – ASK 11b 2 <input type="checkbox"/> No difficulty</p> | <p>8841 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>(3) Getting in and out of bed or a chair?</p> | <p>8842 1 <input type="checkbox"/> Has difficulty – ASK 11b 2 <input type="checkbox"/> No difficulty</p> | <p>8843 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>(4) Taking a bath or shower?</p> | <p>8844 1 <input type="checkbox"/> Has difficulty – ASK 11b 2 <input type="checkbox"/> No difficulty</p> | <p>8845 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>(5) Dressing?</p> | <p>8846 1 <input type="checkbox"/> Has difficulty – ASK 11b 2 <input type="checkbox"/> No difficulty</p> | <p>8847 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>(6) Walking?</p> | <p>8848 1 <input type="checkbox"/> Has difficulty – ASK 11b 2 <input type="checkbox"/> No difficulty</p> | <p>8849 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>(7) Eating?</p> | <p>8850 1 <input type="checkbox"/> Has difficulty – ASK 11b 2 <input type="checkbox"/> No difficulty</p> | <p>8851 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>(8) Using the toilet, including getting to the toilet?</p> | <p>8852 1 <input type="checkbox"/> Has difficulty – ASK 11b 2 <input type="checkbox"/> No difficulty</p> | <p>8853 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>(9) Keeping track of money and bills?</p> | <p>8854 1 <input type="checkbox"/> Has difficulty – ASK 11b 2 <input type="checkbox"/> No difficulty</p> | <p>8855 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>(10) Preparing meals?</p> | <p>8856 1 <input type="checkbox"/> Has difficulty – ASK 11b 2 <input type="checkbox"/> No difficulty</p> | <p>8857 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>(11) Doing light housework, such as washing dishes or sweeping a floor?</p> | <p>8858 1 <input type="checkbox"/> Has difficulty – ASK 11b 2 <input type="checkbox"/> No difficulty</p> | <p>8859 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>CHECK ITEM T18</p> | <p>Is "Yes" marked in item 11b for any of the activities listed above?</p> | <p>8860 1 <input type="checkbox"/> Yes – Go to 12a 2 <input type="checkbox"/> No – SKIP to Check Item T19</p> |
| <p>NOTES</p> | | |

| Section 5 – TOPICAL MODULES (Continued) | | |
|---|---|---|
| Part E – FUNCTIONAL LIMITATIONS AND DISABILITY (Continued) | | |
| <p>12a. You have said that . . . needs the help of another person with one or more activities. Who helps . . . with these activities?</p> <p>Anyone else?</p> | <p style="text-align: center;">FIRST HELPER</p> <p style="text-align: center;">RELATIVE</p> <p>8876 1 <input type="checkbox"/> Son 2 <input type="checkbox"/> Daughter 3 <input type="checkbox"/> Spouse 4 <input type="checkbox"/> Parent 5 <input type="checkbox"/> Other relative</p> <p style="text-align: center;">NONRELATIVE</p> <p>6 <input type="checkbox"/> Friend or neighbor 7 <input type="checkbox"/> Paid help 8 <input type="checkbox"/> Other nonrelative 9 <input type="checkbox"/> Did not receive help – <i>SKIP to 13</i></p> | <p style="text-align: center;">SECOND HELPER</p> <p style="text-align: center;">RELATIVE</p> <p>8878 1 <input type="checkbox"/> Son 2 <input type="checkbox"/> Daughter 3 <input type="checkbox"/> Spouse 4 <input type="checkbox"/> Parent 5 <input type="checkbox"/> Other relative</p> <p style="text-align: center;">NONRELATIVE</p> <p>6 <input type="checkbox"/> Friend or neighbor 7 <input type="checkbox"/> Paid help 8 <input type="checkbox"/> Other nonrelative</p> |
| <p style="text-align: center;"><i>ASK OR VERIFY –</i></p> <p>b. Is (Person mentioned above) a household member?</p> | <p style="text-align: center;">FIRST HELPER</p> <p>8890 1 <input type="checkbox"/> Yes</p> <p style="text-align: center;">Person number</p> <p>8883 <input style="width: 30px; border: 1px solid black;" type="text"/> <input style="width: 30px; border: 1px solid black;" type="text"/> <input style="width: 30px; border: 1px solid black;" type="text"/></p> <p>8885 2 <input type="checkbox"/> No</p> | <p style="text-align: center;">SECOND HELPER</p> <p>8882 1 <input type="checkbox"/> Yes</p> <p style="text-align: center;">Person number</p> <p>8884 <input style="width: 30px; border: 1px solid black;" type="text"/> <input style="width: 30px; border: 1px solid black;" type="text"/> <input style="width: 30px; border: 1px solid black;" type="text"/></p> <p>8886 2 <input type="checkbox"/> No</p> |
| <p>c. For how long has . . . needed the help of another person?</p> | <p>8887 1 <input type="checkbox"/> Less than 6 months 2 <input type="checkbox"/> 6 to 11 months 3 <input type="checkbox"/> 1 to 2 years 4 <input type="checkbox"/> 3 to 5 years 5 <input type="checkbox"/> More than 5 years</p> | |
| <p style="text-align: center;"><i>ASK OR VERIFY –</i></p> <p>d. During the past month did . . . (or . . . 's) family pay for any of the help that . . . received?</p> | <p>8888 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No x1 <input type="checkbox"/> DK } <i>SKIP to 13</i></p> | |
| <p>e. How much was paid for such help in (Read last month)?</p> | <p>8889 \$ <input style="width: 60px; border: 1px solid black;" type="text"/> . <input style="width: 30px; border: 1px solid black;" type="text"/> 00</p> <p>x1 <input type="checkbox"/> DK</p> | |
| <p>CHECK ITEM T19 Is "Has difficulty" marked in items 7a, 8a, 9a, 10a, or 11a for any activity?</p> | <p>8890 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to 15</i></p> | |
| <p><i>(SHOW FLASHCARD AA)</i></p> <p>13. I have recorded that . . . has difficulty with certain activities. Which condition or conditions on this card cause this difficulty? Any other?</p> | <p>8892 <input style="width: 30px; border: 1px solid black;" type="text"/> <input style="width: 30px; border: 1px solid black;" type="text"/> First condition</p> <p>8894 <input style="width: 30px; border: 1px solid black;" type="text"/> <input style="width: 30px; border: 1px solid black;" type="text"/> Second condition</p> <p>8896 <input style="width: 30px; border: 1px solid black;" type="text"/> <input style="width: 30px; border: 1px solid black;" type="text"/> Third condition</p> | |
| <p>CHECK ITEM T20 Are two or more conditions entered in item 13?</p> | <p>8898 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to 15</i></p> | |
| <p>14. Which of the conditions do you consider to be the main reason for . . . 's difficulty?</p> | <p>8900 <input style="width: 30px; border: 1px solid black;" type="text"/> <input style="width: 30px; border: 1px solid black;" type="text"/> Main condition</p> | |
| <p>15. Does . . . have –</p> | <p>a. A learning disability such as dyslexia? 8902 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>b. Mental retardation? 8904 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>c. A developmental disability such as autism or cerebral palsy? 8906 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>d. Alzheimers disease, senility, or dementia? 8908 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>e. Any other mental or emotional condition? 8910 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> | |

| Section 5 – TOPICAL MODULES (Continued) | |
|--|---|
| Part E – FUNCTIONAL LIMITATIONS AND DISABILITY (Continued) | |
| <p>CHECK ITEM T21 Refer to cc item 24. What is ...'s age?</p> | <p>8912 1 <input type="checkbox"/> 15 years old – SKIP to Check Item T27 2 <input type="checkbox"/> 16 to 67 years old 3 <input type="checkbox"/> 68 years old or older – SKIP to 18a</p> |
| <p>CHECK ITEM T22 Refer to cc item 47. Is "Disabled" (code 171) marked on the Control Card for ...?</p> | <p>8914 1 <input type="checkbox"/> Yes – SKIP to 16 2 <input type="checkbox"/> No</p> |
| <p>CHECK ITEM T23 Is "Disabled" (code 171) marked on the ISS for ...?</p> | <p>8916 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – SKIP to 17a</p> |
| <p>16. We have recorded that ...'s health or condition limits the kind or amount of work ... can do. Is that correct?</p> | <p>8918 1 <input type="checkbox"/> Yes – SKIP to Check Item T24 2 <input type="checkbox"/> No – SKIP to 18a</p> |
| <p>17a. Does ... have a physical, mental, or other health condition which limits the kind or amount of work ... can do?</p> | <p>8920 1 <input type="checkbox"/> Yes – Mark "171" on ISS 2 <input type="checkbox"/> No – SKIP to 18a</p> |
| <p>CHECK ITEM T24 Is "Worked" (code 170) marked on ISS?</p> | <p>8922 1 <input type="checkbox"/> Yes – SKIP to 18a 2 <input type="checkbox"/> No</p> |
| <p>17b. Does ...'s health or condition prevent ... from working at a job or business?</p> | <p>8924 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>18a. Does ... have a physical, mental, or other health condition which limits the kind or amount of work ... can do around the house?</p> | <p>8926 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – SKIP to Check Item T25</p> |
| <p>b. Does ...'s health or condition completely prevent ... from doing work around the house?</p> | <p>8928 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |
| <p>CHECK ITEM T25 Is "Yes" marked in 16, 17a, or 18a?</p> | <p>8930 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – SKIP to Check Item T27</p> |
| <p>(SHOW FLASHCARD AA) 19. I have marked that ... is limited in working at a job or around the house – Which condition or conditions on this card are the cause of this limitation? Any other condition?</p> | <p>8932 <input type="checkbox"/> <input type="checkbox"/> First condition 8934 <input type="checkbox"/> <input type="checkbox"/> Second condition 8936 <input type="checkbox"/> <input type="checkbox"/> Third condition</p> |
| <p>CHECK ITEM T26 Are two or more conditions entered in item 19?</p> | <p>8938 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – SKIP to Check Item T27</p> |
| <p>20. Which of the conditions do you consider the main reason for the limitation?</p> | <p>8940 <input type="checkbox"/> <input type="checkbox"/> Main condition</p> |
| <p>CHECK ITEM T27 Refer to cc items 24 and 27. Is ... the designated parent or guardian of children under the age of 6 who live in this household?</p> | <p>8942 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – SKIP to Check Item T28</p> |
| <p>21a. Because of a physical, learning, or mental health condition, do any of ...'s children under 6 years of age have any limitations at all in the usual kind of activities done by most children their age?</p> | <p>8944 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – SKIP to 22a</p> |
| <p>b. Which children have activity limitations?</p> | <p>Person No. Name</p> <p>8946 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>8948 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>8950 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> |

| Section 5 – TOPICAL MODULES (Continued) | | | | | | | | | |
|---|---|------------|------|-------------------------|--|-------------------------|--|-------------------------|--|
| Part E – FUNCTIONAL LIMITATIONS AND DISABILITY (Continued) | | | | | | | | | |
| <p>22a. Have any of . . . 's children under the age of 6 received therapy or diagnostic services designed to meet their developmental needs?</p> | <p>8952 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to Check Item T28</i></p> | | | | | | | | |
| <p>b. Which children have received these services?</p> | <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%; text-align: left; padding: 2px;">Person No.</th> <th style="width: 85%; text-align: left; padding: 2px;">Name</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">8954 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 2px;">8956 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 2px;">8958 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> </tbody> </table> | Person No. | Name | 8954 [] [] [] | | 8956 [] [] [] | | 8958 [] [] [] | |
| Person No. | Name | | | | | | | | |
| 8954 [] [] [] | | | | | | | | | |
| 8956 [] [] [] | | | | | | | | | |
| 8958 [] [] [] | | | | | | | | | |
| <p>CHECK ITEM T28 Refer to cc items 24, 25, and 27. Is . . . the designated parent or guardian of children between the ages of 6 and 21 who live in this household?</p> | <p>8960 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to Check Item T29</i></p> | | | | | | | | |
| <p>23a. Because of a physical, learning, or mental health condition, do any of . . . 's children between the ages of 6 and 21 have limitations in their ability to do regular school work?</p> | <p>8962 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to 24a</i></p> | | | | | | | | |
| <p>b. Which children have difficulty doing regular school work?</p> | <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%; text-align: left; padding: 2px;">Person No.</th> <th style="width: 85%; text-align: left; padding: 2px;">Name</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">8964 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 2px;">8966 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 2px;">8968 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> </tbody> </table> | Person No. | Name | 8964 [] [] [] | | 8966 [] [] [] | | 8968 [] [] [] | |
| Person No. | Name | | | | | | | | |
| 8964 [] [] [] | | | | | | | | | |
| 8966 [] [] [] | | | | | | | | | |
| 8968 [] [] [] | | | | | | | | | |
| <p>24a. Have any of . . . 's children between the ages of 6 and 21 ever received any special education services?</p> | <p>8970 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to Check Item T29</i></p> | | | | | | | | |
| <p>b. Which children have received special education services?</p> | <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%; text-align: left; padding: 2px;">Person No.</th> <th style="width: 85%; text-align: left; padding: 2px;">Name</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">8972 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 2px;">8974 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 2px;">8976 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> </tbody> </table> | Person No. | Name | 8972 [] [] [] | | 8974 [] [] [] | | 8976 [] [] [] | |
| Person No. | Name | | | | | | | | |
| 8972 [] [] [] | | | | | | | | | |
| 8974 [] [] [] | | | | | | | | | |
| 8976 [] [] [] | | | | | | | | | |
| <p>25a. Are any of . . . 's children between the ages of 6 and 21 currently receiving special education services?</p> | <p>8978 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to Check Item T29</i></p> | | | | | | | | |
| <p>b. Which children are currently receiving special education services?</p> | <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%; text-align: left; padding: 2px;">Person No.</th> <th style="width: 85%; text-align: left; padding: 2px;">Name</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">8980 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 2px;">8982 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 2px;">8984 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> </tbody> </table> | Person No. | Name | 8980 [] [] [] | | 8982 [] [] [] | | 8984 [] [] [] | |
| Person No. | Name | | | | | | | | |
| 8980 [] [] [] | | | | | | | | | |
| 8982 [] [] [] | | | | | | | | | |
| 8984 [] [] [] | | | | | | | | | |
| <p>CHECK ITEM T29 Refer to cc items 24 and 27. Is . . . the designated parent or guardian of children between the ages of 3 and 14 who live in this household?</p> | <p>8986 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to Check Item T30</i></p> | | | | | | | | |
| <p>26a. Do any of . . . 's children between the ages of 3 and 14 have a long lasting condition that limits their ability to walk, run, or use stairs?</p> | <p>8988 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to Check Item T30</i></p> | | | | | | | | |
| <p>b. Which children have difficulty with these activities?</p> | <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%; text-align: left; padding: 2px;">Person No.</th> <th style="width: 85%; text-align: left; padding: 2px;">Name</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">8990 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 2px;">8992 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="padding: 2px;">8994 [] [] []</td> <td style="border-bottom: 1px solid black;"></td> </tr> </tbody> </table> | Person No. | Name | 8990 [] [] [] | | 8992 [] [] [] | | 8994 [] [] [] | |
| Person No. | Name | | | | | | | | |
| 8990 [] [] [] | | | | | | | | | |
| 8992 [] [] [] | | | | | | | | | |
| 8994 [] [] [] | | | | | | | | | |
| <p>CHECK ITEM T30 Are any person numbers recorded in items 21b through 26b?</p> | <p>8996 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to 28a</i></p> | | | | | | | | |

Section 5 – TOPICAL MODULES (Continued)

Part E – FUNCTIONAL LIMITATIONS AND DISABILITY (Continued)

27. (SHOW FLASHCARD BB)
I have recorded that (Read names of children identified in items 21b–26b) have difficulty(ies) with certain activities?

Which condition or conditions on this card are responsible for these difficulties?

Any other?

FIRST CHILD

Person No. Name

8998

9000 First condition

9002 Second condition

9004 Third condition

SECOND CHILD

Person No. Name

9006

9008 First condition

9010 Second condition

9012 Third condition

THIRD CHILD

Person No. Name

9014

9016 First condition

9018 Second condition

9020 Third condition

28a. In the last 12 months, has . . . applied for Social Security disability or SSI benefits for him/herself?

9022 1 Yes
 2 No – SKIP to part F, page 74

b. Is . . . receiving Social Security disability or SSI benefits?

9024 1 Yes
 2 No – SKIP to part F, page 74

c. In which of the past 12 months did . . . first receive Social Security disability or SSI benefits?

9026 Month
 x1 DK

NOTES

| Section 5 – TOPICAL MODULES (Continued) | |
|---|--|
| Part F – UTILIZATION OF HEALTH CARE SERVICES | |
| 1a. During the past 12 months, was . . . a patient in a hospital overnight or longer? | <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9100</div> <div> <input type="checkbox"/> Yes <input type="checkbox"/> No — <i>SKIP to 3</i> </div> </div> |
| b. How many different times did . . . stay in a hospital overnight or longer during the past 12 months? | <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9102</div> <div> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Times x1 <input type="checkbox"/> DK </div> </div> |
| c. What was the reason for . . . 's last hospital stay? <i>Mark (X) all that apply.</i> | <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9104</div> <div><input type="checkbox"/> Child birth</div> </div> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9106</div> <div><input type="checkbox"/> Surgery or operation (including bone setting or getting stitches)</div> </div> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9108</div> <div><input type="checkbox"/> Other medical</div> </div> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9110</div> <div><input type="checkbox"/> Mental or emotional problem or disorder</div> </div> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9112</div> <div><input type="checkbox"/> Drug or alcohol abuse problem or disorder</div> </div> |
| d. Was . . . a patient in a VA or military hospital during (this visit/any of these visits)? | <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9114</div> <div> <input type="checkbox"/> Yes, military <input type="checkbox"/> Yes, VA <input type="checkbox"/> Yes, both military and VA <input type="checkbox"/> No </div> </div> |
| 2a. Was . . . a patient in a psychiatric hospital or a psychiatric unit of a hospital during (this visit/any of these visits)? | <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9116</div> <div> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> </div> |
| b. How many nights in all did . . . spend in a hospital of any type during the past 12 months? | <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9118</div> <div> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Nights x1 <input type="checkbox"/> DK </div> </div> |
| c. How many of these nights were in the past 4 months? | <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9120</div> <div> <input type="checkbox"/> All nights OR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Nights OR x1 <input type="checkbox"/> DK x3 <input type="checkbox"/> None </div> </div> |
| 3. During the past 4 months, about how many days did illness or injury keep . . . in bed more than half of the day? (Include days while an overnight patient in a hospital.) | <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9122</div> <div> <input type="checkbox"/> All days OR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Days OR x1 <input type="checkbox"/> DK x3 <input type="checkbox"/> None </div> </div> |
| 4a. During the past 12 months, how many times did . . . see or talk to a medical doctor or assistant? (Do not count occurrences while an overnight patient in a hospital.) | <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9124</div> <div> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Times OR x1 <input type="checkbox"/> DK x3 <input type="checkbox"/> None } <i>SKIP to 5a</i> </div> </div> |
| b. How many of these visits or calls were in the past 4 months? | <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">9126</div> <div> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Times OR x1 <input type="checkbox"/> DK x3 <input type="checkbox"/> None </div> </div> |
| NOTES | |

CARD AA
WAVE 3, 1991 PANEL
WAVE 6, 1990 PANEL
FOR ADULTS
HEALTH CONDITIONS

| Code | Condition |
|-------------|---|
| 01 | — Alcohol or drug problem or disorder |
| 02 | — AIDS or AIDS Related Condition (ARC) |
| 03 | — Arthritis or rheumatism |
| 04 | — Back or spine problems (including chronic stiffness or deformity of the back of spine) |
| 05 | — Blindness or vision problems (difficulty seeing well enough to read a newspaper, even with glasses on) |
| 06 | — Broken bone/fracture |
| 07 | — Cancer |
| 08 | — Cerebral palsy |
| 09 | — Deafness or serious trouble hearing |
| 10 | — Diabetes |
| 11 | — Epilepsy |
| 12 | — Head or spinal cord injury |
| 13 | — Heart trouble (including heart attack (coronary), hardening of the arteries (arteriosclerosis)) |
| 14 | — Hernia or rupture |
| 15 | — High blood pressure (hypertension) |
| 16 | — Kidney stones or chronic kidney trouble |
| 17 | — Learning disability |
| 18 | — Lung or respiratory trouble (asthma, bronchitis, emphysema, respiratory allergies, tuberculosis, or other lung trouble) |
| 19 | — Mental or emotional problem or disorder |
| 20 | — Mental retardation |
| 21 | — Missing legs, feet, arms, hands, or fingers |
| 22 | — Paralysis of any kind |
| 23 | — Senility/Dementia/Alzheimer's disease |
| 24 | — Speech disorder |
| 25 | — Stiffness or deformity of the foot, leg, arm, or hand |
| 26 | — Stomach trouble (including ulcers, gallbladder, or liver conditions) |
| 27 | — Stroke |
| 28 | — Thyroid trouble or goiter |
| 29 | — Tumor, cyst, or growth |
| 30 | — Other |

AA

CARD BB
WAVE 3, 1991 PANEL
WAVE 6, 1990 PANEL
FOR CHILDREN
HEALTH CONDITIONS

| Code | Condition |
|-------------|---|
| 01 | Asthma |
| 02 | Autism |
| 03 | Blindness or vision problems |
| 04 | Cancer |
| 05 | Cerebral palsy |
| 06 | Deafness or serious trouble hearing |
| 07 | Diabetes |
| 08 | Drug or alcohol problem or disorder |
| 09 | Epilepsy or seizure disorder |
| 10 | Hay fever or other respiratory allergies |
| 11 | Head or spinal cord injury |
| 12 | Heart trouble |
| 13 | Impairment or deformity of back, side, foot, or leg |
| 14 | Impairment or deformity of finger, hand, or arm |
| 15 | Learning disability |
| 16 | Mental or emotional problem or disorder |
| 17 | Mental retardation |
| 18 | Missing legs, feet, toes, arms, hands, or fingers |
| 19 | Paralysis of any kind |
| 20 | Speech problems |
| 21 | Tonsillitis or repeated ear infections |
| 22 | Other |

BB