

CASH AND COUNSELING DEMONSTRATION PARTICIPATION QUESTIONNAIRE

Mathematica Policy Research, Inc.

This instrument was developed for the Cash and Counseling Demonstration. This project was conducted under contract #HHS-100-95-0046 between the U.S. Department of Health and Human Services' Office of Disability, Aging and Long-Term Care Policy (DALTCP) and the University of Maryland. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, Pamela Doty, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Pamela.Doty@hhs.gov.

Deciding About Consumer Directed Care



In order to improve the Medicaid project, Consumer Directed Care, we would like to know more about who is interested in applying to the project and why, and who is *not* interested in applying and why not.

INSTRUCTIONS

Thank you for taking the time to complete this form. Directions for filling it out are provided with each question. Because not all questions will apply to everyone, you may be asked to skip certain questions.

- Part A of this form is for people who decided to apply to the project. Part B is for people who decided NOT to apply. Parts C and D are for everyone.
- Follow all "SKIP" instructions AFTER marking a box. If no "SKIP" instruction is provided, you should continue to the NEXT question
- Either a pen or pencil may be used
- When answering questions that require marking a box, please use an "X"
- If you need to change an answer, please make sure that your old answer is either completely erased or clearly crossed out

Thanks again for your help, we really appreciate it.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number of this information is 0990-0223. The time required to complete this information collection is estimated to average 5 minutes, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. Approval expires 10/31/2001.

PART A - If decided TO APPLY to the Consumer Directed Care project

Part A is only for people who decided to apply to the project. If you decided not to apply, start with question B1.

A1. Who made the decision to apply to the Consumer Directed Care project?
Mark (X) one or more.

- 01 Person who would receive the monthly budget (if randomly selected)
- 02 Someone who will be managing the monthly budget as a representative of the person receiving it
- 03 Other family members and friends

A2. What were the main reasons for deciding to apply? Mark (X) one or more reasons.

- 01 Have more control over who to hire
- 02 Get better or more care
- 03 Get care at more convenient times
- 04 Purchase community services not covered under Medicaid
- 05 Purchase equipment or supplies
- 06 Purchase home or car modifications
- 07 Get help from consultants or bookkeeping service
- 08 Pay personal care workers more or provide (more) benefits
- 09 Pay family members or friends
- 10 None of the above

SKIP TO C1

PART B - If decided NOT to apply.

B1. Who made the decision not to apply to the project?
Mark (X) one or more.

- 01 Person who would have been receiving the monthly budget (if randomly selected)
- 02 Someone who would have been managing the monthly budget as a representative of the person receiving it
- 03 Other family members and friends

B2. What were the main reasons for deciding not to apply?
Mark (X) one or more reasons.

- 01 Do not want to hire and possibly fire workers
- 02 Concern about quality of care or personal safety if hire workers
- 03 Do not want to file payroll taxes for workers or track project expenses
- 04 Do not think budget would be enough to pay for all needed care
- 05 Satisfied with current care arrangements
- 06 Afraid change might upset family or friends
- 07 Do not think providing a budget is a good idea
- 08 Do not like random selection, or do not like that participation is guaranteed for only two years
- 09 Afraid family or friends might misuse budget
- 10 None of the above

Continue with Section C

PART C - FOR EVERYONE: About the Person MANAGING the Monthly Budget

Please answer the questions in Section C about the person who will be, or would have been, MANAGING the monthly budget. This could be a person randomly selected to receive the budget or someone else managing the budget as his or her representative.

C1. Did someone explain the Consumer Directed Care project in person or over the telephone to the person who will be, or would have been, MANAGING the monthly budget?

Mark (X) only one.

- 01 In person
 - 02 Over the telephone, not in-person
 - 03 In person AND over the telephone
 - 04 Neither
 - 08 Don't know
- SKIP TO C2

C1a. How useful did this person find the explanations in deciding whether or not to apply? Mark (X) only one.

- 01 Very useful
- 02 Somewhat useful
- 03 Not useful

C2. Did this person receive materials explaining the project, like a brochure or other information in the mail? Mark (X) only one.

- 01 Yes, received materials
- 02 No, did not receive materials → SKIP TO C3

C2a. How useful did he or she find those materials in deciding whether or not to apply to the Consumer Directed Care project? Mark (X) only one.

- 01 Very useful
- 02 Somewhat useful
- 03 Not useful

C3. Has this person EVER supervised another person as part of paid or volunteer work? Mark (X) only one.

- 01 Yes
- 02 No

Continue with Section D

PART D - FOR EVERYONE: About the Person RECEIVING the Monthly Budget

Please answer the questions in Section D about the person who will be, or would have been, RECEIVING the monthly budget, if randomly selected. Please do NOT answer about a representative who is, or would have been, managing the monthly budget for someone else.

D1. What is this person's age? (The person who will be, or would have been, RECEIVING the monthly budget if randomly selected.) Please write in age.

Age in years (at last birthday): |__|__|

D2. What is this person's sex? Mark (X) only one.

- 1 Male
- 2 Female

D3. Is this person of Hispanic or Latino origin, such as Mexican, Puerto Rican, Cuban, or other Spanish background? Mark (X) only one.

- 1 Yes
- 2 No

D4. What is this person's race? Mark (X) one or more races.

- 1 White
- 2 Black or African American
- 3 American Indian or Alaska Native
- 4 Asian
- 5 Native Hawaiian or other Pacific Islander
- 6 Some other race
Please write in

D5. In what county and state does this person live? Please write in county and state names.

County name:

State Name:

D6. How long has this person been receiving home and community-based Medicaid services? Mark (X) only one.

- 0 Have not yet begun receiving services
- 1 Less than three months
- 2 Three months to a year
- 3 More than a year
- 8 Don't know

THANK YOU FOR COMPLETING THIS FORM