



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

**AN EVALUATION OF THE
VETERANS ADMINISTRATION
HOUSEBOUND AND AID
AND ATTENDANCE
ALLOWANCE PROGRAM**

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Office of the Assistant Secretary for Planning and Evaluation

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John M. Grana, Ph.D.
Sandra M. Yamashiro, M.P.A.

Project HOPE
Center for Health Affairs

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PREFACE

This report was prepared by the Project HOPE Center for Health Affairs for the Office of the Assistant Secretary for Planning and Evaluation under Grant No. 84ASPE150A. The grant totaled \$97,152.00. John Grana and Sandra Yamashiro were the principal analysts. Additional analytical support was provided by Glinda Cooper, David Crozier, and Denise Spence. Cleonice Tavani served as Project Officer, and provided guidance and assistance during all phases of this project. Claudia Cole provided secretarial assistance.

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1.0 INTRODUCTION AND EXECUTIVE SUMMARY

There is an incongruity in the way noninstitutional services are subsidized in this country. Disabled persons in the general population with money make decisions daily so to the makeup of their living environments, buying a mix of goods and services which best promotes their independence. In contrast, most disabled persons without sufficient resources have very little freedom of choice: Rather than being provided with a cash supplement which they, too, could spend to maximize independence, the poor in general either are restricted to choices from a narrow list of services paid for by public monies (known as vouchers), or, more commonly, are limited to the type and quantity of services they can receive as dictated by agents of a public authority (known as in-kind transfer payments). Our society is implicitly saying that the financially needy disabled cannot manage their resources as well as all other disabled persons and should not be trusted to do so.

This is not the case in almost every other country in the world. In most countries, including virtually all industrialized nations, public subsidies for noninstitutional long-term care are in the form of cash as well as in-kind (Tracy, 1974). These cash disability grants for long-term care, called "attendance" or "attendant care" allowances in recognition of the need for assistance by another person, are usually the first, and sometimes the only public intervention used to help noninstitutionalized frail elderly cope with the additional burdens imposed by their functional disabilities (Grana, 1983). Recipients who qualify on the basis of medical need, and in most cases on the basis of financing need as well, receive unrestricted cash grants which can be spent on anything they wish.

Attendance allowances were generally adopted first by agencies charged with the affairs of war veterans. The U.S. Veterans Administration (VA) is no exception. The Housebound and Aid and Attendance Allowance Program of the VA provides cash grants to 220,000 disabled veterans and surviving spouses a year in lieu of formally provided homemaker, personal care and other services needed for assistance in activities of daily living and other help at home. VA has been providing these allowances for over 35 years--legislative authority for this program is provided by Public Law 82-149, enacted on November 1, 1951. The program is means-tested for nonservice-connected disabilities under the general pension program (185,160 beneficiaries in 1985); grants for service-connected disabilities are made on the basis of medical need only (35,422 beneficiaries in 1985). Implicit VA policy is to allow competent disabled persons to decide how best to meet their own needs, not to make all those decisions on their behalf.

The advantages of cash compared to in-kind benefits have long been noted by economists. Competent consumers know best how to allocate their scarce budgets among all possible commodities and services to maximize the satisfaction of their needs

and wants; they are more efficient than any other person in promoting their own personal well-being, happiness and independence. The cash equivalent of an in-kind transfer will permit a beneficiary to achieve a higher level of well-being and happiness, and in this sense, the cash transfer is socially optimal and more efficient. A cash benefit has the additional advantage (in most cases) of being easier and less costly to administer.

Cash benefits are used extensively in other public programs in the U.S. For recipients of an old age or survivor's pension, or of supplemental security income, the government does not try to purchase housing, food and clothing in the right quantities for each individual. The task of equating the complex needs and preferences of each individual to a set of in-kind transfers is clearly an impossible one. Instead, the level of entitlement of need is set, and checks are sent to beneficiaries who spend their monies on needed goods and services just like everyone else. Since the need for long-term care also is multidimensional, why, then, should not assistance for help at home be in the form of cash?

Critics of cash disability allowances would argue that most old disabled persons don't know what they need in the way of services, or are not competent to judge what is good for them: that people will squander their grants on unnecessary items, purchase an insufficient amount of needed services, become more frail and ill, need more intensive acute and long-term care, and eventually fall back on the social safety net at an even greater cost to society. They feel that care decisions must be made on behalf of the elderly, and that subsidies should be in the form of in-kind services which leave little decision-making in the hands of the recipient. Others might argue that the number of claims for a cash benefit would be much greater than for an in-kind benefit, so that screening, and hence administrative, costs of the cash benefit could actually be greater.

This project had two major goals. This first was to describe the workings of a successful, large-scale, cash disability allowance program from an administrative perspective. The VA allowance program is described in detail, to provide a benchmark for future research and program design. The second goal was to examine the question whether recipients of a cash allowance for long-term care are worse off than similar persons who receive in-kind subsidies. This study does so by examining the life circumstances of 139 recipients of the VA Housebound Allowance or Aid and Attendance Allowance. The health, functional needs, and use of services of these persons are compared with those of 610 persons interviewed in the 1983 National Long-Term Care Survey who received services in-kind. This report represents the first outside evaluation of this program.

The analytical results of the study suggest that recipients of the cash disability allowance received similar levels of long-term care and were no worse off than the comparison group with regard to acute health care utilization. Evidence on hours of care per week and the direct (non-administrative) costs of the VA cash allowance program suggest that the cash benefit may be the more cost-effective alternative for many beneficiaries. One interesting by-product of the analysis was the finding that the

substitution of subsidized, in-kind care for informal effort was significant and approximately one-to-one.

The full report is organized as follows: Section 2.0 lays out the conceptual issues underlying the use of cash versus in-kind subsidies, and summarizes the literature pertinent to these topics. Section 3.0 describes the VA Housebound and Aid and Attendance Allowance Program, including program benefits, eligibility criteria, and administration. Section 4.0 describes the study research design and methodology. Section 5.0 presents the analytical results and findings, including implications for policy and further research.

2.0 RESTRICTED TRANSFERS VERSUS CASH ALLOWANCE

With the exception of the United States Veterans Administration, most public home care programs are in-kind: after eligibility for the program has been determined, the client is usually provided with a fixed amount of services determined by the administering agency. Services are either provided by salaried personnel from the local public authority or are purchased in the private market on behalf of the client by the authority. Some countries in some states provide vouchers for services which allow the client to select the mix and amount of services from the narrow list of possible alternatives; a few provide cash supplements. Both of these types of programs, however, are rare (Urban Systems Research and Engineering, 1981). In general, the provision of services in-kind predominates.

Due to the lack of such cash transfer programs for long-term care, little research has been conducted to compare their cost and effectiveness with in-kind services. One of the earliest discussions of the advantages of cash allowances is in Humm-Delgado and Morris (1976). They discuss cash allowances in the context of payments to families with mentally retarded dependents. They describe a number of cash payment programs which share three goals: to help support, strengthen and keep families intact; to reduce and prevent the social and economic costs of institutionalization; and to provide necessary services without social service agency and bureaucratic structures and overhead. They point out that the substitution of public dollars for private effort is both a wise intervention and a major concern. They note the fear that some policymakers have that such subsidies will make families refuse to provide services without them. Cash subsidies also are easy to abuse and difficult to monitor. The key public policy issue is how to maximize the economic benefit by supporting the disabled person and enabling caregivers to sustain their effort while, at the same time, trying not to supplant too much private effort with public resources.

It should be noted that the economic benefits of public subsidies for care at home do not necessarily have to take the form of reduced or retarded institutionalization. Recent research concludes that the relationship between home care and reduced institutionalization is tenuous (Weissert, 1985; Skellie, et al, 1982; and Mathematica, 1985). This study takes the view that there are other legitimate and socially useful reasons for subsidizing care at home, such as relieving the burdens of caregivers, and because of which, taxpayers are willing to pay for it. Therefore, this study does not address the relationship between home care and institutionalization. Instead, this study asks the question: Which method of subsidizing care is the most efficient one, given that society wishes to subsidize home care?

2.1 Conceptual Issues

This and the following section discusses the theoretical issues of in-kind services versus cash allowances from the perspective of economics. The economic model, which is but one of many possible conceptualizations of this topic area, establishes the framework for the empirical analysis which follows.

2.1.1 Consumer Sovereignty and Efficiency

The provision of in-kind services for needy persons precludes “sovereignty:” that is, the making of informed and rational choices by consumers to maximize their personal well-being. Under conditions of competitive markets and consumer sovereignty, if the public is interested in the well-being of the recipient of public transfers in general, but not the recipient’s consumption of a particular commodity or service, cash transfers are generally more efficient (less costly for the same beneficial effects) than restricted transfers. Sovereign consumers may spend all of the cash equivalent on exactly the same amount of service they would have received in-kind; the consumer may also spend less than this amount, if he or she feels some portion of it could be better spent on other goods or services. Cash enables the beneficiary to purchase things which are of greatest value. Under these conditions, the value of the benefits are optimal, and the social cost of the program is minimized. (These conceptual issues, and those that follow, are discussed in an excellent article by Gruenberg and Pillemer, 1981, and also by Grana, 1983.)

A common argument for restricting transfers in long-term care is that, like acute care medical services, long-term care services are complex and not capable of being understood even by fully competent consumers who must seek advice before making choices among a set of highly technical alternatives. In consequence, the provider must demand the service on behalf of the individual. The demand for services is thus distorted, markets may not be competitive, and the final allocation of resources does not reflect the preference of consumers. That is, consumers of health care are not sovereign, and it may be more efficient to restrict transfer payments to recipients with vouchers or with in-kind transfers.

It is not necessarily true, however, that long-term care consumers are incapable of informed and rationale choices. Some aspects of personal care in the home are technical, but compared with acute care services, they are far less technical and sophisticated and much easier to match with individual needs. Information gathering in medical care markets and perhaps in long-term care markets may be similar to that in markets for other commodities, such as stereo equipment, where consumer sovereignty exists and technical advice is sought before a purchase is made (Reinhardt, 1981). Many elderly people have an informal network of family and friends to help with important decisions and act as broker to the system in general; local agencies can also fulfill this role by giving advice. Thus, it is not always necessary for medical providers to make choices for the consumer of long-term care.

Cash subsidies also may be more efficient than in-kind subsidies because they permit “time-shifting” of expenditures. Whereas in-kind subsidies are consumed when provided, cash may be saved and accumulated to be spent at a more propitious time. Cash also may be accumulated and spent on needed goods and services which yield equivalent benefit but which costs more than a single unit of an in-kind benefit. An example of this is an electromechanical device which raises and lowers disabled persons into bathtubs. Although an expensive investment, its use may obviate a much greater value of personal attendant care required for the same function. Thus, cash can enhance the sovereignty of consumers by eliminating barriers due to the timing and “lumpiness” of expenditures.

2.1.2 Substitution Effects

Most home care is provided by informal caregivers (Soldo, 1983). This represents an enormous financial burden which is borne by families and friends rather than taxpayers in general. From society’s point of view, it is worthwhile to support the informal support network in their efforts to keep their disabled dependents out of more costly institutions by substituting public resources for the excessive caregiving burden which can ultimately destroy the will to care for a dependent person at home.

As public subsidies to encourage informal caregiving are increased, however, there is the risk that too much informal effort will be reduced; that public resources will substitute for private time and money that would otherwise be spent willingly on behalf of the disabled person. This “substitution effect” can translate into a tremendous waste of public resources. Despite the potential magnitude of this problem, however, little is known about the impact of public subsidies on caregiver behavior.

In light of the dearth of information on this complex problem, we may ask a different question: Does the form of public subsidies for long-term home care matter? That is, is one type of subsidy more efficient than the others in encouraging informal caregiving and not providing incentives for the excessive substitution of public for private effort?

Given any chosen level of care for a dependent, a family or informal support network must decide how much of its own time to substitute for goods and services purchased in the market. This is an economic decision tempered by family preferences. Families that are relatively more efficient at earning incomes will tend to work more and buy more caregiving services in the market; those who can earn only relatively low wages face lower opportunity costs of staying home to care for a dependent elder and will tend to do so, and will tend to purchase fewer caregiving services in the market. In-kind subsidies are inflexible in the sense that they substitute one-for-one for services otherwise delivered by the family and informal caregivers; they do not permit the kinds of allocative decisions mentioned above that families make on the first amounts of home care needed by the dependent person. In contrast to in-kind subsidies, however, for recipients of a cash subsidy, some informal effort may be used to substitute for services otherwise purchased in the marketplace, and the cash retained to be spent on goods

and services which complement rather than substitute for caregiving. This allows the dependent and caregiver to select the mix of substitute care and other goods and services which are most appropriate given family resources and the informal caregiver's available time and opportunity wage (that is, the wage the caregiver could earn if a participant in the labor market). The incentive is clearly to choose the right amount of formal (market-supplied) and informal caregiving which maximizes the value of the subsidy.

Pollak (1986) summarizes the importance of the flexibility of cash subsidies to public policy. Under policies that subsidize only formal noninstitutional care, ". . .there is an incentive to use formal rather than informal care even when the social cost of the informal care is lower. The efficiency of a cash grant system relative to its alternatives derives from shifting actual care tasks toward informal systems when they are the preferred (least social cost) mode, even as, consistent with an equity objective, it shifts burdens from the impaired and their families by providing cash resources. This significant virtue is still further enhanced to the degree that society sees a social benefit in family and informal care even beyond the benefit felt by those directly involved."

2.2 Critiques of Cash Transfers

2.2.1 Competency and Consumer Protection

Some elderly consumers of long-term care are not capable of making rational decisions even with perfect information. Some need formal advice, and a small portion of them require some or all decisions to be made on their behalf. It is the clear responsibility of society to protect those individuals who, because of brain disease or other causes of confusion, are not capable of making appropriate decisions regarding their well-being, and who do not have brokers. Paternalism "is often a realistic response to the elder's preference for happiness over freedom in a world dominated by forces too vast and too complicated for him to manage himself" (Halper, 1980). In this case, cash is not an efficient mechanism and restricted transfers are appropriate. The costs, in both human and economic terms, from the inappropriate allocation of a cash benefit will likely exceed those costs of the inefficient matching of needs and preferences with a set of in-kind benefits.

For most, though, restrictions on the long-term care market may cause problems. Restricted client decision-making greatly diminishes the possibility that limited resources will be spent most appropriately to maximize well-being for many. Incorrect decisions about long-term care use are costly, both in human and financial terms. But there are also costs involved in designing programs for all to protect the few who will make poor decisions. Public programs designed to restrict the choices and hence, the liberty, of recipients, for many of whom such restrictions are not appropriate, tend to undermine an individual's self-confidence and independence, which reinforces dependent behavior. Such programs will tend to promote and propagate stereotypes of old people as decrepit and dependent, further distancing them from the mainstream of society. Thus,

the social and personal costs of paternalism, which are often ignored or neglected by society, can be high.

Even if the effects of long-term care services on well-being were known with great accuracy, it is not clear that individuals preferences for other goods and services are not more important to well-being than long-term care. How do we know that 15 hours of personal attendance is more appropriate for a given individual than 11 hours of personal attendance and a jug of wine? In fact, it is quite possible that for many people the actual act of choosing one's environment may be far more important to well-being and resulting postponement of dependency and institutionalization than any formal service society can provide (Bishop, 1981).

Restricting client decision-making for every public recipient greatly diminishes the possibility that limited resources will be spent most appropriately to maximize well-being for many. Given the heterogeneity of the elderly population in the United States, with a wide range of personal care needs and mental competence, and the uncertainty of existing assessment instruments and the unpredictability of the impact of standard sets of services and therapies, the efficient allocation of noninstitutional long-term care can not be achieved with one policy instrument. Rather, attempts should be made to seek out and employ the whole spectrum of policy instruments: "Given a continuum of individuals with varying degrees of competence, transfer payments need a corresponding continuum of transfers ranging from cash, cash with advice, vouchers, in-kind provision, and finally, compulsion" (Thurow, 1974).

2.2.2 Moral Hazard

A major criticism of cash subsidies is that they are inherently more attractive than equivalent amounts of in-kind subsidies: They will provide an incentive for persons to misrepresent their condition or state of health either to qualify for the subsidy or to receive a larger subsidy. There is also an incentive for families to exaggerate (lower) their capacities and capability to care for a dependent, where such considerations are taken into account by the public agency. This is commonly called "moral hazard." In this regard, an in-kind subsidy such as a particular commodity or service is superior to cash (Krashinsky, 1981).

The primary implication of moral hazard is that administrative costs associated with screening will be greater for cash than for in-kind subsidies for home care. The "woodwork" effect (persons seeking a cash subsidy who would not otherwise have sought an in-kind subsidy) and an "exaggeration" effect (persons falsely overstating their claim for a greater level of subsidy) will increase the level of resources needed to screen out illegitimate claims on the subsidy. Pollack (1983) points out that an in-kind long-term care subsidy for noninstitutional services also faces the moral hazard posed by the cash grant program, but to a lesser degree. Such a benefit aids relatives of the impaired by releasing them from caregiving responsibilities; incentives exist for false representation of the impaired person's degree of infirmity. Better (more accurate) screening and assessment should mitigate this problem. Nevertheless, the number of

screens should be higher, and information gathering costs will be higher. There is, therefore, an empirical question: Do the increased administrative costs for screening outweigh the savings from a more efficient cash program? One study observed seven small-scale cash subsidy programs and noted negligible rates of fraud as well as reduced levels of administrative burden (CSR, 1983). Because of the expense involved and the unavailability of key information on administrative costs for the VA cash disability allowance program, this study is not able to address this issue.

2.2.3 *Adjusting for Family Situation*

Pollak (1986) points out that in the ideal case, the cash grant benefit should be equal to the excess of needs over family assistance. The problem is measuring what the family can, is willing to, or should do. Inaccurate measurement will lead to a higher or lower grant than necessary. The question is whether the social costs of not adjusting the benefit level for family situation outweigh the social benefits of the cash program. This is an empirical question; a matter of degree. Some elements can be measured; for example, the presence or absence of a relative or caregiver, and also the relative burden of a task. Some elements can not be measured; for example, the willingness of families and the strength of familial relationships. It should be noted that this is a problem with in-kind benefits as well.

2.2.4 *Beneficiary and Caregiver Preferences*

A final criticism of cash allowances for long-term care is the claim that both care receivers and caregivers prefer services to cash (Sussman, 1979; Horowitz and Shindelman, 1980 and 1983). Such claims are based on studies of real life caregiving situations, but hypothetical, and poorly stated, alternatives. In general, the level of services or the total costs of services was not stated in the alternatives presented to recipients of services and their families, and legitimate comparisons were not capable of being made with a cash equivalent. For example, this was not the same as asking the question: To relieve this identified stress, would you prefer \$400 per month worth of homemaker services or \$400 in cash? These studies are policy irrelevant with respect to research on cash allowances.

2.3 Experience with Cash and Voucher Programs in the U.S.

2.3.1 *Existing Home Care Programs with Other than In-Kind Benefits*

Cash, vouchers, and tax reductions are three types of alternative mechanisms currently being utilized in the United States for financing public social services. Cash subsidy programs involved direct assistance or cash reimbursement to clients to finance social services. A voucher, which is given to the eligible recipient, represents a written guarantee or promise of payment to a service provider. In response to the desire by families to exercise choice in the amount, type, source, and use of family support services, the use of cash subsidies and vouchers in the delivery of family support

services is on the increase (Agosta and Bradley, 1985). A survey of family-support programs in 17 states reported that 14 of these states employed a cash subsidy or voucher mechanism (Bird, W.A., 1984). Tax reductions utilize the tax system to indirectly encourage persons or their families to purchase needed social services. All three mechanisms aim to stimulate the private market to supply long-term care services as well as to subsidize their consumption.

2.3.1.1 Cash Subsidy Programs for Home Care

As of 1983, 17 states had small scale cash subsidy programs for community-based home care (CSR, 1983). Some programs provided one-time grants intended to fill a particular gap in care. Other programs offered on-going assistance aimed at meeting day-to-day needs. CSR observed seven of these programs and found suggestive evidence that under this type of program, client choice was enhanced within limits,¹ while agency control in, and accountability over, service delivery remained strong. Program administration, involving initial determination of eligibility and subsequent monitoring of care and allocation of subsidy, was found to limit necessary agency contact with clients, decreasing administrative burden. By limiting effort on the cash subsidy population and increasing their interaction with the private marketplace, “publicly-supported services are conserved for others who cannot be served with the cash subsidy approach.” Also, as noted in Section 2.2.2., for cash subsidies, as well as for vouchers and tax reductions, negligible rates of fraud were found.

In their examination of cash programs, Agosta and Bradley (1985) report similar findings and argue that cash allowances “represent a cost-effective and flexible means for states to accommodate the unique needs of individual families.” They note, however, that the success of cash programs are dependent on the availability of needed services in the private market, the level of cash payment, and the competency of the beneficiary.

2.3.1.2. Vouchers for Home Care

The largest and oldest voucher program for long-term care in the United States is California’s In-Home Supportive Services program (IHSS). Begun in 1958, this program made payments to over 100,000 beneficiaries in 1984 at a cost of \$318.5 million (Clinkscale, et al 1985). Two groups of people qualify for this program: 1) persons who receive SSI and/or state supplementation (SSP); and, 2) persons with income above the SSI/SSP ceiling, but who meet IHSS income limits. Beneficiaries are allowed to choose from three different types of delivery systems: 1) individual providers who are selected by the IHSS recipient, and who may be a recipient’s relative; 2) private vendors; and, 3) county social services agencies.

The Supportive Home Care (SHC) program in Wisconsin is similar administratively to the IHSS program in California and acts as the primary social service program for providing in-home services to persons who require assistance with activities

¹ Although clients have a strong role in choosing their provider, agencies maintain a significant amount of control through licensing, contracting, and approval of client choice.

of daily living. Seventy-seven percent of the SHC caseload in 1983, with total expenditures of \$15.5 million, were impaired elderly (Clinkscale, 1985).

The Colorado Home Care Allowance program utilizes the SSI system in the distribution of allowances. Although non-SSI eligible persons are eligible for home care allowances, monies are disbursed in combination with State SSI Supplementation checks.² Currently SSI is the major Federal income maintenance program providing support for elderly persons with long-term care needs (Callahan, et al 1980). Monies from this program are intended to provide for basic living expenses only and not for expenditures related to long-term care needs. The SSI program provides an infrastructure through which a national cash disability allowance program could potentially be administered.

In their analysis of financial incentives to families for the provision of long-term care services, Clinkscale et al (1985) reports that payments to families are becoming an increasingly popular option among states. Reasons cited by states for their support of this policy option included the following: 1) the ability of long-term care consumers to have input into service decisions; 2) the additional flexibility afforded to the long-term care delivery system; 3) an increase in the cost-effectiveness of public long-term care support; 4) an increase in the quality of care; and 5) the positive reinforcement of the informal support network. Although these reasons constitute strong arguments in support of family payments, Clinkscale et al (1985) points out that the major criticism of such payments is the issue of the substitution of public support for familial support. In order to decrease the likelihood of substitution effects, states have established broad guidelines to target program monies to specific populations. The authors note, however, that if programs continue to expand and targeting of services becomes more stringent, it will become increasingly difficult to maintain program equity. Many of these same issues will face efforts to implement cash allowance programs.

2.3.1.3 Tax Credits for Home Care

Tax subsidies in the Federal income tax system take three basic forms: exemptions, deductions, and credits. At present, few families can claim a dependent elderly family member as an exception because of the \$1,000 dependent income cap. As of 1982, the Child and Dependent Care Credit under the Internal Revenue Code became applicable to expenditures for out-of-home noninstitutional care of disabled spouses or other dependents. The Department of Treasury estimates that ten percent of this credit, which cost approximately \$1.3 million dollars in 1981, went for dependent care (Select Committee on Children, Youth and Families, 1984, and Clinkscale, et al, 1985).

As of 1983, 21 states also provided reductions in state taxes for general dependent care for employment-related expenses of a taxpayer (CSR, 1983). Four states--Arizona, Idaho, Iowa, and Oregon--have subsidies targeted specifically to elderly

² Clinkscale et al (1985) reported that Colorado was planning to transfer funding of this program over to the Section 2176 waiver program.

dependent care (Clinkscale, 1985). The form of tax subsidy varies among the states, utilizing one or a mix of tax credit, deductions and exemptions.

2.3.2 Food and Housing Support Programs

The use of vouchers to subsidize the provision of long-term care services is a relatively new concept in the United States; however, vouchers (in the form of food stamps) have been used for a number of years to provide food support for the needy. According to Giertz and Sullivan (1978), taxpayers ('donors') motivations have played a major role in determining the voucher structure of this program. A desire by a large number of taxpayers to maximize the food consumption instead of the utility of the transfer recipient limits the role of cash subsidies in food subsidization. The unsuccessful effort under the Carter administration to reform this program by cashing out food stamps reflects the continued preference of taxpayers to limit recipient benefits to food consumption.

Housing vouchers and cash allowances were used on an experimental basis in the 1970's under the Experimental Housing Allowance Program (EHAP); as of 1982, housing vouchers continued to be provided under Section 8 (Khadduri and Struyk, 1982). In examining the voucher component of this program, Khadduri and Struyk (1982) argue that vouchers are a more efficient method of providing housing assistance than the more traditional housing and rent subsidies. Vouchers allow recipients to purchase housing in the private market, saving the government money with regard to construction costs. Decreased costs per recipient assisted allows more needy persons to be served with the same budgetary amount.

Benedick (1983) believes, however, that if the government is interested in maximizing the utility of the poor, unrestricted income transfers rather than earmarked rent vouchers would be more effective. In support of his conclusion, he note that low-income households receiving housing allowances through the EHAP in the form of unrestricted cash payments spent their increased resources primarily for non-housing goods--from 5.7 to 19.0 percent on average were spent on increased housing expenditures (Struyk and Benedick, 1981). A similar expenditure pattern was true for persons receiving earmarked housing vouchers; vouchers were used to purchase pre-program levels of housing and monies previously used for housing were spent on non-housing goods. Voucher programs also have additional administrative costs, which constitute approximately three percent of total program costs.

2.4 Cash Disability Allowances in Other Countries

Attendance allowances are prevalent in western industrialized countries. They are found under veterans legislation, general invalidity and the work injury provisions of social security legislation, social assistance or welfare programs, and in some cases under legislation for the elderly. In 1974, 47 countries supplied attendance allowances or constant attendance supplements under the invalidity provisions of programs similar

to the old age, survivors, and disability insurance (OASDI) program of the United States (Tracy, 1974). By 1981, attendance allowances under OASDI-type programs were found in 59 countries; when work injury programs were included, 95 countries provided attendance allowance programs (United States Social Security Administration, 1982). Almost every European nation, and most other western industrialized countries, have some form of cash disability allowance for long-term care.

Grana (1983) studied attendance allowances in detail in six countries: France, The Federal Republic of Germany, Italy, Switzerland, The United Kingdom and The United States. All of these countries are concerned about expenditures on institutional care and have formal policies designed to slow down the rapid rates of increase in those expenditures. These countries are turning to noninstitutional long-term care services as a possible cost-effective and humane way of reducing expenditures for institutional care. The attendance allowance is considered one component of a broad strategy to encourage care in the home or other sheltered living environment.

The countries in Grana's study demonstrate the wide spectrum of design characteristics observable in existing attendance allowance programs. In general, disability criteria usually entail the need for a third person to assist or supervise disabled persons' bodily functions and activities of daily living. Age is usually used as a criterion to exclude very young children as beneficiaries as their ultimate functional capacity can not be discerned, to make a distinction between young and old (usually on the basis of retirement age), or to exclude minors for purposes of social assistance. In the case of the United States Veterans pension program, a combination of age and percentage of disability is used as the primary eligibility criterion. In no country is the need for "constant attendance" a criterion for eligibility, nor are attendance allowances expected to provide for "constant attendance."

Generally there is no means test in war veterans, general invalidity (except for Switzerland), work injury or special aged programs. Means testing is found in social assistance or welfare programs, as well as in the United States Veterans pension program, which includes nonservice connected disablement. Allowances are usually suspended or reduced if the client enters an institution, particularly one operated by the government, or at which in-kind benefits are provided. Family status is not taken into account for purposes of eligibility.

Under many of the programs, payment levels are modified according to the degree of the disability; in some countries payment levels are based on the application of a formal assessment instrument. In social assistance programs, payment levels are modified by allowable taxable income relative to ceilings used to determine eligibility, and have the effect of sliding scales.

In 1980, nearly 300,000 persons received an attendance allowance in the United Kingdom. This results in significant expenditures for attendance allowances--L243 million in that year. Notable also is the case of the Italy, where in May, 1982, the monthly allowance was raised from Lit. 35,000 to Lit. 250,000, bringing the Italian

allowance up to the same standard as in the other European countries. In the countries studied by Grana, attendance allowances in social assistance programs represent on an average from 10 to 25 percent of gross average monthly earnings from production workers, and attendance allowances in old age, invalidity or veterans programs from 25 to 50 percent of gross average monthly earnings for production workers, with higher allowances in cases of very great disability.

One evaluation of the French attendance allowance program, "Allocation Compensatrice," was performed by Lasry (1982). Although the evaluation does not address questions of efficiency or impact on institutionalization, it is useful as a critique of the design flaws which may befall cash disability allowances in general. Lasry found that the disability criterion for eligibility was too stringent, and that large numbers of individuals who need assistance or special equipment were denied benefits. Irregularities in the application of eligibility rules were found across regional authorities. Another problem was the use of means testing, which often discriminates against persons with unearned income. The amount of the allowance was sometimes inadequate. On the assumption that services could be obtained on a minimum wage, it was found that the allowance permitted the recipient to pay for a maximum of four hours per day; conditions could be worse for those not receiving the full allowance. As a result, the allowance was sometimes used merely as a complement to income, compromising the original intention of the program. The question whether institutions could fulfill the role of "third-party" was unclear, again compromising the original aim of the allowance to encourage social integration in a normal environment. Finally, the effectiveness of the assisting persons was very seldom checked, raising the issue of quality of care. This study does not address the quality issue.

3.0 CASH DISABILITY ALLOWANCES AT THE VETERANS ADMINISTRATION

3.1 The Allowance Program in the Context of VA Benefits

The Aid and Attendance and Housebound (A&A and HB) Allowance Program at the Veterans Administration is part of the pension program administered by the Department of Veterans Benefits, and must be viewed in that context. The pension program provides non-service connected monetary support for low-income veterans and their survivors. Other components of the VA long-term care system are administered by the Office of Geriatrics and Extended Care, in the Department of Medicine and Surgery. Services provided include nursing home care, domiciliary care in VA facilities, hospital-based home care, and personal care and supervision in residential care homes. All veterans age 65 years and older, veterans with service-related conditions, and indigent veterans also are eligible to receive free medical care at VA facilities.

3.1.1 Pension³

In FY 1985, approximately 3.84 billion dollars were disbursed to nearly 1.4 million veterans and surviving spouses under the pension program. Before World War I, pensions for service in the armed services were provided only as compensation for service-connected disabilities and injuries. Disabilities incurred in periods other than other periods of active duty did not qualify for pensions. After World War I, however, qualified veterans with non-service connected disabilities became eligible to receive pensions. In December 1985, 687,276 veterans were receiving non-service connected pensions. There were 665,963 additional persons (surviving spouses and children) receiving death pensions.

Today four pension programs cover veterans from different wartime periods. One program covers veterans of the Spanish-American War (1898 to 1902). This program provides a fixed payment to veterans (or their surviving dependents) who received other than a dishonorable discharge from service which lasted a minimum of 70 days (90 days of service by the veteran are required for surviving dependents to be eligible under this program). This is strictly a service-based pension and no disability is required for eligibility.

The first disability pension program covering nonservice-connected disabled veterans (and their surviving dependents), enacted in 1946, is referred to as the "Old Law." This law provides a disability pension of a fixed amount to veterans who received other than a dishonorable discharge, served at least 90 days in active duty, and have a

³ Except where noted, the following are based on interviews with David A. Brigham, Executive Assistant, Office of the Director, Veterans Administration, and on other unpublished VA documents.

total and permanent disability. Total disability is a function of the actual disability percentage assessed under the Rating Schedule, evaluated in light of the veteran's age and the effect of the actual disability on his/her ability to perform substantial gainful employment. Persons age 65 years or older are presumed to meet the disability requirement. There is also an income limit under the Old Law above which a veteran or his/her family cannot receive a pension. Income received under another Federal pension may be partially disregarded. Upon a veteran's death, surviving dependents can continue to receive a pension, and do not have to meet the disability requirement.

The Section 306 Pension Law modified the Old Law in 1960. The same service and disability requirements in the Old Law were retained, but the pension amount was placed on a graduated scale where personal income reduced the veteran's pension. New provisions were also made to take into account the size of the veteran's estate in calculating eligibility and level of pension. Veterans could elect to receive benefits under the Section 306 Law if they had already qualified for a pension under one of the earlier laws and felt that it would be to their advantage to do so.

In January 1979, the pension program at the Veterans Administration was revised a third time, creating the "Improved Pension" program (Public Law 95-588). The major intent of this revision was to eliminate inequities in the prior programs which excluded some or all of the income which certain beneficiaries received. As a result, outside income that would be disregarded in calculating the pension was further restricted. All family household income became counted as personal income on a dollar-for-dollar basis, and all countable income reduced a veteran's pension dollar-for-dollar. As with the three other pension programs, the spouse and eligible dependents became eligible to receive benefits after the death of the veteran. Beneficiaries receiving pensions under prior laws were allowed to elect payments under the new program or to continue receiving benefits under prior programs.

Under all four pension programs, veterans and surviving spouses who qualify as housebound or requiring aid and attendance (see Section 3.2.1) may be eligible to receive an allowance to assist them in coping with their disabilities. In 1984, expenditures for the pension aid and attendance program were over \$452 million (see Table 3-1). Veterans receiving a basic pension under prior pension laws are required to elect the Improved Pension program if they wish to begin receiving an aid and attendance or housebound allowance. However, those already receiving either allowance under the previous programs could continue to do so. The Housebound Aid and Attendance program is the mechanism the VA uses to assist veterans in obtaining social support services which it is not authorized to provide (U.S. Congress, 1985).

TABLE 3-1. Number of Cases and Experiences, VA A&A and HB Non-Service Connected Program 1982 to 1985

	1982			1983			1984			1985		
	Cases	Annual Rates	Cost (\$000s)	Cases	Rates	Cost (\$000s)	Cases	Rates	Cost (\$000s)	Cases	Rates	Cost (\$000s)
PENSIONS A&A												
Veterans												
Improved Law	62,727	3,049	\$191,255	66,814	3,196	\$213,538	70,763	3,289	\$232,740	74,708	3,405	\$254,381
Prior Law	49,034	1,980	97,087	39,460	1,980	78,131	31,639	1,980	62,645	25,287	1,980	50,068
Old Law	2,385	680	1,623	1,718	680	1,169	1,234	680	840	868	680	591
Total	114,146		\$289,965	107,992		\$292,838	103,636		\$296,225	100,863		\$303,040
Survivors												
Improved Law	37,711	2,043	\$77,044	41,372	2,142	\$88,619	45,414	2,205	\$100,138	51,152	2,281	\$116,678
Prior Law	27,128	948	24,717	21,771	948	20,639	17,293	948	16,394	13,525	948	12,822
Old Law	2,401	600	1,441	1,804	600	1,082	1,376	600	826	1,065	600	639
Total	67,240		\$104,202	64,947		\$110,340	64,083		\$117,358	65,742		\$130,139
PENSIONS A&A	181,386		\$394,167	172,939		\$403,178	167,719		\$413,583	166,605		\$435,179
PENSIONS H B												
Veterans												
Improved Law	10,156	1,131	\$11,486	11,021	1,185	\$13,060	11,688	1,219	\$14,248	12,001	1,261	\$15,133
Prior Law	11,541	255	2,943	9,628	255	2,455	7,860	255	2,004	6,379	255	1,627
Old Law	436	732	319	337	732	247	245	732	179	175	732	128
Total	22,133		14,748	20,986		\$15,762	19,793		\$16,431	18,555		\$16,888
Survivors												
Improved Law	N/A	758	\$0	N/A	795	\$0	N/A	818	\$0	N/A	847	\$0
Prior Law	---		0	---		0	---		0	---		0
Old Law	---		0	---		0	---		0	---		0
Total	0		\$0	0		0	0		0	0		0
PENSIONS A&A	22,133		\$14,748	20,986		\$15,762	19,793		\$16,431	18,555		\$16,888
A&A AND H B	203,519		\$408,915	193,925		\$418,940	187,512		\$430,014	185,160		\$452,067

As mentioned above, the non-service connected pension and the A&A and HB programs are means-tested; veterans and/or their dependents who are otherwise eligible to receive a pension must also meet certain income criteria. The amount of the allowance (HB or AA) is added to the total pension amount that a beneficiary is eligible to receive. If countable income falls below a specified income ceiling (varying according to disability, dependency, and war service status), the VA will issue a monthly check⁴ to the new beneficiary for the amount of the difference between countable income and the ceiling. If beneficiaries qualify for the aid and attendance or housebound allowance, their income ceiling is raised. Persons eligible for the aid and attendance or housebound allowance whose countable income previously exceeded allowable limits, may now qualify to receive a pension check from the VA under the higher income ceiling. An individual already being issued a check will receive a pension increase equal to the amount added to the income ceiling by the aid and attendance or housebound allowance.

3.1.2 Long-Term Care⁵

The Office of Geriatrics and Extended Care oversees a wide range of extended care programs, including nursing home care, domiciliary care, residential care, hospital-based home care, adult day health care, outpatient care, and hospice programs.

The nursing home program is comprised of three different components: VA-owned nursing homes, community (contract) nursing homes, and state-run nursing homes. VA-owned nursing homes are equipped with sufficient personnel and other resources to handle heavy care patients. Patient needs at these homes, which care for 9,000 persons per day, range from the intermediate care level to a “super” skilled nursing level. In addition to its own homes, the VA contracts out to approximately 3,000 private nursing homes to provide care for 10,800 veterans daily. These community homes generally provide varying levels of patient care needs ranging from intermediate care to a high level of skilled nursing care. The remainder of VA nursing home care is provided by state-run facilities. With regard to these state-run homes, the VA has two grant programs; a per diem program through which the VA assists states in providing care to eligible veterans, and a construction program through which the VA provides up to 65 percent Federal funding for the building of new nursing home care facilities and the renovation of existing facilities. Nursing home care in these state institutions is available only to veterans and their spouses. Approximately 7,000 VA beneficiaries are cared for daily in state institutions.

For veterans who require care but not at the level given by a nursing home, the VA operates a domiciliary care program. The VA provides care to 8,000 veterans daily at their 16 domiciliary homes. Eligibility for placement in these homes is partially based on income. The VA provides domiciliary care to an additional 5,000 veterans through

⁴ For beneficiaries who receive pensions equal to less than four percent of the maximum, checks may be issued less frequently (i.e., quarterly, semi-annually, or annually).

⁵ Except where noted, the following information is based on an interview with Jim Kelley, Dan Schoeps, and Mary Shiraishi, Office of Geriatrics and Extended Care, Veterans Administration.

state-run domiciliary homes. These state-run facilities are funded by the same mechanism as the state-run nursing homes. Veterans who live in either the VA-run or state-run domiciliary homes do not receive help with activities of daily living. A minimal medical care plan is currently being implemented.

The largest extended care program is the residential care program. Minimal personal care is provided to veterans in privately-run, community facilities. There is a daily census of 12,000 persons in 3,124 homes, with a preferred size of six persons or less per home. The VA system, through hospitals and social workers, acts as brokers for veterans with regard to these residential care facilities, commonly known as board and care homes. VA staff visit each of the participating homes once a week in order to review the quality of care. Veterans who live in these board and care homes pay an average of \$440 per month in rent. Residents stay an average of over five years, receiving medical care in nearby VA hospitals. A number of board and care veterans have a service-connected disability rating beyond 50 percent and they are eligible to receive \$800-1200 per month tax-free, a sufficient income to pay for their own board and care.

The hospital-based home care program, which is regulated by the Joint Committee for Accreditation of Hospitals (JCAH), is seen as an alternative to nursing homes. There are 49 home care programs operating nationwide, with a daily census of 50 patients per program. A primary care team of health professionals is assigned to each patient. The teams, headed by a physician and staffed by a public health nurse, LPN, LVN, social worker, rehabilitation specialist, and dietician, develop individualized treatment plans for all patients. On average a patient is seen 3 times a week by a nurse. Each patient receives a 60-day review in order to evaluate his or her progress and update the treatment plan.

The hospital-based home health care program serves persons who tend to suffer from chronic diseases such as pulmonary illnesses and cancer. The majority of patients suffer from general medical problems; few post-acute surgical cases are served by in this program. Of the over 6,500 patients treated in FY 1982, approximately 22 percent were terminally ill cancer patients (Annual Report of the Administrator, 1982). In order to be eligible for VA hospital-based home health care, a veteran must be referred from a hospital and in general must require the services of at least three of the members of a home care team. Also, a veteran cannot have any dependents.

The VA is presently developing an adult day health care program, based on a medical model. The program will provide clinical day services to post-hospital patients whose families can provide night-time care. This program is targeted towards a population less disabled than that served by the hospital-based home care program.

3.1.3 Health Care Services

The Veterans Administration provides a wide range of health care services, including hospitalization, outpatient medical care, outpatient dental treatment, and

psychiatric care, to eligible veterans. Veterans who are 65 years of age or older, veterans who have service-related health problems, and indigent veterans can receive free care at VA medical facilities (Tames, 1985).

In 1982, over 1.3 million persons received in-patient hospital care; total VA expenditures for hospital care in that year were 4.38 billion dollars (CBO, 1984). VA hospitals have increased by 30 percent the number of patients served over the last decade. Recent estimates indicate that 1.4 million inpatient cases as well as 19 million outpatient medical and dental visits were expected to be handled by the VA in 1985 (Tames, 1985). The number of veterans eligible for free care is expected to increase by 200 percent from 1980 to the year 2000, due to the general aging of the U.S. population. Veterans receiving aid and attendance or housebound allowances under the nonservice-connected pension program are eligible to receive two major types of services: hospitalization and outpatient medical care. In order to be eligible for hospitalization, the need for such care must be verified by appropriate medical personnel and beds must be available. Veterans with service-incurred or service-aggravated disabilities have greater priority than A&A and HB beneficiaries with regard to hospital admission.

Outpatient care is generally limited to veterans with service-connected injuries and/or disabilities. However, A&A and HB veterans are eligible for outpatient services, which include medical examinations and related medical services such as rehabilitation, professional counseling, consultation and training, and mental health services. Veteran A&A and HB beneficiaries are also eligible for free prescription drugs from VA hospitals. Surviving dependents are, in general, ineligible to receive either medical care or free prescription drugs.

3.2 Administrative Details of the Allowance Programs

3.2.1 Application Process

Applying for aid and attendance or housebound benefits is a complicated and often confusing process. Processing delays of applications caused by the submission of incomplete information to the VA are not uncommon. Applicants' difficulties in dealing with this long process are exacerbated by their fragile health status and immobility. To streamline the application process, the VA created a program application checklist for Veterans Services Division (VSD) employees, who assist persons in this process (see Appendix 1). Applicants may obtain assistance either at regional VA offices or by telephone (using a toll-free number). VSD employees also provide outreach to veterans and dependents who may be unaware of their eligibility for aid and attendance or housebound benefits. In addition, applicants may obtain assistance in filing claims from local veterans services organizations, such as the Disabled American Veterans and the Veterans of Foreign Wars.

Step 1: To apply for aid and attendance or housebound benefits, applicants not already receiving a VA disability pension must complete the "Veteran's Application for

Compensation or Pension"--VA form 21-526 (See Appendix 2). (Surviving spouses use VA Form 21-534, "Application for Dependency and

[Page 3-13 missing from original; they will be added at a later date]

examine a veteran who is unable to afford the cost of a physical examination, completing a standard form for submission. Use of the standardized form is not permitted outside of VA institutions so as to prevent non-VA doctors from anticipating those conditions and severity of conditions necessary to qualify as disabled under the program.

Step 3: Claims are filed at the regional office serving the area in which the claimant resides. Applications for an allowance are received by a ratings team from the VA. The ratings team is comprised of three members: a VA physician, a VA lawyer, and a VA occupational specialist. The occupational specialist compares the stated disability with the activities required for the kind of work the veteran did before the disability occurred.

To qualify for a basic disability pension, a veteran less than 55 years old must be 60 percent or more disabled as determined by the ratings team. After 55 years of age, a beneficiary can claim for eligibility purposes an increased level of disability for each year beyond age 55. At 65 years, the veteran is presumed to be 100 percent disabled; that is, the normal retirement age is equated with inability to work. Title 38 of the U.S. Code states that the specific disability criteria should be determined by the Veterans Administration.

Basic eligibility guidelines used by the VA for the Housebound Allowance are that the veteran or eligible surviving dependent must be "substantially confined," due to severe mental or physical disability, and this condition must be "reasonably likely to continue." For the aid and attendance allowance the veteran or eligible surviving dependent must require regular aid and attendance of another person to cope with hazards of daily living, to perform basic self-care, or to perform medical procedures recommended by physicians.

A veteran's stated disabilities are compared with a ratings schedule by the ratings team. A housebound allowance is awarded if the ratings team judges that the applicant is confined to the premises and can get around only with the aid of someone else. The aid and attendance allowance is awarded to veterans and eligible surviving dependents who have more severe disabilities and need a second party for help in activities of daily living. Persons are rated as eligible for an allowance for life and do not need to reverify their disability status at any future time. There is no review procedure currently in place to account for persons who experience an improvement in health status.

If the claimant is in a VA nursing home, a State veterans' home or a licensed nursing home, the entitlement is automatic. For non-VA facilities the home's

administrator need only certify the admission and that the claimant regularly requires skilled or intermediate level nursing care (as defined under Title 42, United States Code). In all other cases medical evidence must establish the claimant's inability to perform basic self-care, including daily activities like bathing, dressing or eating. The incapacity may arise from mental or physical disabilities, including conditions typically associated with advanced age.

3.2.2 Competency Procedure

The Veterans Administration generally assumes that pension beneficiaries are mentally competent, unless otherwise informed. Competency becomes an issue generally in one of four ways: (1) an interested party such as a family member or a neighbor informs the VA of the beneficiary's problem; (2) the beneficiary is adjudged incompetent, or otherwise placed under a legal disability by court action; (3) a veteran is evaluated by a doctor at a VA medical facility while receiving treatment; and, (4) a beneficiary voluntarily seeks help from the VA. This last situation occurs much less frequently than the other three.

The following is a summary of the events that occur when competency is an issue:

1. When evidence is received that a court of competent jurisdiction has adjudicated a VA beneficiary to be incompetent or otherwise placed the person under a legal disability and has appointed a fiduciary to administer the beneficiary's estate, the VA will perform an independent investigation to determine whether the beneficiary is, in fact, incapable of administering VA benefits. Based on this investigation, the VA will determine whether to recognize and pay the VA benefits to the court-appointed fiduciary or recognize and appoint some other type of fiduciary, or continue payments direct to the beneficiary, whichever is in the best interest of the beneficiary.
2. Also independent of the court action is the VA rating process when competency is an issue. If evidence is received indicating that a VA beneficiary may be incompetent, the VA rating board, which is composed of a medical doctor, a lawyer, and an occupational expert may request a field examination to gather the facts relating to competency, and request specific medical evidence having a bearing on the issue. More often than not, the rating is based on a sufficiency of medical evidence alone. If, after evaluating all the evidence, the board believes that the beneficiary is incompetent, a notification of their intent to declare him or her incompetent is sent to the beneficiary. As a result of due process requirements, the beneficiary has 30 days in which to challenge this ruling.
3. After 60 days, the board's ruling of incompetency becomes finalized if it is not challenged by the beneficiary. If the beneficiary challenges the ruling, any new evidence is reviewed by the board before any ruling becomes finalized.

4. When a beneficiary is declared incompetent by the VA, another investigation is performed, this time to determine the payee best suited to the needs of the beneficiary. The VA may seek appointment of a fiduciary by the court if the estate or other issues warrant such protection, or the VA may select a person as a federally appointed fiduciary. If the beneficiary is institutionalized, the VA may make arrangements to pay for care and maintenance and otherwise provide for the beneficiary's needs by making an award directly to the institution. The beneficiary may also be paid directly while under the supervision of the VA rather than a third party fiduciary. The last method of payment is called supervised direct payment (SDP). Fees for providing fiduciary services are generally paid only to court-appointed fiduciaries in accordance with the State statutes governing the court of appointment, and come out of the beneficiary's estate. Under certain limited conditions some Federal fiduciaries may be authorized by the VA to take a fee of up to four percent of VA benefits received during any one year from the estate for services rendered. These fiduciaries generally would be professional persons such as attorneys or professional fiduciaries.
5. The VA maintains a program of regular evaluation to determine whether the beneficiary continues to remain incompetent and whether or not the fiduciary is performing according to State and/or Federal requirements. The VA will perform field visits, or field examinations as they are called, on each case every one to four years, depending on the circumstances of each case. Those beneficiaries being paid under SDP are visited no less frequently than annually because there is no third party handling the money and because this method of payment is sometimes used to give the beneficiary the opportunity to demonstrate competency. If, after any visit to any incompetent or legally disabled VA beneficiary, it is determined that the beneficiary appears to be competent to handle his or her funds, then appropriate recommendations are made to the VA rating board and/or State court to reevaluate the rating or court judgement. Upon removal of the VA rating of incompetency, the beneficiary may be paid directly without supervision. Upon removal of the legal disability, and assuming no VA rating of incompetency, the beneficiary may be paid directly. If the VA rating of incompetency remains, then the VA must continue some form of supervision. If only the legal disability remains, then the VA must decide whether or not it is in the beneficiary's interest to be paid directly or to continue supervision.
6. In addition to personal visits with the incompetent beneficiary and the fiduciary, the VA monitors many cases through audits of accountings. Accountings may be required of Federal fiduciaries depending on the amount of VA income and/or the size of the VA estate or because of issues uncovered during the field examinations. Court-appointed fiduciaries are generally required to account in accordance with State statutes, and the VA being an interested party will audit those accountings. Under some State statutes, the fiduciary may be required to account to the VA for only VA income and estate, while under other statutes the VA audits the administration of the entire estate.

In FY 1982, approximately 125,000 (3 percent) of compensation and pension beneficiaries were under supervision because of their competency status. Approximately 60 percent of the beneficiaries rated incompetent were veterans, 32 percent were other adult beneficiaries, and 8 percent were minors.

3.2.3 Reverification of Pension Entitlement

Once entitlement to pension is established, a claimant is responsible for notifying the VA of any change in income, net worth status or dependency status. The VA reviews each claim annually to reconfirm entitlement. In addition, the VA performs regular checks with other Federal agencies to verify the amount of payments they issue under several programs. These programs currently include Social Security, civil service annuity, Black Lung benefits (paid by either the Department of Labor or the Social Security Administration), and Railroad Retirement Board benefits.

Individual claims reviews are spread throughout the year. Each claimant is required to file an Eligibility Verification Report (EVR) on a reporting anniversary date. The EVR requests information about income, net worth, and dependents. These reviews frequently uncover status changes which claimants have not reported. Depending on the nature of a change and when it occurred, a retroactive benefit adjustment may result. Such adjustments frequently result in money owed to the VA to repay pension to which a claimant had no entitlement.

3.2.4 Determination of Pension Amount

The actual amount of pension received varies according to the beneficiary's specific pension program. Within each program, a number of additional factors are taken into consideration including disability rating, income and assets level, number of dependents, and veteran or surviving spouse/child status.

Under the Improved Pension Program, the VA subtracts countable household income from the maximum pension amount (which varies according to factors mentioned above) and yields the amount of pension the beneficiary is eligible to receive. The calculated amount is usually divided by 12 and sent to the beneficiary in monthly amounts.

Currently the Improved Pension maximum payments, which effectively set income limits, are:

Claimant	12-1-85 Maximum Pension (Income Limits)
Veteran Without dependents:	
Without SMP	5,886
With housebound	7,194
With A&A	9,416
Veteran With a dependent:*	
Without SMP	7,710
With housebound	9,019
With A&A	11,240
Surviving Spouse Without dependents	
Without SMP	3,944
With housebound	4,822
With A&A	6,309
Surviving Spouse With a dependent:*	
Without SMP	5,167
With housebound	6,042
With A&A	7,530
* Add \$999 for each additional dependent.	
The Improved Pension maximum payments increase at the same time and by the same percentage as Social Security increases. Such increases are tied to rise in the CPI, assessed on a 12-month basis.	
SMP = supplemental medical pension	

The VA excludes income from certain sources in determining countable income--the most commonly excluded income source is welfare payments from public or private sources. In addition to income exclusions, the law permits the deduction of certain types of expenses from countable income amounts. The most frequently occurring expense deductions are for medical, burial, and educational expenses. Medical expenses eligible for deduction include health insurance premiums, doctors' and nurses' charges, therapy charges, medicine charges, and payments for special equipment (prescribed by a doctor or required as a result of a disability). A beneficiary's out-of-pocket medical expenses must exceed 5 percent of the maximum pension set by law in order to deduct.

If a claimant is entitled under the income test, a separate net worth test is applied. In evaluating net worth the VA will exclude personal property and the value of a claimant's residence. All other assets are considered. Non-liquid assets are considered at the value of cash to be realized from normal disposition. All liabilities are used to offset assets. The remaining value of assets is net worth.

If, based on the claimant's age and considering recurring living expenditures, the value of net worth is such that it is reasonable to expect some part of it be used for maintenance (of the claimant and any dependents), the claim will be denied. In assessing expenditures, allowance is made for funds necessary to educate any dependent children. Other expected expenses, such as housing adaptation for a disabled person, may be considered in specific claims.

For persons covered under the Section 306 pension program, beneficiaries' pension amounts are dependent on where their countable income falls on a set graduated scale, on whether they receive A&A or HB, and on whether they are age 78 or older (see Appendix 4). For example, a 79 year old single, housebound veteran who received \$500 per month of countable income is entitled to \$315 per month: \$191 is basic pension, \$47.75 for being age 78 years or older, and \$76.25 for being housebound and over 78 years of age (based on annual rates effective December 1, 1984).

Veterans or surviving spouses under the Section 306 law have a slightly higher income ceiling than beneficiaries under the Improved Pension law (\$6,493 in 1985). For beneficiaries under the Old Law, pension limits fall in between those for the Improved Pension and those for the Section 306 Pension Law. However, the Old Law differs in that a set pension amount--\$78.75 in 1985--is disbursed to all persons who fall under the income limit. Another advantage of the Old Law is that other Federal pensions are partially excludable when calculating countable income.

As for the Spanish-American War pension program, there is no income limit. A set pension is disbursed to qualified beneficiaries--\$101.59 per month for a veteran with no dependents who served for 90 days or more.

Surviving spouses of veterans are not eligible to receive a housebound allowance under the Improved Pension law. They can qualify under all four pension programs for an aid and attendance allowance if they meet both the requirements for a basic disability pension for surviving spouses and those for the allowance. Surviving spouses, unlike veterans, do not receive special medical provisions or free prescription drugs. Children who became physically or mentally incapable prior to age 18 must meet the same requirements as spouses and are eligible for the same benefits.

If a pensioner is hospitalized, the total benefit amount may be changed. If the veteran receives only the basic pension and has dependents, no changes will be made. If a veteran is receiving an aid and attendance allowance and has dependents, the allowance portion of the pension reverts to the housebound allowance after one month in the hospital. If there are no dependents, however, then the allowance reverts to an amount of \$60 per month after three months of hospitalization. These conditions also apply in cases where veterans are temporarily institutionalized in nursing homes (either Veterans Administration nursing homes or in nursing homes where the Veterans Administration is paying for the stay). For nursing home stays longer than three months, a veteran's eligibility for a pension or allowance is revoked if he is living in a nursing home run or paid for by the VA. If a veteran is paying for his own nursing home care out-of-pocket, then there is no reduction in the Housebound or Aid and Attendance Allowance.

3.2.5 Claimants' Rights -- Due Process of Law

The VA recognizes by regulation each claimant's "due process" rights. Under regulation the VA affords each claimant an opportunity for a hearing with VA personnel prior to deciding any aspect of a claim. This opportunity exists for both original and supplemental claims filed. Claimants also may request hearings after decisions are made when they desire reconsideration or want to present new and material evidence.

As a matter of policy, the VA does not make any unfavorable adjustment based on third party information without first notifying the claimant about the proposed adjustment. This allows the claimant the opportunity to rebut the information before a final decision. Rebuttal may be in writing or in person. In the latter case, a hearing may be requested; less formal presentations may also be used.

A claimant for VA benefits may appoint a power of attorney as a representative in all aspects of a claim. Most often the claimant will select one of the veterans service organizations. A private attorney or a VA recognized "agent" may be selected. Service organizations do not charge fees to represent claimants. Attorneys and agents may charge fees, not to exceed \$10.00 for any one claim. Severe penalties may be imposed when fee violations occur.

Any claimant dissatisfied with a claim decision may formally appeal it. The appeal must be made within a year following notice of the decision. Appeals are reviewed by the Board of Veterans Appeal (BVA) located in Washington, D.C. The BVA has jurisdiction to consider all aspects of the claim and may issue a decision differing wholly, or in part, from the decision made at the regional office. The BVA decision is binding and final.

Judicial review of claims decisions, i.e., by the courts, is not permitted under current law. For several years the Congress has introduced legislation to permit such review; however, no legislation has been enacted.

3.3 The Future of the Aid and Attendance Allowance Program

Since the A&A and HB program is an integral part of the VA pension program, it is affected significantly by any changes or cutbacks in the basic pension rules and regulations. With each revision of the VA's non-service connected pension program, income eligibility criteria have become increasingly stringent. The pension program began with no income limits (SAW program). Next, under the "Old Law", an income ceiling was established. Section 306 set up a system whereby pension amounts were determined by a graduated income scale. The "Improved Pension Law" allows a smaller amount of outside income and assets to be disregarded when calculating pension amounts.

Over the last five years, veterans benefits have come under increasing budgetary attack. The current administration has proposed cuts in veterans benefits a number of times--each effort has been strongly opposed by veteran lobby groups and congressional supporters. In fiscal year 1985, the U.S. Department of Treasury proposed but later dropped the idea of taxing compensation and pension monies. Under the current deficit-reduction mandates of the Gramm-Rudman Act, the compensation and pension programs are considered protected programs and will not be subject to mandatory budget cuts.

In future years, the pension program is likely to face increasing budgetary pressure. This will arise not only from Federal budget constraints but from a substantial rise in the number of aged veterans who are eligible to receive non-service connected pensions (subject to income and service constraints).

The VA, however, believes that the effects of two trends will help to counteract some of this budgetary pressure. First, a trend analysis performed by the VA, shows that many eligible claimants, both veterans and survivors, will not meet the means test provisions, and therefore, will not be entitled to receive pension payments.

Coupled with this trend is another showing that actual losses from the protected pension rolls, generally attributed to the higher death rate among the oldest claimants, exceed accessions in the current program and will for some time. When considered with the better financial status of new claimants, the VA believes that short-term problems will be counterbalanced. Long-term problems in funding will be counterbalanced by slow growth in entitled claimants and this generally should support maintenance of current programs (even considering inflation and resulting effects on the CPI).

4.0 RESEARCH DESIGN AND METHODOLOGY

4.1 Research Questions

This study was designed to examine:

- 1) the relationship between different forms of subsidy for in-home care (cash disability allowances and in-kind provision of care) and an individual's functional and health status, use of medical and institutional care, use of informal support systems, and net social costs; and
- 2) the administration and management of an existing cash disability allowance program.

The Veterans Administration Housebound and Aid and Attendance Allowance program is described in detail in Section 3.0. The impact of subsidy type on recipients' well-being and use of services is analyzed by comparing data collected in a survey of recipients of the VA AA/HB program with data from the national Long Term Care (LTC) survey of noninstitutionalized elderly conducted in 1982 by the U.S. Department of Health and Human Services. The comparisons have been designed to address the following major research questions:

- Do the VA and comparison groups differ along socioeconomic dimensions?
- Are the VA A&A and HB recipients more frail or more functionally impaired, or do they have higher rates of chronic and acute medical conditions than the comparison groups?
- How much in-home help (ADL and IADL) is received by the VA recipients and the comparison groups?
- How much help is purchased, provided by family and friends, or provided by formal helping organizations?
- Do the VA and comparison groups differ in their consumption of nursing home care, hospital care, physician services, and prescription drugs?
- Do the two groups differ in self-report measures of life-satisfaction? Happiness? Satisfaction with living environment?

4.2 Methodology

4.2.1 Sampling

The VA HB/AA program is the only large, nation-wide program of cash grants for disabled persons available for study in the U.S. (others exist abroad, but they that may have less relevance to U.S. policy). Thus, recipients of the program were chosen as the study population despite the fact that differences may exist between beneficiaries of this program and a potential target population, all disabled elderly (including non-veterans). A comparison group was selected from the long-term care survey population which resembled as much as possible the VA A&A and HB population in initial impairment and sociodemographic characteristics, but which received in-kind benefits directly in the form of home nursing, homemaker or home health aid services, 21.6% in Los Angeles, 21.6% in Minneapolis-St. Paul, and 19.4% in Philadelphia. As mentioned earlier, however, response rates could not be improved due to the data sharing between Project HOPE and the VA.

[Pages 4-3 through 4-6 missing from original; they will be added at a later date]

TABLE 4-1. Veterans Administration Housebound and Aid and Attendance Allowance Recipients Surveyed and Interviewed					
	Metropolitan Area				Total
	Philadelphia	Tampa-St. Petersburg	Los Angeles	Minneapolis-St. Paul	
Total HB/AA Beneficiaries*	762	780	938	770	3250
Number Selected	500 (65.6%)	500 (64.1%)	500 (53.3%)	500 (64.9%)	2000 (61.5%)
Total Responses	97	149	108	108	462
Did Not Wish To Participate/Deceased	11	22	10	47	90
Willing to Participate	86	127	98	61	372
Ineligible (NH)	8	31	28	42	109
Ineligible (Other)	0	0	3	0	3
Interviewed	67	84	56	15	222
Reason for No Interview					
Death	1	1	1	0	3
Could not be reached	3	0	0	2	5
Refused	3	2	4	0	9
Other	4	9	6	2	21

* Fulfilling selection criteria (competency, disability, pension amount, and receipt of HB or AA).

Of those persons who responded, 80.5% (n=372) indicated a willingness to participate in the survey. However, 29.3% of those who wished to participate indicated on the screen that they were nursing home resident and thus were not eligible for the study. In Minneapolis-St. Paul a disproportionate number of persons wishing to participate in the study were ineligible because they were institutionalized. An additional 24 persons could not be interviewed because of a variety of reasons including death of respondent, inability of interviewee to contact respondent in order to arrange an interview, and refusal by respondent to be interviewed. A total of 222 persons were

interviewed--83 (37%) of the interviews could not be included in the main study analysis group because they were not 65 years of age or older or found to be ineligible for other reasons. Although the original study design had included only those persons 65 years and older, the age variable was improperly specified in the computer program which created the mailing list of 2000 VA beneficiaries. A description of this 64 and under group will be included in the results section of this report; this population will not be included in multivariate analyses due to the lack of a comparison group.

The LTC survey employed county based clusters stratified by characteristics such as geographic region, level of urbanization, percentage of non-white population, and per capita retail sales. Medicare recipients as of December 31, 1981 (updated with a 10% sample over the following three months) were stratified by age group, and a sample of 55,000 was drawn from 173 LTC Primary Sampling Units (PSUs). This was systematically reduced to 36,000 for the initial screening. From this group, about 6400 persons were chosen which fit the eligibility criteria for the survey (e.g., level of impairment, not-institutionalized etc.), and almost 6,100 people were interviewed. About 5,000 LTC respondents received help from one or more caregivers, and 1,380 received help from a source other than hired help or family and friends. This latter group comprises the comparison group for this study. Persons in this group are distinguished by their receipt of assistance in the form of services "in-kind" (in contrast to cash or a voucher). Persons in this group may be required to pay something for the care they receive, but the care is essentially subsidized. They may also receive services from family and friends, or from people they hire, but they are chosen for comparison because they receive an in-kind subsidy (see Section 5.2.1). For comparability with the VA sample, those persons living in rural areas are not included; this results in a comparison sample of 610 persons.

4.2.2 Survey Development, Validation, and Implementation

The Long-Term Care Survey was designed to provide national data on noninstitutionalized persons age 65 or older who are chronically impaired. Data from the survey include: the number and type of physical limitations affecting aged persons, the kind and amount of help received by impaired individuals, the use and costs of health care services, the amount that impaired persons and their families pay for care, and the number and characteristics of impaired individuals not receiving care.

The beneficiary survey for the VA study instrument was developed using selected questions from the Long-Term Care survey. These questions were well-tested for validity and reliability. This approach maximized the comparability between the study and control groups, and reduced the cost of the study by obviating the development of new survey instruments for the study. Additional questions pertaining specifically to the VA program were included in the VA survey, however.

The beneficiary survey was designed to take no longer than one hour. After being pre-tested on 20 beneficiaries in the Washington, D.C. area (identified and contacted using the criteria and random selection process described previously), the

instrument was revised to clarify instructions. Seven experienced interviewers employed by the National Opinion Research Corporation (NORC) were trained to use the instrument during a one-day training session in June, 1985. Over a three month period interviewers conducted the surveys. Copies of the survey and instruction forms are included in Appendix 6.

4.2.3 Analysis Plan

Since the VA and comparison groups were selected from the entire U.S. population using two different sets of criteria, the first task of analysis is to assess if and to what extent the groups differ with respect to personal characteristics which might affect the use of health care or help at home with ADL and IADL needs. These important differences are identified by the calculation of means and frequency distributions for each group, which are compared using student t and chi-square statistics. Differences between the groups identified in this phase of the analysis are controlled for in latter analyses with multivariate statistical methods, especially regression analysis.

Since the sample of persons receiving a cash allowance is relatively small (n=139), the analysis must be limited to a small, select set of explanatory variables, which explain as much of the variance in the explained variables as possible. A small set of sociodemographic characteristics were included in the analyses: age, sex, race, marital status, household status, education level, type of area, Medicaid eligibility, and family income. The age, sex, and race parameters were included because of their influence on health status, and access to informal care. Limitations in activities of daily living have been shown to increase with age (Corroni-Huntley, 1985); care receiver age may also be positively correlated with the age, and thus the caregiving capacity, of the primary caregiver. For both reasons, age might be expected to be positively related to the need for more care in general, and perhaps formal assistance in particular. Additional parameters which appear to affect the level of formal care are marital status and household status. Soldo and Manton (1985) found that for disabled community-based persons aged 65 and over, those living with a spouse or other relative received significantly less formal services than those who lived alone or with nonrelatives, for all types of need.⁶ To conserve degrees of freedom, a summary variable, NOAVAIL, was created to capture the influence on care received when no informal caregiver was available. Neither survey provided physical or time distance between care receivers and potential caregivers. As a proxy measure for this phenomenon, a person was said to have no available informal caregiver if that person both lived alone and received no care from family and friends.

Family income, Medicaid eligibility, and type of area are factors which affect access to both the acute and long-term care systems. Persons in families with higher

⁶ Nine types of need were identified by Soldo and Manton: IADL need only; ADL need only; medical need only; ADL and IADL need; ADL, IADL, and medical needs; all types of need; all types of need and incontinence problems; all types of need and supervision problems; and all types of need and incontinence and supervision problems.

incomes have greater private resources which permit them to better access private systems, but which may serve as a barrier to access to public help. Medicaid eligibles generally receive more public help, primarily in the form of in-kind services. Areas with higher population densities tend to have higher input (e.g., labor) costs and higher prices for services, which may reduce individual demand for purchased care and enhance demand for publicly-funded care. The dichotomous variable AREA was used to distinguish between persons living in cities from those in suburbs and towns.

Despite problems inherent in the definition of what persons constitute the family unit for purpose of analysis, it was decided that a family income variable needed to be used. Family income, not solely personal income, is used by the VA in its calculation of countable income to set the level of a beneficiary's pension amount. Also for the comparison (LTC Survey) population, categorical information on income was collected only on a family basis. Income was then split into three categories based on the income distribution: high-income (HINC), \$12,000 and over; middle-income (MINC), \$6,000 to \$11,999; and low-income (LINC), \$5,999 and under. Limited available information on assets, specifically home values and automobile ownership, was examined but not included in the analyses.

Health status, limitations in activities of daily living, and instrumental activities of daily living are important factors which affect utilization of health care and long-term care (Soldo and Manton, 1985). A health status variable (DXTOT) was created which summed responses indicating the absence or presence of 27 selected medical conditions.⁷ Time, resource and degrees of freedom limitations prevented a more careful classification of persons with different subsets of chronic and other medical conditions (Manton and Woodbury, 1984; Soldo and Manton, 1985). Relative weights to account for differences in severity among these conditions, (e.g., type of cancer, type of paralysis), were not available. The summing of these medical conditions is intended only as a crude estimate of health status.

Two additional variables were created which summed the number of ADL limitations and the number of IADL limitations (ADLSUM and IADLSUM, respectively). Activities included in ADLSUM correspond to those found in the Katz ADL scale--eating, transfer, dressing, toileting, bathing, and continence (Kane, et al 1983). Persons who either received human assistance with an activity or used special equipment to perform an activity are considered to be limited in that activity. Activities included in IADLSUM are the following: heavy and light work around the house, laundry, meal preparation, grocery shopping, and money management. Persons who did not perform these activities for disability or health reasons were considered to be limited in that activity. As with health conditions, relative weights were not assigned to each of the specified limitations due to information and resource constraints; this limits the accuracy of these

⁷ The following is a list of the 27 medical conditions: rheumatism or arthritis, paralysis, other permanent numbness or stiffness, multiple sclerosis, cerebral palsy, epilepsy, parkinson's disease, glaucoma, diabetes, cancer, frequent constipation, frequent trouble sleeping, frequent severe headaches, obesity, arteriosclerosis or hardening of the arteries, heart attack, any other heart problem, hypertension or high blood pressure, stroke, circulation trouble in arms or legs, pneumonia, bronchitis, flu, emphysema, asthma, broken hip, and other broken bones.

summed variables. An additional indicator of limited activity examined but not included in the analyses was how often persons avoided doing things because of lack of energy.

The use of health care is analyzed using regression analysis. A separate regression equation is used to describe each of the following measures of an individual's use of care: the number of hospital days in the past 12 months; the number of emergency room visits in the past month; the number of visits to a doctor's office in the past month; the number of other doctor visits (e.g., dentist, foot doctor, optometrist, chiropractor) in the past month; the number of prescription drugs used in the past month; and the number of therapy visits (e.g., physical, occupational, speech, and hearing therapy) in the past month. The parameters of these equations are estimated using ordinary least squares (OLS), controlling for a set of variables (personal characteristics) which are believed to influence the use of care, and controlling for differences between the study and comparison groups identified in the first phase of the analysis. Group membership is represented in each equation by a dichotomous dummy variable; a significant coefficient for this variable indicates that the groups are different with respect to the use of care variable analyzed. Two additional measures of health care use the number of admissions to a hospital and admissions to a nursing home, are analyzed using logistical regression analysis. Because of the influence of insurance coverage on access and utilization care (Newhouse, et al 1981), private insurance coverage of hospital and physician care were included as control variables in the multivariate analyses.

The use of home help provided by various sources is also analyzed using regression analysis. The amount of help received from the informal care network (family and friends), from formal helping organizations (such as Medicaid agencies which provide in-kind services), and care purchased in the market is estimated controlling for a set of socioeconomic and personal characteristics which might also affect the use of home help. Again, a group dummy variable is used to distinguish those persons receiving a cash allowance.

The measure of the amount of home help from each source--the number of days each helper provided help during the past week--is noticeably weak. The problem is that the average number of hours per visit per helper, as well as the intensity of each visit was not collected in the Long-Term Care Survey (average hours per visit were collected on the VA population and are presented in Section 5.0). Despite these shortcomings, the total number of days of help per week (which may total to more than seven days under this definition) are used to describe the use of home help, with the understanding of the potential for severe measurement errors in the dependent (explained) variables.

Another problem with the variable used to describe help received in the home is that it measures a level of effort received regardless of level of need. The Long-Term Care Survey does ask detailed questions on unmet needs in specific areas; these questions were mistakenly dropped from the survey of VA beneficiaries. A single question on unmet needs was developed for the VA study which required interviewees to identify areas of unmet need without prompting of specific areas. While not strictly

comparable along this dimension, the two populations are, nevertheless, compared with an explicit understanding of the limitations.

Out-of-pocket expenditures for help received in the home was examined. For persons in the LTC survey, cost information on helpers who are paid relatives was not sought. Data collected on all paid helpers for the VA sample group indicate however that this subgroup is a negligible percentage of the helper population.

A limited number of variables which describe the degree of social interaction and life satisfaction were also analyzed. Variables related to social interaction include the amount of contact with relatives and friends, either in person or by phone, personal hobbies, and community activities (e.g., church services, senior center visits, etc.). A variable, PHONE, was created to indicate whether a person had anyone check to make sure he or she was all right; this variable was used as a proxy measure of contact and the strength of relationships with informal caregivers outside the household. General life satisfaction and satisfaction with living environment is likely to be of high importance to this relatively housebound population.

Finally, questions relating specifically to the VA program were examined. These include questions concerning the type and amount of allowance received, use of the grant money received, and the sufficiency of the allowance in meeting the needs of the disabled. As decided in Chapter 3, the allowance program is part of the VA pension program and allowance monies are included in a beneficiary's regular pension check. A significant number of VA allowance beneficiaries could not distinguish between monies received under the basic pension program and the additional monies provided under the allowance program. Limitations on the use of VA files (described earlier) prevented the use of additional information for revealing the type of grant received. Without information on type of allowance received, it is not possible to estimate the allowance amount. The allowance amount variable is therefore used only descriptively, based on the information obtained from persons who knew the type and size of the allowance.

Standard formulas used to calculate variance estimates for parameters are based on the assumption of simple random sampling (i.e., independence and equal probability of selection). Complex sampling techniques violate these assumptions; adjustments to the standard statistical methods may be necessary. The unadjusted variance estimates may produce an inappropriate rejection of the null hypothesis because the actual variability of the sample is underestimated (Cohen, 1983). Several programs available for use in making the necessary corrections (SESUDAAN, RATIOTEST and SURREGR) were examined. Discussions with other professionals using the Long-Term Care Survey data indicated that such adjustments did not significantly affect results. Therefore, these correction procedures were not employed in the analysis.

4.2.4 Limitations

The generalizability of the results of this study is a major concern. This was not a blinded, randomized experiment: The selection processes, of people into specific programs and of VA program recipients into this study, undoubtedly affects the representativeness of the sample population.

The main issue is the extent of differences between veterans and nonveterans, and between survey respondents and nonrespondents. The most obvious example of the former is the predominance of males over females in the veteran population compared to the general population, particularly for older age groups. In 1980, 5.8 percent of veterans over age 65 were female, compared to 59.6 percent of the total over 65 population (Stockford, 1985; U.S. Bureau of the Census, 1982). However, because the study sample contains female surviving spouses, this factor is reduced. Other differences between the veteran and nonveteran populations may remain, however, and must be considered before extending the results of this study to the target population of disabled elderly.

The requirement that members of the selected VA sample could not be recontacted if they refused or did not respond also reduces the generalizability of the study. The resulting nonrespondent bias arises from possible differences in factors of health, functional status, and satisfaction with program between those initially agreeing and initially refusing to participate. Given the confidential nature of the VA files, however, follow-up efforts could not be made. Some basic demographic information for responders and the entire population or VA HB/AA recipients is compared in order to assess some aspects of this potential problem.

Another limitation of the study is that the Veterans Administration is unable to provide information on administrative costs for the allowance program. We are unable, therefore, to assess the potential effect of "moral hazard" on program costs (see Section 2.2.2). Also, the choice of control group necessitated strict adherence to the content and format of the 1982 LTC and Caregiver surveys. This limited our ability to fully explore some areas, such as satisfaction with care and consumer choice in choosing the amount and type of care.

5.0 ANALYSIS AND FINDINGS

5.1 Description of the Populations

5.1.1 Sociodemographic Characteristics

The composition of the VA group differed significantly from that of the comparison group with regard to sex, race, and geographical location (Table 5-1). The proportion of females in the VA group was low: 54.7 percent compared to 74.6 percent in the comparison group. This variation is not surprising due to the small number of female veterans in the United States--1.2 million at the end of fiscal year 1982 (U.S. Veterans Administration, 1982). In addition, the percentage of non-whites and urban residents was greater in the sample population: 37.2 percent of the VA group versus 12.4 percent of the comparison group were non-white; 64.0 percent of the VA group versus 17.9 percent in the comparison group were urban dwellers.⁸ Again, these differences were not unexpected. The selection of four major SMSAs and their surroundings areas for this study introduced a bias towards the selection of urban dwellers. The means testing required by the VA cash disability allowance program and the strong correlation between race and income may explain a large amount of the variation in race between the two groups.

TABLE 5-1. Selected Sociodemographic Characteristics			
	VA Group	Comparison Group	Chi-Square
SEX			
Male	45.3%	25.4%	20.80
Female	54.7%	74.6%	(P=0)
	(n=139)	(n=610)	
RACE			
White	62.8%	87.6%	49.11
Black/Other	37.2%	12.4%	(P=0)
	(n=137)	(n=598)	
AREA			
Large City (over 250,000)	64.0%	17.9%	121.67
Other	36.0%	82.1%	(P=0)
	(n=139)	(n=610)	

Percentage of single households differed slightly but not significantly among the two groups--with 46.8 percent of the VA group living alone compared to 52.6 percent of the LTC group. Although there were slight differences between the groups in median age, median educational level, and marital status, none of these differences were statistically significant (Table 5-2). For the VA group and the comparison group respectively, the median age was 77.4 versus 78.2 years; 24.1 percent of the VA group were married versus 28.8 percent of the comparison group; the median level of education was 9.2 years for the VA group versus 9.6 years for the comparison group.

⁸ Urban dwellers were defined as persons residing in a large city (over 250,000).

The median income range for the VA group is greater than that for the LTC group--the VA group's median is \$8,000-\$8,999 compared to the LTC's group median of \$7,000-\$7,999 (Table 5-3). This was not unexpected since amounts received through VA pensions work as income supplements to push elderly veterans above the poverty line. The distribution among income categories is significantly different among the two groups as well. Another indicator of available resources is food stamp eligibility: A significantly greater proportion of persons in the comparison group receive food stamps, 16.9 percent versus 4.3 percent. Again, the income supplementation function of the VA pension can account for much of this difference.

TABLE 5-2. Selected Sociodemographic Characteristics Part II			
	VA Group	Comparison Group	T-Value
AGE (in years)	77.396	78.223	.99
	(n=139)	(n=610)	(p=.322)
EDUCATION LEVEL (by grade K-12 system)	9.240	9.6	1.24
	(n=121)	(n=610)	(p=.208)
	VA Group	Comparison Group	Chi-Square
MARITAL STATUS			
Married	24.1%	28.8%	2.16
Widowed	61.3%	55.8%	(p=.7368)
Other	14.6%	15.4%	
	(n=137)	(n=604)	

TABLE 5-3. Total Combined Family Income (before deductions) in Last 12 Months		
	VA Group	Comparison Group
Under \$3,000	1%	6%
\$3,000 - 3,999	1%	14%
\$4,000 - 4,999	3%	12%
\$5,000 - 5,999	12%	12%
\$6,000 - 6,999	20%	8%
\$7,000 - 7,999	8%	9%
\$8,000 - 8,999	12%	6%
\$9,000 - 9,999	12%	7%
\$10,000 - 11,999	13%	9%
\$12,000 - 14,999	6%	6%
\$15,000 - 19,999	5%	5%
\$20,000 - 24,999	2%	2%
\$25,000 - 29,999	1%	1%
\$30,000 - 39,999	3%	1%
\$40,000 - 49,999	1%	1%
\$50,000 or more	0%	1%
	100%	100%
(Chi-square = 53.32, P = .0001)		
Mean Yearly Income Range	\$8,000 - 8,999	\$7,000 - 7,999

With regard to assets, the percentage of persons whose living quarters were owned or being bought by a household member were very similar for both groups--54

percent of the VA group versus 53 percent of the comparison group. Thirty-four percent of the VA group owned at least one car compared to 40 percent of the LTC group.

A significantly greater percentage of the LTC group, 32.2 percent versus 13.2 percent of the VA group, reported being eligible for Medicaid. Since VA pensions push elderly pensioners above the poverty line, a number of them are unable to meet the means-test for Medicaid services. As for private hospital insurance, 45 percent of the comparison group versus 37 percent of the VA group reported having private coverage of hospital services. This difference was not significantly different. For physician services, private coverage was significantly greater among the LTC group: 48 percent had such coverage versus only 35 percent of the VA group. Potential differences in access to hospitals and physicians between the two populations is balanced to a certain degree by veterans' access to the VA health care system.⁹

5.1.2 Limitations in Activities of Daily Living and Instrumental Activities of Daily Living

Comparing total number of ADL limitations (eating, transfer, dressing, bathing, toileting, and continence) between the groups, the VA group has a significantly higher average number of ADLs--1.91 for the VA group versus 1.17 for the comparison group (Table 5-4). In addition, the VA group has a relatively higher number of persons with four or more ADL limitations, 23.7 percent versus 13.3 percent.¹⁰

Number of Limitations	VA Group	Comparison Group
0	35%	49%
1	16%	25%
2	17%	7%
3	9%	6%
4	9%	7%
5	12%	5%
6	4%	2%
(CHI SQ = 36.26, P=0)		
AVERAGE NUMBER ADLS	1.906 (t = 4.26)	1.167
* Limitations in eating, transfer, dressing, bathing, and toileting is defined as "did not do activity in past week or received human assistance in performing activity." Limitation in continence is defined as "lacking total self-control in urination or defecation."		

With regard to six selected IADLs (heavy work around the house, light work around the house, laundry, meal preparation, grocery shopping and money management) the VA group has a significantly higher number of IADLs than the

⁹ The level of access to the VA health care system varies depending on a number of factors, including regional VA resources and type of care needed.

¹⁰ A simple summing of ADL limitations does not take into account the varying degree or severity of burden among the categories. The ADL sum is merely intended to provide a rough estimate of the relative differences between the two groups with regard to ADL limitations.

comparison group (Table 5-5)--3.72 IADLs for the sample versus 3.26 IADLs for the comparison group.¹¹

Another indicator of limited activity was how often persons avoided doing things because of lack of energy (five categories which ranged from all of the time to never)--50 percent of the sample group versus 45.1 percent of the LTC group avoided activity all or most of the time. This difference is not significantly different.

Owing to data collection problems, findings on unmet needs are equivocal.¹² Crude estimates of unmet ADL need indicate that 3.2 percent of the LTC group reported one or more unmet ADLs compared to 6.5 percent of the VA group. In contrast, however, an average of 1.59 ADL needs were reported as unmet by the LTC group versus 1.17 for the VA group. With regard to selected IADLs, the VA group reported lower levels of unmet need, with 15.1 percent of the VA versus 22.6 percent of the LTC population having one or more unmet IADLs. The LTC group has an average of 1.05 unmet IADL needs as compared to 1.4 for the VA group. Due to the difference in variable creation, it is not known whether the difference in unmet need are statistically significant. It is also difficult to draw conclusions about unmet need differences due to the very small proportions in each sample showing unmet need.

Number of Limitations	VA Group	Comparison Group
0	4%	5%
1	14%	14%
2	10%	19%
3	17%	19%
4	12%	14%
5	22%	15%
6	22%	14%
AVERAGE NUMBER IADLS	3.72 (t=2.66)	3.26
* Limitation in doing heavy work around house, doing light work around the house, doing laundry, preparing own meals, shopping for own groceries, and managing money is defined as "unable to perform activity because of a disability or health problem (including old age)."		

5.1.3 Health Status

Of 27 selected health conditions, the VA group has a significantly higher incidence of the following 8 conditions: paralysis, other permanent numbness or stiffness, glaucoma, frequent severe headaches, arteriosclerosis, stroke, circulation

¹¹ As for ADLs, the simple summing of IADLs does not take into account the varying degree or severity of burden among the different categories. The IADL sum is meant only to provide a rough estimate of the relative degree of IADL impairment.

¹² As mentioned in the methods section, unmet need measurements were not identical for the two groups. For the VA group, the question on unmet need not only asked what activities a persons needed (but did not receive) assistance with (as was asked in the LTC Survey), but what activities a person wanted assistance with. Therefore, it should be noted that the two populations are being compared with an explicit understanding of the limitations of this variable.

trouble, and flu. A comparison of the overall health status for the two groups, however, shows a similar distribution pattern with respect to self-reported health: 37 percent of the VA group versus 34 percent of the comparison group indicated that they were in excellent or good health compared to others of the same age, and 63 percent of the VA group versus 66 percent of the comparison group indicated that they were in fair or poor condition.

5.1.4 Social Interaction/Quality of Life

The amount of contact with relatives in person or by phone differed between the two groups. The estimated number of visits with relatives during the last month was significantly different among the two groups--44 percent of the VA group versus 34 percent of the comparison group visited with friends less than three times in the last month. Contact by phone, however, differed only slightly--33 percent of the VA group versus 25 percent of the comparison group had spoken with relatives less than three times in the last month.

With regard to friends, the amount of contact also differed. Persons in the VA group were slightly less likely to have visited with friends two times or less in the last month than were persons in the comparison group--28 percent versus 21 percent. The amount of phone contact with friends was significantly different in the VA group--50 percent of the VA group versus 27 percent of the comparison group had spoken with friends five times or less in the last month. Overall, the VA group appears to be somewhat less isolated than the comparison group.

Respondents in both groups indicated similar levels of general life satisfaction. The following are percentages for the VA and comparison group respectively: 21 percent versus 20 percent were very satisfied with life; 54 percent versus 55 percent were satisfied with life; and 25 percent of persons in each group were not satisfied with life.

Satisfaction with his/her living environment, likely to be of great importance to this relatively housebound population, was similar in both populations: 44 percent of the VA group and 49 percent of the LTC group were very satisfied with their living environment, 43 versus 42 percent were satisfied, and 13 versus 10 percent were not satisfied.

5.1.5 Additional Information Available on the VA Population¹³

Limited data were available on the decision-making process with regard to helpers: who decided that help was needed, who decided on who would provide this help, and who decided how much help would be provided. Nearly half of the respondents; 47.4 percent, stated that they had decided they needed help; 62.3 percent stated they had decided on who would be the caregiver; and 53.3 percent stated they decided how much help they would receive.

¹³ These data were not collected on the LTC Survey and no comparison between groups can be made.

In the VA sample, 59.7 percent of the group were veterans and the remaining persons were surviving spouses or other veteran dependents. Forty-two and three tenths percent of the veterans served during World War II; 53.3 percent served during World War I. The vast majority of the VA sample group, 84.2 percent, had no dependents (according to VA eligibility criteria). Beneficiaries had been receiving the VA pension an average of 16.14 years.

With regard to the disability allowance, the majority of beneficiaries, 56.5 percent, did not know what type of allowance (AA or HB) they were receiving. The primary reason for this is that the disability allowance is simply added to the monthly pension check, and recollection of the original award is difficult, especially if it was made in the distant past. Of those responding, 71.7 percent reported receiving an AA allowance and 28.3 percent received a HB allowance.

Although a large percentage of allowance recipients surveyed were unable to distinguish between monies received under the basic pension program and those received under the allowance program, a number of persons did appear quite knowledgeable about the connection between allowance monies and their need for long-term care. When these respondents were questioned about the source of money used to pay for particular helpers, they indicated that allowance funds were the source. This was true in several cases where spouses were recognized as paid helpers who would have had to go to work outside the home in absence of monies received through the allowance program.

5.1.6 Information Regarding Veterans Administration Pension

The median pension amount (regular plus disability allowance) was \$289.72 per month. However, nearly 76 percent of responding pensioners (n=128) felt that their monthly pension amount was not enough. An additional \$160 per month was the mean amount that they reported was necessary in order for the pension to be sufficient. Other pensioners merely responded that they "did the best with what they had".

Concern was expressed by a number of veterans that the government was trying gradually to take away their benefits. In some cases, hostility was expressed by interviewees against the government for attacking what the interviewees felt were earned benefits (through war service). This may indicate that, given a particular amount of resources, these families are utilizing these resources in the manner that they believe is most efficient.

General attitudes towards the VA ranged from frustration to strong appreciation. A number of persons expressed frustration with the bureaucracy at the VA and their inability to get sufficient services. At the other end of the spectrum, a large number of interviewees expressed a great deal of gratitude for the Veterans Administration's assistance, without which they do not know how they would get by--this attitude was especially common in Minneapolis recipients. In almost all cases, however, recipients

felt that allowance monies had been earned through service rendered for their country. The stigma generally associated with transfer programs was not apparent.

VA beneficiaries reported using their pension monies (including disability allowance) to pay for the following items:

Activity	% of Respondents
Housing/Utilities	77.7
Food	79.9
Social Activities	23.0
Clothing	61.9
Over-the-Counter Drugs	61.2
Transportation	48.2
Household Appliances	30.2
Home Health Care	7.9
Homemaker Services	16.5
Health Care Supplies/Equipment	15.1
Other Support Services	12.2

One elderly couple reported that they were saving up their pension monies to help pay for a trip to their 50th high school reunion--an example of the ability of recipients of a cash allowance to time-shift their expenditure of benefits to coincide with their needs. One innovative recipient combined his/her allowance monies with other limited personal resources to start up a business, obtain attendant care, and meet other daily needs. This situation was an excellent example of the ability of cash recipients to determine individualized and sometimes innovative approaches to dealing with their disabilities.

5.1.7 Special Concerns

Each of the four data collection sites had varying degrees of publicly supported assistance available to the VA beneficiaries. In Minneapolis/St. Paul, a small proportion of the sample received public assistance in the form of subsidized housing and home care. In Tampa/St. Petersburg, a number of beneficiaries also lived in government-subsidized housing and/or received other assistance from public agencies. In this metropolitan area, the problem of a VA pension potentially preventing a beneficiary from qualifying for Medicaid by pushing them over the Medicaid income ceiling was an area of concern identified by regional VA personnel. In Philadelphia, many of the beneficiaries who were age 65 and older were participants in a state-supported program of prescription medicine subsidization called PACE. All prescription medications under this program cost \$4.00 and can be purchased at local drugstores. In the Los Angeles County area, a number of beneficiaries received care under a county-run, state-supported program called In-Home Supportive Services (IHSS). Under this program, participants receive the services of a home attendant for a specified number of hours per week. An important program concept is the ability of program participants to choose their own caregiver; relatives are eligible to be paid caregivers under the IHSS program.

As a result of the varying degrees of additional public assistance available to VA beneficiaries in each of the four sites, clear interpretation of the findings may be a problem. To the degree that these cities are not representative of the rest of the nation with regard to available services for the impaired elderly, this study may not be generalizable.

5.1.8 Under 65 Population

Persons in the initial VA sample who were under the age of 65 (n=56, mean age: 60.0 years) differed significantly from the over 65 group with regard to sex, household status, and marital status. 94.6 percent of the under 65 group versus 54.7 percent of the over 65 group were male. Only 21.4 percent of the under 65 group lived alone versus 46.8 percent of the over 65 group. As for marital status, over double the percentage of the under 65 group, 57.4 percent, were married compared to the over 65 group, 24.1 percent. Taking into account the higher percentage of married persons among the younger VA sample population, it is not surprising that fewer of them live alone.

5.1.9 Nonrespondents

The average age of the general AA/HB population is slightly higher than that of the sample VA group, 78.05 versus 77.40 years, a difference which is not statistically significant. Information was not available on the sex of surviving spouse beneficiaries. Nevertheless, using available data which shows that 96.7 percent of veterans are male and assuming that the vast majority of surviving spouses are female,¹⁴ it is not unreasonable to assume that the veteran versus surviving spouse distribution, 44.7 versus 55.3 percent, is similar to the male versus female distribution. Based on these assumptions, the proportion of females in the sample group--45.3 percent--is similar to that of all VA beneficiaries.

Information was not available on the competency status of surviving spouses. With regard to veteran beneficiaries, 77.6 percent are rated competent by the VA. As for the actual sample group, incompetents were excluded in the initial selection process; therefore, 100 percent of this population was rated competent by the VA. As for disability status, housebound versus need for aid and attendance, 90.8 percent of the general AA/HB group are rated AA compared to 71.7 percent of the sample group.¹⁵ The percentage of HB beneficiaries in this sample group was significantly greater than that in the total VA allowance population (n=97,000).¹⁶ There are two major reasons that probably account for this difference: 1) AA beneficiaries are more disabled than those receiving HB and may thus be less able or willing to participate in a study; and, 2) those persons who expressed a willingness to participate, but were ineligible due to institutionalization, were predominantly AA level beneficiaries.

¹⁴ Based on the small proportion of female veterans in this population.

¹⁵ As noted in the analysis plan, a significant percentage (67 percent) of the VA group did not know what type of allowance they were receiving. Therefore, the usefulness of this data is limited.

¹⁶ See analysis plan for details (e.g., data sources, composition of group) on total VA population of non-service connected pension beneficiaries who are receiving an AA or HB allowance.

5.2 Multivariate Analysis of Long-Term Care and Acute Care

5.2.1 Home Care Markets

Data from the VA and LTC surveys permit insight into the relative importance of the various sources of home care to disabled elderly. Table 5-6 compares the average number of days during a one week period persons received help, by type of caregiver (the VA group (n=139) and the LTC group (n=610) were described in Section 4.2.1) Note that, as used here, a “day” of care is really a euphemism for visits by a formal caregiver or periods of help by an informal caregiver; since a person can receive such interventions from more than one caregiver per day, the total number of “days” of care per day can exceed one, and the total number of “days” of care received per week can exceed seven. Table 5-6 above that the number of days of help received per week as well as the number of days of help received from certain types of caregivers is different for the two groups: The goal of this analysis is to explain these differences.

It should be noted that these categories are a mixture of relationship to care receiver and funding type. Although they are intended to be mutually exclusive, they obviously may obscure certain important phenomena, such as the purchase of care from informal caregivers or from helping organizations. Despite this limitation, however, these categories may be collapsed into three groups which can be used to illustrate caregiver and care receiver decisions about care in the home.

Caregiver	VA Group	LTC Group
1. Spouse	1.45	1.29
2. Father	0	0
3. Mother	0	0
4. Son	0.50	0.54
5. Daughter	1.10	1.09
6. Brother	0.12	0.07
7. Sister	0.29	0.21
8. Son-in-Law	0.08	0.05
9. Daughter-in-Law	0.26	0.13
10. Other Male Relative	0.27	0.22
11. Other Female Relative	0.53	0.41
12. Male Friend	0.24	0.11
13. Female Friend	0.47	0.35
14. Someone Hired	1.16	0.47
15. Someone from Helping Organization	0.18	2.39
16. Someone Else	0.11	1.30
TOTAL	6.76	8.63

* There are 139 persons in the VA group; 610 in the LTC group, which includes those persons in the LTC Survey who received at least some subsidized, in-kind help from a helping organization or someone else (that is, other than family and friends and other than hired help). The LTC group is also restricted to persons not living in rural areas and who were not designated as senile or mentally retarded.

One particularly useful conceptualization of care in the home is an economic model. Home care (measured in “days” of care) is received from three major sources: formal helping organizations, such as visiting nurse associations, area agencies on aging, and church groups, that provide subsidized in-kind care for nominal or no out-of-pocket expense by the recipient (SUBDAYS); public and private providers that are hired directly by the care recipient, family or friends, and paid out of private funds that may be supplemented with a cash disability allowance (BUYDAYS); and care provided by informal caregivers, family and friends, whether or not remunerated by the care receiver (INF DAYS). Help may be hired from formal helping organizations, but the distinction between SUBDAYS and BUYDAYS is made because the relationships between consumers and providers are different in each case. The important distinction is the different nature of the markets; exactly what these helping organizations are does not matter. Survey respondents, given the choice, made the distinction between help that was hired and help that was not hired, and that is the distinction used in this analysis.

It should be noted that this is a departure from the common distinction made between formal and informal care. The formal care sector has been divided in this analysis into two sources of care to reflect the different incentives and choices faced by care recipients and their families. In one case, the disabled persons receive a subsidy in the form of services which requires no choices to be made between care and other goods and services; in the second, they must decide whether to spend their limited incomes on services or something else. Because of this difference, it is possible that care decisions and costs may differ depending on whether a subsidy is in the form of services or cash, and this is important for public policy.

The levels of care received from these sources can be viewed as being demanded and supplied in three separate markets, each characterized by the needs, incomes and other sociodemographic characteristics of care receivers, costs and prices. A reorganization of the information in Table 5-6 is presented in Table 5-7 which illustrates the levels of care received from each market.

TABLE 5-7. Average Days of Care Received Per Week by Group by Market		
	VA Group	LTC Group
INF DAYS (Family & Friends)	5.31	4.47
SUBDAYS (Helping Org. & Other)*	0.29	3.69
BUYDAYS (Someone Hired)	1.16	0.47
TOTAL	6.76	8.63
* The “other” category presumably includes non-relative, non-friend good Samaritans who are not hired.		

It is apparent that the way care in the home is subsidized does have an effect on the relative importance of source of caregiving. Persons who receive public support in-kind but no cash subsidy have an order of magnitude more care from that source than persons who receive a cash subsidy. In contrast, persons receiving cash purchase more care and receive more informal care than persons receiving an in-kind subsidy. The two groups chose for comparison are, however, different along certain dimension (for example, the VA group is more frail), and it is not clear whether differences in the total amount and source of care received are due to differences in subsidy type or to

socioeconomic and demographic differences. The multivariate analysis below answers this question.

One potential flaw in this and subsequent analyses is that these “days” of care may not be comparable. The mix of care received from the different sources may, on average, be qualitatively different (e.g., more ADL care versus IADL care from another). In addition, the level of intensity of care from one source may be greater than that from another, so that what may be called a helping intervention may take place in a longer or shorter period (e.g., informal caregivers may take much longer to accomplish the same task than a more efficient formal caregiver). There also may be multiple visits by formal caregivers or multiple “interventions” by informal caregivers during a single day which are not captured by the “day” measure.

Intensity or hours of care per period of intervention was not queried in the LTC Survey, a serious omission. This error was redressed in the VA Survey, where the following information was asked: “Thinking about all of the things (caregiver name) does for you because of your disability, about how many extra hours does he/she spend helping you on an average day?” The responses to this question and reported days per week are presented in Table 5-8 for persons in the VA group who received some positive level of support from the sources of care.

TABLE 5-8. Days of Care and Hours of Care Received Per Week by Persons Receiving an AA or HB Allowance (Includes only persons in each category who received some positive level of care)			
Source of Care	Average Weekly Hours of Care	Average Weekly Days of Care	Average Number of Hours of Care Per “Day” of Care
INFDAYS	41.989 (n=88)	7.341 (n=91)	5.720
SUBDAYS	5.187 (n=8)	4.375 (n=8)	1.186
BUYDAYS	26.794 (n=31)	4.094 (n=32)	6.545
NOTE: Not all persons with positive levels of care responded to the hours per day question. Persons who reported receiving care from a caregiver but did not report either hours or days of care are omitted from these calculations.			

Small sample size, especially for consumers of SUBDAYS, must be of concern here, and conclusions must be tempered accordingly. Nevertheless, the finding that a SUBDAY is the equivalent of approximately one hour of care is not surprising since this is consistent with common experience. It is also not surprising that the average duration of a helping intervention by informal or paid caregivers takes longer than that of caregivers providing subsidized, in-kind care: More care may be provided during a given day; caregivers providing subsidized care may be relatively more efficient at caregiving than informal caregivers; or subsidized care may be fundamentally different (e.g., more skilled). Since INFDAYS are approximately 4.8 times longer than SUBDAYS, and BUYDAYS 5.5 times longer, the difference is probably due to all three reasons. These findings are important to the analysis of substitution below.

If the relative number of hours per day of intervention are different for different sources of care, than it is not appropriate to sum days of care from the three markets.

Using the data in Table 5-8, it is possible to transform days of care into hours of care from each source. These results are shown in Table 5-9, assuming that hours per day estimates derived from the VA sample also hold for persons in the LTC comparison group. This is not necessarily the case (for example, the VA group is more frail, and hours of care per day for this group may be greater), and findings based on that assumption must be considered suggestive only.

	VA Group			LTC Group		
	Days	Hours/Day	Hours	Days	Hours/Day	Hours
INF	5.31	5.720	30.37	4.47	5.720	25.57
SUB	0.29	1.186	0.34	3.69	1.186	4.38
BUY	1.16	6.545	7.59	0.47	6.545	3.08
TOTAL			38.31			33.03

A different pattern emerges if hours per day of care are used. Now it is the VA group that receives more care, at least in terms of hours. The distribution of care among sources remains the same, however. It is still not known whether the distribution of hours of care is different in terms of skill level (e.g., ADL and nursing care versus IADL help). Neither survey permits a breakdown of care by days of care and by type of caregiver. Some insight is obtained by examining the proportion of caregivers that provide ADL, IADL, or nursing services within each market. The results for the two groups together, which are presented in Table 5-10, are limited to the categories shown because of the way the questions were asked in the surveys.

	Informal	Subsidized	Paid
ADL Only	0%*	13%	2%
IADL Only	57%	58%	48%
Nursing Only	0%	2%	1%
ADL and IADL	7%	6%	8%
ADL and Nursing	0%	7%	6%
IADL and Nursing	35%	10%	31%
ADL, IADL and Nursing	1%	5%	4%
	100%	100%	100%

* 0% indicates less than 0.5%.

The figures in Table 5-10 indicate that the distribution of the type of care helpers provide is similar for the informal and paid caregivers: greater proportions of these caregivers provided IADL and nursing care and less ADL only care than caregivers providing subsidized care. This finding further supports the estimates of hours per day in Table 5-8 which indicate that INFDDAYS and BUYDDAYS appear to be different than SUBDDAYS. Nevertheless, it is clear that all three types of care are obtained from each of the three markets.

The average days of care received by group by market reported in Table 5-7 are the “equilibrium” levels: they are the resolution of the demands of consumers with the supply of providers, given the costs and prices in each market. The following describes

each of the three markets and their interaction, with the goal of explaining the differences in outcomes among the groups. The markets are specified to reflect the realities and peculiarities of care at home. The research question is whether the VA group is statistically different with respect to these outcomes, and in what way.

The Market for SUBDAYS

The salient characteristic of the market for help from helping organizations providing subsidized, in-kind care is that the price of care to consumers is intended to be virtually zero. Small copayments for each visit may be required by the helping agency, but these are likely to be negligible (in some cases, e.g., Medicare services, copayments might be substantial). For persons in the comparison group, approximately one-quarter (156/610) actually paid something out-of-pocket for care received from a helping organization; only 14% paid more than \$5.00 per visit. Only two persons in the VA group of the 12 who received SUBDAYS paid anything for that care.

At zero or negligible price, it can be expected that the demand for SUBDAYS is essentially infinite (with respect to price) within the relevant range, and because of this, demand plays no role in determining the ultimate (or equilibrium) level of care or help provided in this market. It should be noted that individual consumer preferences have a definite role in determining individual demand for SUBDAYS but do not affect the equilibrium supply in this market within the relevant range. (Strictly speaking, although any one individual's physical needs may be fulfilled, at zero cost that person may continue to demand SUBDAYS because they meet other needs and wants. Further, from the perspective of providers, the demand for their product is essentially insatiable, since persons with minor or no disabilities would also want such services at zero price. As a practical matter, the low number of observations on persons who paid a positive amount for SUBDAYS rules out estimation of the demand for SUBDAYS.) Consequently, it is assumed that the rationing of SUBDAYS is based on mechanisms other than price, and is determined entirely by the conditions of supply.

Formal helping organizations providing subsidized care presumably supply help according to need, and in many cases, according to inability to pay. Some organizations may base their decisions on the beneficiary's absolute level of need; others on the level of unmet need, taking into consideration levels of informal and purchased care. Some agencies may be limited by budgets and are sensitive to resource costs such as the wages of personnel; others may be required to provide care to all who are entitled regardless of total costs, and are insensitive to the prices of inputs.

The supply of SUBDAYS can be represented more formally by the following equation:

$$\text{SUBDAYS} = a_0 + a_1\text{VA} + a_2\text{ADL} + a_3\text{IADL} + a_4\text{DXTOT} + a_5\text{AGE} + a_6\text{SEX} + a_7\text{RACE} + a_8\text{LALONE} + a_9\text{URBAN} + a_{10}\text{LINC} + a_{11}\text{HINC} + a_{12}\text{MEDICAID} + u_1 \quad (1)$$

Equation (1) describes the supply of SUBDAYS as a linear function of a set of variables which are expected to influence supply. The “a”s are parameters (a_0 is a constant) which describe the impact of each variable on supply, taking into account the impact of the other variables. The u_1 is an error term representing the influence of errors in measurement of the variables, errors in the specification of the equation, and random error. These parameters are estimated using regression analysis. Since (by assumption) the demand for SUBDAYS plays no role in this market, Equation (1) also determines the equilibrium level of SUBDAYS.

ADL and IADL are measures of recipients’ levels of needs for assistance in activities of daily living and instrumental activities of daily living; DXTOT is a measure of the number of chronic conditions each person has; LALONE is a dichotomous variable distinguishing persons who live alone; age is self-explanatory. It is hypothesized that the coefficients a_2 , a_3 , a_4 , a_5 and a_8 are all positive; that is, that SUBDAYS are greater for persons with greater needs. Sex and race are included because of their potential effect on need; but because discrimination by helping organizations on the basis of sex and race is not permitted, their effect on supply is indeterminate a priori (i.e., a_6 , a_7 $>$, $=$ or $<$ 0). The supply of SUBDAYS should be less the greater are prices of inputs which are likely higher in URBAN areas (a_9 should be negative). The greater a person’s income, the less likely it should be that that person would qualify or receive support from this source of help (and vice versa); thus, it is hypothesized that $a_{10} > 0$, $a_{11} < 0$ (family income has been divided into three dummy variables: high (HINC), medium (MINC) and low (LINC) income; the left out category is MINC). Membership in the VA group, characterized by the receipt of an AA or HB cash grant as well as a pension designed to raise persons above the poverty line, should also reduce a person’s chance of receiving SUBDAYS (a_1 should be negative).

It is likely that the helping organization’s ability to assess levels of informal effort (informal and purchased care) will be limited either by the failure of recipients to be fully revealing of their personal circumstances, or by regulations which prevent discrimination against persons who receive care from available caregivers. Thus, INFDDAYS and BUYDDAYS are not included in Equation (1). Equation (1) was estimated a second time with INFDDAYS and BUYDDAYS as explanatory variables to test whether helping organizations make decisions on the basis of unmet need instead of just need. This assumption introduces the complication of simultaneity into the estimation process and requires a multi-stage estimation procedure. The hypothesis of helping organizations making decisions on the basis of unmet need (as measured crudely by these variables) was not confirmed by the data.

The Market for INFDDAYS

Because decisions as to the level of informal care and help to be provided by family and friends are often joint ones, taking into consideration the availability and willingness of informal caregivers as well as the needs and resources of the care receiver, it is difficult to imagine demand and supply occurring separately in what strictly may be called a market. Nevertheless, an attempt is made here to do so in order to

isolate and highlight the determinants of the supply of informal care and the factors which influence informal caregivers to substitute publicly-funded, in-kind care or others forms of public assistance for their own effort when it is offered. This framework also will permit an examination of whether public support in the form of cash instead of in-kind care has a differential effect on substitution of public resources for private effort. Consumers and providers of informal help are strictly separate in theory; the absence of readily observable prices and costs does not permit their distinction empirically.

As in the market for SUBDAYS, a key element in the market for INFDDAYS is missing: price. Conceptually, the price of INFDDAYS is the payment made by care receivers to informal caregivers necessary to encourage the flow of services. At best, this phenomenon is hard to measure; in reality, it probably has little relevance to the supply of informal services forthcoming; and, in practice, our data are not very revealing of its magnitude (payments to relatives were not queried on the LTC Survey). Data from the VA Survey indicate that the frequency of side payments to informal caregivers was very low: only 13 persons in the VA sample of the 104 who received help from a relative or friend (12.5%) actually paid something for that care. Consequently, this framework explicitly assumes that the price of informal care is zero, and it is excluded from the analysis even though at the margin, such payments may encourage a greater supply of care (money given to informal caregivers to pay for expenses such as gasoline may not be considered payments per se by either party and are not reported as such; yet, they are in fact).

At a zero price (in strictly pecuniary terms) the demand for INFDDAYS effectively would be infinite in the relevant range, and would have no effect in determining the equilibrium level of INFDDAYS consumed. Other non-pecuniary costs to the recipient (particularly emotional ones) are likely to limit demand, but these are virtually impossible to quantify for purposes of analysis. Thus, it is assumed that the amount of care observed in this market is determined solely by the conditions of supply.

The supply of INFDDAYS is represented formally by Equation (2):

$$\text{INFDDAYS} = b_0 + b_1\text{VA} + b_2\text{ADL} + b_3\text{IADL} + b_4\text{DXTOT} + b_5\text{AGE} + b_6\text{SEX} + b_7\text{RACE} + b_8\text{LALONE} + b_9\text{TOUCH} + b_{10}\text{SUBDAYS} + u_2 \quad (2)$$

The “b”s in Equation (2) are parameters which are estimated; u_2 is an error term. It is hypothesized that more INFDDAYS are supplied to persons with greater need ($b_2, b_3, b_4, b_5 > 0$); that people who live alone have fewer available informal caregivers and receive fewer INFDDAYS ($b_8 < 0$); and that sex and race may affect the supply of INFDDAYS ($b_6, b_7 >, = \text{ or } < 0$). TOUCH is a dichotomous variable indicating whether relatives or friends keep in touch with the sample person either by phone or by visiting, a crude measure of the strength of informal ties (b_9 is hypothesized to be positive). The pecuniary costs of providing informal care, that is, the opportunity costs, are the wages (or some other value of time) foregone by providing care rather than being engaged in some other (possibly remunerative) activity. This has been omitted from Equation (2) because of lack of data, but also because of its likely unimportance to elderly caregivers, and evidence that it is not a serious issue with other relative caregivers

(Department of Health and Human Services, 1982 National Long-Term Care Survey, 1985). With expected changes in the caregiver population resulting from different sociodemographic forces, this issue may become more important in determining the supply of informal care. Because of the infrequency of side payment in this sample, it is presumed that income is unimportant to supply and it is omitted from the equation.

The coefficient of VA in Equation (2), b_1 , is a measure of the impact of receiving a cash subsidy for home care versus services in-kind. It was argued above that cash subsidies permit recipients and their informal caregivers to substitute informal effort for purchased care and to spend the savings on whatever they wish--an option not available if the subsidy is in-kind services. Consequently, it is hypothesized that the substitution of public resources for informal effort will be no greater for the VA beneficiaries than for the LTC comparison group; that is, controlling for differences in sociodemographics and need, the VA group will receive either the same amount or more informal care ($b \geq 0$).

SUBDAYS is included in Equation (2) to measure the rate of substitution of public (or private) resources for public effort. Informal caregivers are expected to react rationally to the provision of essentially free care by reducing their caregiving efforts ($b_{10} < 0$); if the care provided by each source is similar, then the substitution of SUBDAYS for INFDDAYS will be perfect (i.e., adjusting for differences in hours per day, b_{10} would equal -1).

The Market for BUYDAYS

In contrast to the markets for INFDDAYS and SUBDAYS, price may play an important role in the market for BUYDAYS. Of the 39 persons in the VA group who purchased BUYDAYS, 21 (53.8%) said they themselves paid something out-of-pocket for that care (presumably care for the remainder was paid for by friends or relatives); 70.9% (56/79) of persons consuming BUYDAYS in the comparison group reported a positive expenditure for BUYDAYS. Persons in the entire sample reporting a positive expenditure for BUYDAYS (77 persons) paid an average of \$32.23 per BUYDAY, or \$5.72 per hour. This figure is the out-of-pocket cost to the disabled person, and does not necessarily represent the average market price of care since some of the care purchased may have been paid for by someone else (the total cost of care was not queried on the LTC Survey.)

For convenience, it is assumed that in metropolitan market areas such as being examined here, there are many sellers of BUYDAYS who, in the relevant range, can sell all of their available product at the given market price, and cannot influence that price through their own production behavior. In consequence, it is assumed that equilibrium in this market is determined primarily by the conditions of demand, not supply. (As a practical matter, characteristics of the firms supplying BUYDAYS to persons in the sample are not available, making estimation of a supply function almost impossible.)

The demand for BUYDAYS is represented formally in Equation (3):

$$\text{BUYDAYS} = c_0 + c_1\text{VA} + c_2\text{ADL} + c_3\text{IADL} + c_4\text{DXTOT} + c_5\text{AGE} + c_6\text{SEX} + c_7\text{RACE} + c_8\text{LALONE} + c_9\text{URBAN} + c_{10}\text{LINC} + c_{11}\text{HINC} + c_{12}\text{INFDAYS} + c_{13}\text{SUBDAYS} + u_3 \quad (3)$$

The “c”s in Equation (3) are parameters to be estimated; u_3 is an error term.

It is hypothesized that persons with greater needs will demand more BUYDAYS ($c_2, c_3, c_4, c_5 > 0$); need for purchased care will be greater for persons who live alone ($c_8 > 0$); less care will be demanded where prices are higher, as indicated by the URBAN variable ($c_9 < 0$); and more care will be demanded by persons with higher incomes ($c_{10} < 0, c_{11} > 0$). The coefficients of sex and race (c_6 and c_7) are uncertain a priori.

Prices calculated for persons purchasing BUYDAYS are not used in Equation (3) because they are not available for persons deciding not to purchase BUYDAYS but who could have. Since this would severely restrict the sample to only those persons with BUYDAYS ($n=77$), the variable URBAN is used as a proxy for price.

As argued above, a cash subsidy such as the VA AA/HB allowance enhances the income of recipients, who may then spend all or part of that additional sum on BUYDAYS ($c_1 > 0$). The prices of substitutes (SUBDAYS and INFDAYS) have been omitted from the demand equation because of their relative unimportance.

INFDAYS and SUBDAYS appear in Equation (3) to account for the possibility that care from these sources substitutes for care purchased ($c_{12}, c_{13} < 0$). This model explicitly assumes that individuals fill gaps in care with BUYDAYS after the level of informal care and subsidized, in-kind care from formal helping organizations has been established. Other models of home care markets which examine the possibility that decisions about SUBDAYS, INFDAYS and BUYDAYS are made simultaneously were estimated using three stage least squares. The results of those models did not confirm such simultaneity and are not presented.

5.2.2 Empirical Analysis of Home Care Markets

The results of the multivariate analyses (ordinary least squares regressions) of SUBDAYS, INFDAYS and BUYDAYS are reported in Table 5-11 (sample sizes differ because of missing values for some of the variables). The figures in Table 5-11 indicate that the pattern of care received from the three major markets presented in Table 5-7 is confirmed when differences in socioeconomic and demographic factors between the two groups are controlled for, although the magnitudes change somewhat.

Persons in the VA group received 3.27 fewer days of in-kind care per week than persons in the comparison group. This is the equivalent of approximately 3.9 hours per week. Other variables indicating need and resources are probably not significant because the comparison sample, which represents 81 percent of the entire sample, is comprised of only those persons in the LTC Survey who received at least some in-kind help from a helping organization: The results of the SUBDAYS equation estimation in

Table 5-11 imply that once a person is receiving in-kind care from a helping organization, additional levels of need (with the exception of living arrangement) do not result in more care from this source. This might mean either that persons who are eligible for SUBDAYS are relatively homogeneous with respect to need, or that care provided by helping organizations comes in

[Page 5-43 missing from original; it will be added at a later date]

TABLE 5-11. Determinants of Days of Care by Caregiver Type Estimated Regression (OLS) Parameters (Standard Errors in Parentheses)			
Independent Variables	Dependent Variables		
	SUBDAYS	INFDAYS	BUYDAYS
VA GROUP	-3.273 (0.304)***	-0.029 (0.463)	0.586 (0.245)**
ADL SUM	0.045 (0.078)	0.191 (0.112)	0.295 (0.059)***
IADL SUM	0.046 (0.072)	0.483 (0.104)***	0.083 (0.055)
DXTOT	-0.024 (0.038)	0.112 (0.056)**	-0.033 (0.029)
AGE	0.004 (0.013)	0.014 (0.019)	0.009 (0.010)
SEX	-0.157 (0.228)	0.110 (0.341)	0.112 (0.173)
RACE	0.197 (0.299)	-0.144 (0.422)	-0.155 (0.221)
LALONE	0.259 (0.256)	-4.024 (0.333)***	0.192 (0.210)
TOUCH	---	2.423 (1.120)**	---
URBAN	-0.023 (0.266)	---	-0.395 (0.202)*
LINC	0.514 (0.260)**	---	-0.088 (0.195)
HINC	0.858 (0.319)***	---	0.392 (0.244)
MEDICAID	-0.241 (0.245)	---	---
INFDAYS	---	---	-0.092 (0.020)***
SUBDAYS	---	-0.178 (0.059)***	-0.033 (0.031)
INTERCEPT	2.737 (1.093)**	1.261 (1.927)	-0.114 (0.826)
F VALUE	16.290	33.653	5.918
ADJ R ²	0.231	0.310	0.094
n	612	732	613
*** Significant at 0.01 ** Significant at 0.05 * Significant at 0.10			

caregivers; the coefficient for IADL is about double that for ADL, possibly indicating that, although informal caregivers provide both types of care to this relatively very frail and dependent population, they provide more IADL rather than ADL care. This relationship is stronger when all persons are considered, i.e., whether or not they received SUBDAYS (see the INFDAYS equation in Table 5-12).

Persons who live alone receive about 4 fewer days of care from informal sources. Those persons who are less socially isolated (as measured by the TOUCH variable) receive significantly more care from informal sources. The coefficient for SUBDAYS in the INFDAYS equation is discussed in a separate section below.

Persons in the VA group purchase .586 more days of care per week (about 3.8 hours per week) than persons in the comparison group (see the BUYDAYS equation in Table 5-11). This makes up almost exactly for the fewer hours of subsidized, in-kind

care they receive from helping organizations. ADL score is the only need variable which is a significant determinant of the level of BUYDAYS. Using the larger comparison group in the analysis (Table 5-12), which includes a less frail group as well as those who receive SUBDAYS, it is apparent that the need for both types of care is important in determining the level of BUYDAYS. Both ADL and IADL coefficients are positive and significant.

TABLE 5-12. Determinants of Days of Care by Caregiver Type Estimated Regression (OLS) Parameters (Standard Errors in Parentheses)			
Independent Variables	Dependent Variables		
	SUBDAYS	INFDDAYS	BUYDAYS
VA GROUP	-0.514 (0.154)***	-0.774 (0.386)**	0.373 (0.142)***
ADL SUM	0.153 (0.028)***	0.095 (0.064)	0.228 (0.026)***
IADL SUM	0.094 (0.019)***	0.835 (0.045)***	0.148 (0.019)***
DXTOT	-0.011 (0.011)	0.058 (0.026)**	-0.023 (0.010)**
AGE	0.003 (0.004)	0.018 (0.009)**	0.013 (0.004)***
SEX	0.009 (0.062)	0.186 (0.147)	0.098 (0.058)*
RACE	0.113 (0.087)	-0.459 (0.197)**	-0.106 (0.080)
LALONE	0.493 (0.073)***	-3.349 (0.152)***	0.125 (0.071)*
TOUCH	---	2.180 (0.879)**	---
URBAN	-0.108 (0.074)	---	-0.126 (0.069)*
LINC	0.107 (0.075)	---	-0.001 (0.069)
HINC	-0.096 (0.075)	---	0.206 (0.070)***
MEDICAID	0.080 (0.070)	---	---
INFDDAYS	---	---	-0.072 (0.006)***
SUBDAYS	---	-0.192 (0.062)***	-0.046 (0.016)***
INTERCEPT	-0.277 (0.312)	0.422 (1.175)	-0.636 (0.290)**
SUBNO	---	0.650 (0.299)**	---
F VALUE	15.602	145.810	30.608
ADJ R ²	0.050	0.279	0.104
n	3329	4115	3330
*** Significant at 0.01			
** Significant at 0.05			
* Significant at 0.10			

Persons with higher incomes purchase more days of care (although not significantly more), and the price of care (as measured crudely by the URBAN variable) does reduce the demand for care. Care received from informal sources, but not that received from helping organizations, does substitute somewhat for purchased care (one day of informal care reduces the amount of purchased care by only .092 days). The small coefficient may indicate that care from these sources may be more complementary than substitutes for persons with some informal care (i.e., that bought care is used to fill gaps in care).

As described in Chapter 3, beneficiaries of the VA AA/HB allowance program received an average subsidy of about \$185 per month, or \$42.70 per week. At an average out-of-pocket price for bought care of \$32 per day, this works out to 1.33 BUYDAYS per week, which is slightly greater than the mean number of BUYDAYS purchased by persons in the veteran sample (1.16 days per week). Thus, beneficiaries

of the VA program spend the equivalent of about 87 percent of their entire allowance on care. But compared to a similarly disabled comparison group, and controlling for differences in income, they bought only .586 days per week more (i.e., persons without an allowance also purchased care out of personal income). This implies that VA beneficiaries were given the means, but chose not, to purchase an additional six-tenths of a day of care (1.16 - .586) per week. These monies (\$18 per week, or \$80 per month) were presumably spent on things which brought the recipient a higher level of personal well-being. Also, these additional funds may have encouraged a greater supply of informal care to VA recipients than would otherwise be forthcoming (the difference in informal care received by the two groups was not, however, statistically significant): Although few recipients reported direct payments to informal caregivers for services rendered (9%), additional income available for the family to spend as it wishes may serve to encourage additional informal caregiving effort at the margin.

5.2.3 The Substitution of Public Resources for Private Effort

An interesting by-product of this analysis is the finding that subsidized, in-kind care from formal helping organizations does substitute for care provided by informal caregivers. The coefficient for SUBDAYS in the INFDDAYS equation (Table 5-11) implies that each “day” of care provided by a helping organization (the equivalent of slightly more than one hour) causes a drop of .178 “days” of care provided by informal caregivers. This coefficient is highly significant and was highly stable under many alternative specifications of the informal care supply equation, varying by no more than .02 days. The importance of the coefficient becomes evident when translated into hours of informal care: .178 “days” of informal care is the equivalent of approximately 1.02 hours of informal care (using hours per day of care information asked of persons in the VA Survey). Thus, each hour of subsidized care provided by a helping organization supplants approximately an hour of informal care--hour for hour, one for one.

This finding is not surprising when caregivers and care receivers are viewed as rational decision-makers responding to straightforward economic incentives. It is also a sign that programs of help, whether publicly funded or private, do accomplish at least one of the objectives they are designed for: they relieve the informal support network’s burden of care in the short-run by supplanting informal care with formal services. Since both sources of care supply ADL and IADL care, it is likely that substitution occurs within, not across, types of help. Presumably, relief of informal burden in the short-run will encourage greater informal support over the long-run, so that dependent and frail care receivers will be able to avoid or delay institutionalization. This analysis confirms only the first half of the proposition.

It should be noted that the findings reported in Table 5-11 are relevant only for persons who are receiving at least some position level of subsidized care from a helping organization. The estimates do not address the behavior of informal caregivers of persons who have not sought subsidized care from a helping organization, even though the persons they help may be eligible for such care. Because, in the short-run, some informal caregivers probably provide care beyond their long-term capacity to do so, it is

likely that the greatest marginal rate of substitution of subsidized, in-kind care for informal care occurs when they have exceeded their burden threshold and seek outside help; that is, when the care receiver makes the transition from no SUBDAYS to some positive level of SUBDAYS. The INF DAYS equation estimated on all persons in the LTC comparison sample (n=3329) reported in Table 5-12 is an attempt to estimate the additional (actually initial) substitution effect of going from none of some SUBDAYS.

An additional variable, SUBNO, has been added to the list of independent variables in the INF DAYS equation which distinguishes persons who received some and no SUBDAYS. The coefficient of SUBNO implies that persons who did not have any subsidized help from a helping organization received .650, or approximately two-thirds more INF DAYS per week. Transforming this figure into hours, it is estimated that the first hour of subsidized care from a helping organization supplants about four (3.718) hours of informal effort. This may indicate either that some hours of informal care which were given up were not essential, or that the excessive burdens of high levels of informal care made informal caregivers relatively less efficient in providing those last marginal units of care.

The analytic results of the Channeling Demonstration are actually very supportive of these findings, despite the conclusions of the principals involved in the project which appear to ignore the large number of findings in their own analysis indicating widespread short-term substitution effects (Mathematica, 1985). In fact, findings of substitution effects are strong, significant and persistent at several levels of analysis.

Over and over again, findings of strong statistical significance (at five percent and one percent confidence levels) are reported, and then downplayed. Substitution effects were reported in the following areas: receipt of meal preparation and chores in the basic case management model, and receipt of meal preparation, housework, laundry or shopping, general supervision, delivery of prepared meals, and help with transportation under the financial control model, and the number of types of in-home care received and the presence and number of informal caregivers under the financial control model. Also, the magnitudes of the significant findings are consistent: a reduction in informal effort is apparently brought on by an increase of formal effort that is three, four or five times as large. Rather than ask why these effects are of this magnitude and what are the implications, the researchers conclude that there is little evidence of substitution and where it did occur, its effect was small in magnitude.

The key is that a period of caring intervention by a formal caregiver is not necessarily equivalent in intensity or duration to that of an informal caregiver. Implied coefficients of the effect of formal care on informal care in the Channeling Demonstration of 0.2 (5:1) to .033 (3:1) are similar to coefficients estimated in this study of about 0.18 (5.5:1). If for members in the Channeling sample the average period of informal caregiving is on the order of three to five times longer than that of a formal caregiver, then substitution not only exists but is perfect (i.e., one to one), and a different assessment of the intervention emerges: the basic model is ineffective because it does not relieve the burden of informal caregivers; the financial control model

is effective in this regard, and has the potential, in theory, therefore, to encourage informal support over longer periods of time (the cost of this intervention, however, is another, more significant, concern).

Relieving the excessive burdens of caregivers is a legitimate public policy, whether or not it results in a net economic benefit. Rather than asking whether substitution exists, researchers should be asking what is its magnitude and what can be done to limit its detrimental effects on the family and society: that is, what is the most efficient way of subsidizing home care for disabled persons.

5.2.4 Acute Care Utilization

The findings so far have suggested that persons receiving a cash disability allowance receive about the same amount of help at home as persons receiving subsidized services in-kind from a helping organization, although the importance of the various sources of care differs significantly for the two groups. The VA group was somewhat more disabled than the LTC comparison group in terms of both ADL and IADL score, but findings regarding differences in needs were not conclusive. The question remains whether recipients of an allowance were worse off in terms of acute care needs and utilization.

The determinants of acute care utilization were estimated for six categories of care, controlling for a number of variables also likely to affect a person's consumption of care. In addition to the various variables representing need and personal resources that were used to explain the distribution of care received in home care markets, the equations describing the consumption of acute care also contain variables denoting whether the person had private hospital insurance (PVTHINS) and private insurance covering the services of physicians (PVTMDINS). The results are reported in Table 5-13.

Reading across the six equations in Table 5-13, it can be seen that the VA group compared with the comparison group of persons who had some subsidized help from a helping organization but not a cash grant, had 8.4 fewer hospital days (HDAYS) during the year prior to the interview, consumed 1.18 more prescription drugs (RX) in the previous month, and had .668 fewer visits to a therapist (TV) during the previous month; the groups did not differ with respect to emergency room visits (ERV), MD visits (DV) and other doctor visits (ODV). Despite the fact that the VA acute care system is essentially free to qualifying veterans, rapid growth over the past decade in utilization of VA hospitals (see Section 3.1.3) may have resulted in more efficient use of existing facilities through reduced lengths of stay and admissions per veteran. Prescription drug use probably is higher for the VA group because recipients of an Aid and Attendance Allowance are given drugs through the VA Medical System for no charge. Only two persons in the VA group had a stay in a nursing home during the 12 months prior to the interview, so it was not feasible to compare the two groups along this dimension of care received.

TABLE 5-13. Determinants of Acute Care Utilization Estimated Regression (OLS) Parameters (Standard Errors Not Reported)						
Independent Variables	H DAYS	ERV	DV	ODV	RX	TV
VA GROUP	-8.444***	0.110	-0.143	0.129	1.180**	-0.668**
ADL SUM	1.384**	0.003	-0.024	-0.041*	0.104	0.162**
IADL SUM	1.085*	-0.008	-0.001	-0.022	0.178	-0.084
DXTOT	0.384	-0.001	0.031**	0.002	0.237***	-0.004
AGE	-0.117	-0.004	-0.005	-0.006	-0.032	-0.004
SEX	-3.401*	-0.101	0.011	0.058	0.086	-0.150
RACE	1.244	0.024	0.008	0.084	0.994**	-0.045
LALONE	2.594	0.041	0.114	-0.022	0.350	0.538**
URBAN	-2.620	-0.069	0.048	-0.025	-0.700	-0.016
LINC	-2.344	-0.081	-0.072	-0.064	-0.224	-0.551***
HINC	2.351*	0.068	0.047	0.065	0.185	0.534***
MEDICAID	-0.359	-0.052	0.042	0.044	-0.300	0.011
PVTHINS	1.250	0.017	0.232	-0.031	-0.180	0.802*
PVTMDINS	0.385	-0.164	-0.001	0.205	0.047	-0.495
TOTDAYS	0.049	0.007	0.002	0.004	-0.047	0.026
INTERCEPT	14.764	0.551	0.788*	0.666*	3.418*	0.725
F VALUE	2.982	0.938	1.759	1.343	2.911	2.448
ADV R ₂	0.039	0.001	0.015	0.007	0.038	0.029
*** Significant at 0.01						
** Significant at 0.05						
* Significant at 0.10						

Although the acute care equations are generally of low explanatory power, some estimated coefficients of certain variables are highly significant. The findings suggest that recipients of a cash disability allowance are no worse off than other persons with similar disabilities and chronic problems with respect to their use of acute care.

5.2.5 Relative Cost Efficiency of In-Kind Versus Cash Subsidies for Long-Term Care

Although a majority of persons in the VA sample were not capable of recalling or identifying the dollar amount of their monthly allowances (and such information was not available through data sharing agreements with the VA), analysis of all persons receiving an AA or HB allowance from the VA indicates an average amount of \$185 (see Chapter 3). This may be assumed to be the average direct per recipient cost of the program. The findings above suggest beneficiaries of this program are not worse off with regard to either acute or long-term care. Persons in the VA group are slightly more frail, but they may also receive more total care; if the data on hours are accurate, the VA group does receive more total hours of care per week. In general, then, it is probably safe to conclude that the disability allowance program has at least the same beneficial effects on recipients as the in-kind services program, and does not leave those persons in any way worse off.

The direct (non-administrative) cost of the in-kind services program per person per month is not readily discernable from the survey data, as the total cost of services to

recipients was not queried. If the estimate of the number of hours per day for a SUBDAY described above is representative of actual care provided and received in this market, then persons receiving services in-kind receive approximately 16.8 more hours of subsidized care from helping organizations per month than persons in the VA group. If the direct additional costs of the two subsidies were the same (i.e., \$185 per month), then this would imply that these 16.8 more SUBDAYS would cost approximately \$11 per day--an unreasonably low figure for an "average" day comprised of both relatively inexpensive IADL services and relatively costly ADL services. It is likely that the mean monthly direct costs of in-kind services per recipient is a lot higher than \$185; perhaps twice that much, and more. If this is true, then it is probable that for many persons, cash is a more efficient benefit than in-home in-kind transfers.

These costs are not, however, the total costs of the program. First, there are costs associated with the basic administration of the program. As discussed above, it is likely that mailing a check to a recipient is many times less expensive per recipient than the costs of supervising a staff of caregivers. Second, there are additional administrative costs in the form of screening of information gathering costs. As discussed above, it would be hypothesized that because the cash allowance is a more attractive benefit, more persons would come out of the woodwork to attempt to qualify for the benefit, thereby raising the costs of screening per recipient as well as the costs per recipient of giving benefits erroneously to persons who otherwise would not have qualified. Neither of these costs could be calculated in this study, although it should be pointed out that the second problem, the woodwork effect, is also a problem with persons desiring an in-kind benefit, although the degree of moral hazard is likely to be less. Thus, it is not possible in this study to conclusively determine whether one subsidy type is more cost-effective (in the short- or long-run).

5.3 Summary and Conclusions

5.3.1 Summary of Findings

The economic model used in this analysis provides a very robust framework for examining the issues. It is especially useful in distinguishing the sources of in-home care, providing motivation and a consistent rationale for the provision of services in each sector. The important phenomenon of short-term substitution becomes a logical manifestation of the forces acting on informal supports, as viewed in the context of rational caregivers facing a set of economic incentives.

One key measure of the relative efficiency of the cash allowance mechanism, from the beneficiary's point of view, is whether or not persons receiving cash have different utilization patterns for acute and long-term care services. Study results show that the VA group as a whole received similar levels of long-term care (measuring levels in hours of care) and were no worse off than the comparison group with regard to acute health care utilization. One potential criticism of cash allowance, that beneficiaries of cash payments will need more intensive acute and long-term care services because

they will purchase an insufficient amount of needed services, is, thus, not supported by this study.

From the funding source's point of view (i.e., local, state, or federal agency), one key measure of a mechanism's efficiency is its cost-effectiveness. The overall costs of providing long-term care assistance through cash allowances versus in-kind services could not be compared. Relative administrative costs in particular, which include screening and monitoring expenditures, were not available. Nevertheless, evidence on hours of care per week and the direct (non-administrative) costs of the VA cash program suggest that the cash benefit may be the more cost-effective alternative for many beneficiaries.

Another key issue with regard to program efficiency is the substitution of subsidized, in-kind home care for that provided by the informal network. The substitution effect was found to be significant and approximately one-to-one.

The reader is cautioned that these results must be considered tentative and suggestive only. They are based on the comparison of two relatively small samples narrowly defined, which may not be representative of the disabled elderly population at-large. Nevertheless, the study represents a solid first step in examining an area in which so little has been done and so much more is needed.

Future research on this topic should focus on the following items: Better data sharing agreements with the Veterans Administration, which allow the sharing of critical information such as the amount and type of cash allowance, and a larger, more nationally-representative sample, should be key components of a follow-up study. In addition, the important issue of administrative costs should be examined in detail. If resources permit, the selection and collection of original data on a new comparison group should be undertaken. Key variables which were missing in the LTC comparison group data set, including hours of care provided and the cost of in-kind services, could then be collected. Finally, alternative specifications of the three market equations should be estimated; different models of the interactions among the three sectors should be tested using simultaneous equations estimation techniques.

5.3.2 Conclusions

Cash allowances appear to be a viable policy option with regard to the provision of long-term care assistance to the disabled elderly in the general population, as is demonstrated by the success of the Veterans Administration Housebound and Aid and Attendance Allowance Program. This mechanism could be incorporated into the Supplemental Security Income program, an approach similar to that used in the Colorado Home Care Allowance Program. It also could be offered as an option under the Section 2176 community care waivers, or perhaps under other government programs such as Medicare.

This study suggests that cash disability allowances are cost-effective mechanisms for assisting chronically impaired persons. They do so in a way that provides maximum self-determination and does not have society assume more responsibility. They are an important element of the spectrum of long-term care policy instruments that is missing in our present (non-VA) system of social assistance. They exist throughout the world, and should be given serious consideration in the U.S. The Veterans Administration has the experience to provide needed guidance.

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APPENDIX 1. INSTRUCTIONS OF APPLYING FOR AID AND ATTENDANCE

Department of Veterans Benefits
Veterans Administration
Washington, D.C. 20420

DVB Circular 27-84-2

March 15, 1984

USE OF VA FORM 27-8944 INSTRUCTIONS FOR APPLYING FOR AID AND ATTENDANCE OR HOUSEBOUND BENEFITS

1. Purpose. The purpose of this circular is to create an awareness among VSD (Veterans Services Division) employees of the importance of A&A (aid and attendance) or housebound benefits and to explain the use of VA Form 27-8944, Instructions for Applying for Aid and Attendance or Housebound Benefits (see exhibit A). This form will be distributed in the near future.

2. Background

a. As our aging veteran population expands, it is anticipated that the impact on services by DVB (Department of Veterans Benefits) and DM&S (Department of Medicine and Surgery) will be critical. Both Departments are committed to ensuring that an appropriate level of benefits is provided within the law to all eligible veterans and beneficiaries as efficiently as possible. Veterans benefits personnel must be increasingly aware of the opportunities to serve the aging population, a group "exceedingly at risk" in terms of medical problems and socio-economic concerns.

b. Medical problems and aging generally mean a less mobile population, more housebound situations, and greater use of our telephone service system. Therefore, effective communication by telephone and followup mail becomes increasingly important in dealing with this segment of our clientele. It also means an increase in special care for these people; e.g., nursing homes, senior citizen homes and residences, personal care facilities, and hospices. Thus, more "third parties" (families and social service personnel, for instance) will be seeking help on behalf of elderly veterans and their dependents.

c. Recent history shows insufficient supporting information being submitted to rating boards to enable full processing of housebound and A&A claims. It is incumbent on VSD personnel to clarify instructions to claimants so that complete claims are received and less followup required, thus assuring timely claims processing and reduction of claimant frustration.

3. Counseling and Outreach

a. There are many eligible veterans and dependents drawing too little pension or none at all because they are unaware of A&A and housebound benefits. They do not understand income limitations, are not encouraged to file, do not remember these benefits if medical circumstances change, or do not know what type of medical evidence or information is needed

to support their claims. Inquiries from or on behalf of pensioners or potential claimants give VSD employees an excellent opportunity to provide information on these two most important benefits.

b. Counselors should be particularly alert to the higher income limitations provided by A&A and housebound benefits. There are many older persons who have previously applied for pensions and been denied because income exceeded limits at that time. They may not be aware that changed circumstances could now make them eligible.

c. The “unusual medical expenses” provision of the law should be thoroughly explained to all persons to whom it may apply. VBC’s should encourage claimants to keep track of all unreimbursed medical expenses including medical insurance costs and/or medicare.

4. Instructions

a. VA Form 27-8944 has been developed to guide counselors in interview situations and to assist claimants in submitting complete applications.

b. When a recipient of a protected pension inquires about A&A or housebound benefits, VA Form 27-8944 may be used to explain the steps, involved in applying. VA Form 21-2680, Examination of Housebound Status or Permanent Need for Regular Aid and Attendance, may also be used as a guide to the types of medical evidence required by the VA, although it should not be sent to the claimant. Although the type of medical evidence required is critical to the A&A and housebound claim, the claimant should be made to understand that he/she does not have to incur the cost of a physical exam from his/her private doctor or hospital. The VA can arrange for an examination at one of its facilities if the information required is not readily available.

c. Blocks applicable to the specific case should be checked and the form mailed to the claimant with the appropriate forms and/or applications. These include but are not limited to an income statement (VA Form 21-6897 for a veteran or 21-4100 for a dependent) and a Statement in Support of Claim, VA Form 21-4138, for election of benefits or any other supporting statement.

/S/

DOROTHY L. STARBUCK
Chief Benefits Director

Distribution: CO: RPC 2906
FD FLD: RPC 2035 plus VBC, 1 each
EX: ASO and AR, 1 each

INSTRUCTIONS FOR APPLYING FOR AID AND ATTENDANCE OR HOUSEBOUND BENEFITS

A veteran of surviving spouse who is a patient in a licensed nursing home receiving skilled or intermediate level or otherwise determined to be in need of the regular aid and attendance of another person, or is permanently housebound, may be entitled to higher income limitations or additional benefits, depending on the type of pension received.

If you currently receive pension benefits under one of the prior pension laws, an election of the Improved Pension Program would be required before the aid and attendance or housebound benefits could be included in your monthly payment. This election may be made on the enclosed Statement In Support Of Claim (VA Form 21-4138), but would not be made unless it is advantageous to you. Your eligibility to aid and attendance or housebound benefits will be determined before the election is considered.

To assist us in helping you, the following forms should be completed and information submitted:

- Complete the enclosed income statement.
- On the Statement In Support Of Claim, (VA Form 21-4138), include the following statement: "I elect to receive benefits under the Improved Pension Program, Public Law 95-588, if it is to my financial advantage. I understand that once the election is made, and the first check is cashed, it cannot be changed." Any other information you wish to provide in support of your claim may also be included on this form.
- If you are a nursing home patient, supply a certification from the administrator of the nursing home affirming your patient status and the level of nursing care you receive.
- If you are a nursing home patient and have a constant high level of monthly unreimbursed medical expenses, furnish an itemized statement of these recurring, unreimbursed expenses. Unreimbursed expenses are those not covered by insurance, medicare, and medicaid.
- If you are not a nursing home patient, furnish a medical statement covering the findings, diagnosis and prognosis of any recent medical treatment or examination. The doctor's statement or hospital report should include the number of hours in bed; posture and general appearance; restriction of use of lower and upper extremities; restrictive use of spine, trunk and neck; effects of advancing age (such as loss of memory and or balance, which affects ability to perform self care, ambulate or travel beyond home or ward); and what is done during a typical day if that information is a part of the record.

However, you are not required to incur the expense of the physical examination by a private physician in order to receive consideration. If the detailed medical information about your ability to care for yourself is not available from the doctor's or hospital's current records, the VA can arrange for a physical examination.

You may also furnish any other information which will help determine that you are unable to care for yourself or that you are unable to walk or travel beyond your home because of your condition.

Be sure your name and VA file number are on all correspondence mailed to us and that you have signed all VA forms.

APPENDIX 2. INSTRUCTIONS FOR COMPLETING APPLICATION FOR COMPENSATION

(Detach and retain Instructions for future reference.)

INSTRUCTIONS FOR COMPLETING APPLICATION FOR COMPENSATION OR PENSION

PRIVACY ACT INFORMATION: No allowance of compensation or pension may be granted unless this form is completed fully as required by existing law (38 U.S.C. Chapters 11 and 15). The information requested by this form is considered relevant and necessary to determine maximum benefits provided under law. The information submitted may be disclosed outside the Veterans Administration only as permitted by law, including the routine uses identified in VA system of records 58 VA 21/22/28, Compensation, Pension, Education and Rehabilitation Records - VA published in the Federal Register.

Disclosure of Social Security number(s) of those for whom benefits are claimed is requested under the authority of Title 38, U.S.C. and is mandatory as a condition to receipt of pension (38 C.F.R. 1.575). Social Security numbers will be used in the administration of veterans' benefits, in the identification of veterans or persons claiming or receiving Veterans Administration benefits and their records and may be used to verify Social Security benefit entitlement (including amounts payable) with the Social Security Administration and, for other purposes where authorized by both Title 38, U.S.C. and the Privacy Act of 1974 (5 U.S.C. 552a) or, where required by another statute.

GENERAL INSTRUCTIONS

NOTE: PLEASE READ VERY CAREFULLY

- A. **DISABILITY COMPENSATION** is paid for disability resulting from service in the armed forces. An additional amount of compensation may be payable for a spouse, child, and/or dependent parent when a veteran is entitled to compensation based on disability(ies) evaluated as 30 percent or more disabling. The additional benefit for a spouse is payable in a higher amount when he/she is a patient in a nursing home or is so disabled as to require the regular aid and attendance of another person.

DISABILITY PENSION is paid for permanent and total disability not resulting from service in the armed forces. If the veteran is 65 years of age or older and is not substantially gainfully employed, permanent and total disability is presumed. Pension is paid only to veterans of wartime service, or, of service on or after June 27, 1950 and prior to February 1, 1955, or, during the period between August 5, 1964, and May 4, 1975. Additional amounts of pension may be paid for a spouse and/or child(ren).

If you need information about the meaning of any question, contact your nearest Veterans Administration Regional Office. If additional space is needed for any item, use Item 40, "Remarks," page 4 or number a separate sheet of paper to correspond to the items you are answering and attach the sheet to the application.

- B. **REPRESENTATION.** You may be represented, without charge, by an accredited representative of a veterans organization or other service organization, recognized by the Administrator of Veterans Affairs, or you may employ an attorney to assist you with your claim. Typical examples of counsel

who may be available include attorneys in private practice or legal aid services. The services of a recognized attorney are subject to a maximum fee limitation of \$10, set forth in 38 U.S.C. 3404(C). If you desire representation, let us know and we will send you the necessary forms. If you have already designated a representative, no further action is required on your part.

C. HEARINGS

You have the right to a personal hearing at any stage of claims processing, either before or after a decision is made. This right may be exercised with regard to an original claim, supplemental claim or with regard to any subsequent action affecting your entitlement. All you need do is inform the nearest VA office as to your desires, and we will arrange a time and place for the hearing. You may bring witnesses if you desire and their testimony will be entered in the record. The VA will furnish the hearing room, provide hearing officials, and prepare the transcript of the proceedings. The VA cannot pay any of your expenses in connection with the hearing.

D. EVIDENCE - GENERAL

If you have not previously filed claim, furnish the separation forms you received from the armed forces. If you are a pension applicant, 65 years of age or older, no medical evidence is necessary. A statement from your doctor showing the extent of your disabilities should be furnished with your application if you are under 65; if you are housebound or if you require the aid and attendance of another person and are not a patient in a nursing home. If you are a nursing home patient, you should furnish a statement signed by an official of the nursing home showing the date of your admission and patient status. Also, indicate in Item 40, "Remarks," that you are a nursing home patient and give the name and address of the nursing home.

E. REPORTING NET WORTH FOR PENSION FOR DISABILITY NOT RESULTING FROM SERVICE NET WORTH - Pension cannot be paid if net worth is sizeable. Net worth is the market value of all interest or rights in any kind of property except ordinary personal effects necessary for daily living such as automobile, clothing or furniture and the dwelling (single family unit) used as your principal residence. Therefore, all other assets must be reported so that may determine whether net worth prevents you from receiving pension benefits.

F. INCOME LIMITS AND RATES OF PENSION. The rate of pension paid to a veteran depends upon the amount of family income and the number of dependents, according to a formula provided by law. Because benefit rates and income limits are frequently changed, it is not feasible to keep such information current in these instructions. Information regarding current income limitations and rates of benefits may be obtained by contacting your nearest VA office.

(1) A higher rate of pension is payable to a veteran who is a patient in a nursing home or otherwise determined to be in need of regular aid and attendance or who is permanently housebound due to disability.

(2) Pension rates are also increased for a veteran who served during the Mexican Border Period or World War I.

IMPORANT

THRE ARE CERTAIN TYPES OF INCOME WHICH MAY BE EXCLUDED IN DETERMINING THE INCOME COUNTABLE FOR VA PURPOSES. HOWEVER, YOU MUST REPORT THE SOURCES AND AMOUNTS OF ALL INCOME BEFORE DEDUCTIONS FOR YOURSELF, SPOUSE, AND DEPENDENT CHILDREN. WE WILL DETERMINE ANY AMOUNT WHICH DOES NOT COUNT. INCLUDE ALL SEVERANCE PAY OR OTHER ACCRUED PAYMENTS OF ANY KIND OR FROM ANY SOURCE. WHEN NO INCOME IS RECEIVED OR EXPECTED FROM A SPECIFIED SOURCE, WRITE "NONE" IN THE APPROPRIATE BLOCK (ITEMS 36a THROUGH 39A). IF INCOME FROM ANY SOURCE IS ANTICIPATED BUT THE AMOUNT IS NOT YET DETERMINED WRITE "UNKNOWN" IN THE APPROPRIATE BLOCK. ATTACH SEPARATE SHEETS IF ADDITIONAL SPACE IS NEEDED.

G. FAMILY UNUSUAL MEDICAL EXPENSES are amounts actually paid by you during the calendar year for unusual medical expenses for which you are not reimbursed by insurance or otherwise. You

should report the total unreimbursed amount you paid for medical expenses for yourself or for relatives you are under an obligation to support. You may include premiums paid for health, sickness or hospitalization insurance. In computing your income for pension purposes, the VA will deduct the amount you paid for medical expenses if they qualify for exclusion under the formula provided by law.

H. LAST ILLNESS AND BURIAL EXPENSES

Your countable income may be reduced by the amount of expenses of the last illness and burial of a spouse or child paid by you at any time prior to the end of the year following the year of death for which you were not reimbursed. Use Item 40, "Remarks," to report such expenses.

- I. EDUCATIONAL OR VOCATIONAL REHABILITATION EXPENSES are amounts paid for courses of education, including tuition, fees, and materials and may be deducted from the respective incomes of a veteran and the earned income of a child if the child is pursuing a course of postsecondary education or vocational rehabilitation or training. If you or your school child(ren) paid these expenses, report the total amounts paid, dated of payment, and state to whom the expenses apply.

SPECIFIC INSTRUCTIONS

IMPORANT: These instructions are numbered to correspond with the items on the application. If additional space is required, attach a separate sheet and identify your statements by their item numbers.

ITEMS 3A and 3B - The number entered in 3A, Veteran's Social Security Number, should be your own social security number. In Item 3B enter your spouse's social security number. These social security numbers are necessary for identification purposes.

ITEMS 14A and 14D inclusive - Retired Pay - A veteran may not receive full service retired pay and VA compensation at the same time. In the absence of a request to the contrary, filing of this application will constitute an election to receive VA compensation in lieu of the total amount of retired pay, or a waiver of that portion of retired pay equal in amount to the VA compensation. No special action will be required of you, as we will notify the retired pay division of your waiver if entitlement, to VA benefits is established. A claim should be filed regardless of whether you will elect to waive retired pay. Under existing law a military retiree must establish entitlement to VA compensation so that survivors may be entitled to certain VA death benefits.

ITEMS 15A and 15B - Disability Severance Pay - The full amount of disability severance pay received for the disability or disabilities for which VA compensation is payable will be recouped from that benefit.

ITEMS 16A and 16B - Lump Sum Readjustment Pay - Recoupment of 75 percent of readjustment pay you received will be made from any VA compensation payable.

ITEMS 17A to 21D inclusive - Marital Information - Complete information concerning all marriages entered into by either you or your spouse and the termination of such marriages must be furnished. Specific details as to the date, place and manner of dissolution of marriage must be included. If your spouse is also a veteran, include his/her VA file number (if known) in Item 17F.

ITEMS 31C and 32C - Months Worked - the time actually worked should be stated. For example: If you worked full time for 2, 4, 6, 8 or 10 months, you should so state. If you did not work full time each month you should state the months or parts of months you actually worked. For example: 2 months, 1 week, 2 days.

ITEM 33A - Include market value of stocks, checking accounts, bank deposits, savings accounts and cash. If such assets are held jointly by you and your spouse, one half of the total value of these holdings should be reported for each of you.

ITEM 33B - Do not include the value of the single dwelling unit or that portion of real property used solely as your principal residence. On all other real estate reduce the market value by amount of the indebtedness thereon and further report only one-half of the net value when the real estate is held jointly between husband and wife.

ITEM 33C - Report the total market value of your rights and interest in all other property not included in Items 33A and 33B. Do not include value of ordinary personal effects necessary for your daily living such as an automobile, clothing and furniture. Include gifts, bequests and inheritances of all property other than cash.

ITEM 33D - Report all debts except mortgage(s) on real estate.

ITEM 33E - Report the total of Items 33A through 33C less 33D. This should be you NET WORTH.

ITEMS 34A to 35E - If you or your spouse have applied for social security, unemployment or workmen's compensation or any disability benefit, show the expected payment in the appropriate column. If the amount or date of payment is not yet determined, enter the word "unknown."

ITEMS 36, 37 and 38 inclusive - You should report under these items your expected total income for the periods covered. You must report total income of yourself and your dependents from all sources. When reporting income, report the total amount to which you are entitled before any deductions, not the amount you actually receive. Include as income all amounts received or expected as severance pay or accrued payments of any kind or from any source. If you and your spouse receive income from dividends, interest, rents, investments or operation of a business, profession or farm, which you own jointly, report one-half of the income as yours and one-half as your spouse's. Report Social Security Benefits (Green Check) on Line B, and Supplemental Security Income (SSI) benefits (Gold Check) on Line E.

ITEMS 39A and 39B - You should report under these items the total amount of your final pay at termination of employment, not the amount you actually received, and the date you received this pay.

NOTE: If you furnish a copy of your latest award letter from Social Security stating the type and gross amount of your benefit, it will help us in our initial determination of the amount of VA benefits to be paid.



VETERAN'S APPLICATION FOR COMPENSATION OR PENSION

IMPORTANT: Read attached General and Specific Instructions before completing this form. Type, print or write plainly. (DO NOT WRITE IN THIS SPACE) VA DATE STAMP

1A. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN		18. TELEPHONE NO. (Incl. Area Code)	
2. MAILING ADDRESS OF VETERAN (Number and street or rural route, city or P.O., State and ZIP Code)		3A. VETERAN'S SOC. SECURITY NO.	
		3B. SPOUSE'S SOC. SECURITY NO.	
4. DATE OF BIRTH	5. PLACE OF BIRTH	6. SEX	7. RAILROAD RETIREMENT NO.

8. HAVE YOU EVER FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKERS' COMPENSATION PROGRAMS? (Formerly the U.S. Bureau of Employees Compensation)

YES NO

9A. VA FILE NUMBER
C-

9B. HAVE YOU PREVIOUSLY FILED A CLAIM FOR ANY BENEFIT WITH THE VETERANS ADMINISTRATION?

<input type="checkbox"/> NONE	<input type="checkbox"/> VOCATIONAL REHABILITATION (Chapter 31)	<input type="checkbox"/> DENTAL OR OUTPATIENT TREATMENT
<input type="checkbox"/> HOSPITALIZATION OR MEDICAL CARE	<input type="checkbox"/> VETERANS EDUCATIONAL ASSISTANCE (Chapter 33 or 34)	<input type="checkbox"/> OTHER (Specify)
<input type="checkbox"/> WAIVER OF NSLI PREMIUMS	<input type="checkbox"/> WAR ORPHANS OR DEPENDENTS EDUCATIONAL ASSIST. (Chap. 35)	
<input type="checkbox"/> DISABILITY COMPENSATION OR PENSION		

9C. VA OFFICE HAVING YOUR RECORDS (if known)

SERVICE INFORMATION

NOTE: Enter complete information for each period of active duty including Reservist or National Guard Status. Attach Form DD 214 or other separation papers for all periods of active duty to expedite processing of your claim. If you do NOT have your DD 214 or other separation papers check (✓) here

10A. ENTERED ACTIVE SERVICE		10B. SERVICE NO.	10C. SEPARATED FROM ACTIVE SERVICE		10D. GRADE, RANK OR RATING, ORGANIZATION OR BRANCH OF SERVICE
DATE	PLACE		DATE	PLACE	

10E. HAVE YOU EVER BEEN A PRISONER OF WAR? YES NO (If "Yes," complete Items 10F and 10G)

10F. NAME OF COUNTRY

10G. DATES OF CONFINEMENT

11. IF YOU SERVED UNDER ANOTHER NAME, GIVE NAME AND PERIOD DURING WHICH YOU SERVED AND SERVICE NO.

12. IF RESERVIST OR NATIONAL GUARDSMAN, GIVE BRANCH OF SERVICE AND PERIOD OF ACTIVE OR INACTIVE TRAINING DUTY DURING WHICH DISABILITY OCCURRED

13A. IF YOU ARE NOW A MEMBER OF THE RESERVE FORCES OR NATIONAL GUARD GIVE THE BRANCH OF SERVICE

13B. RESERVE STATUS ACTIVE RESERVE OBLIGATION INACTIVE

13C. RESERVE OR NATIONAL GUARD UNIT ADDRESS

14A. ARE YOU NOW RECEIVING OR WILL YOU RECEIVE RETIREMENT OR RETAINER PAY FROM THE ARMED FORCES? YES NO (If "Yes," complete Item 14B, 14C, and 14D)

14B. BRANCH OF SERVICE

14C. MONTHLY AMOUNT \$

14D. RETIRED STATUS PERMANENT TEMPORARY DISABILITY RETIRED LIST

15A. HAVE YOU EVER APPLIED FOR OR RECEIVED DISABILITY SEVERANCE PAY FROM THE ARMED FORCES? YES NO (If "Yes," complete Item 15B)

15B. AMOUNT \$

16A. HAVE YOU RECEIVED LUMP SUM READJUSTMENT PAY FROM THE ARMED FORCES? YES NO (If "Yes," complete Item 16B)

16B. AMOUNT \$

MARITAL AND DEPENDENCY INFORMATION

17A. MARITAL STATUS (Check one) MARRIED WIDOWED DIVORCED NEVER MARRIED (If so, do not complete Items 17B through 21D)

17B. SPOUSE'S BIRTHDATE

17C. NUMBER OF TIMES YOU HAVE BEEN MARRIED

17D. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED

17E. IS YOUR SPOUSE ALSO A VETERAN? YES NO (If "Yes," complete Item 17F, (If known)

17F. SPOUSE'S VA FILE NO. C-

18A. DO YOU LIVE TOGETHER? YES NO (If "No," complete Items 18B through 18D)

18B. REASON FOR SEPARATION

18C. PRESENT ADDRESS OF SPOUSE

18D. AMOUNT YOU CONTRIBUTE TO YOUR SPOUSE'S SUPPORT-MONTHLY \$

19. CHECK (✓) WHETHER YOUR CURRENT MARRIAGE WAS PERFORMED BY:

CLERGYMAN OR AUTHORIZED PUBLIC OFFICIAL OTHER (Explain)

Furnish the following information about each of your marriages. A certified copy of the public or church record of your CURRENT marriage is required.

20A. DATE AND PLACE OF MARRIAGE	20B. TO WHOM MARRIED	20C. TERMINATED (Death, Divorce)	20D. DATE AND PLACE TERMINATED

FURNISH THE FOLLOWING INFORMATION ABOUT EACH PREVIOUS MARRIAGE OF YOUR PRESENT SPOUSE

21A. DATE AND PLACE OF MARRIAGE	21B. TO WHOM MARRIED	21C. TERMINATED (Death, Divorce)	21D. DATE AND PLACE TERMINATED

IDENTIFICATION OF CHILDREN AND INFORMATION RELATIVE TO CUSTODY

Furnish the following information for each of your unmarried children. A certified copy of the public or church record of birth or court record of adoption is required.

22A. NAME OF CHILD (First, middle initial, last)	22B. DATE OF BIRTH (Month, day, year)	22C. SOCIAL SECURITY NUMBER OF CHILD	22D. CHECK EACH APPLICABLE CATEGORY					
			MARRIED PREVIOUSLY	STEPCHILD OR ADOPTED	ILLEGITIMATE	OVER 18 ATTENDING SCHOOL	SERIOUSLY DISABLED	

NAME AND ADDRESS(ES) OF PERSON(S) HAVING CUSTODY OF CHILD(REN), IF OTHER THAN VETERAN.

YOUR FATHER DEPENDENT UPON YOU FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete 23B)	23B. NAME AND ADDRESS OF DEPENDENT FATHER	23C. IS YOUR MOTHER DEPENDENT UPON YOU FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete 23D)
NAME AND ADDRESS OF DEPENDENT MOTHER	23E. NAME AND ADDRESS OF NEAREST RELATIVE	23F. RELATIONSHIP OF NEAREST RELATIVE

NATURE AND HISTORY OF DISABILITIES

NATURE OF SICKNESS, DISEASE OR INJURIES FOR WHICH THIS CLAIM IS MADE AND DATE EACH BEGAN

ARE YOU NOW OR HAVE YOU BEEN HOSPITALIZED OR FURNISHED DOMICILIARY CARE WITHIN THE PAST 3 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete 25B and 25C)	25B. DATES OF HOSPITALIZATION OR DOMICILIARY CARE	25C. NAME AND ADDRESS OF INSTITUTION
--	---	--------------------------------------

Items 26, 27, and 28 need NOT be completed unless you are now claiming compensation for a disability incurred in service.

IF YOU RECEIVED ANY TREATMENT WHILE IN SERVICE, COMPLETE THE FOLLOWING INFORMATION

26A. NATURE OF SICKNESS, DISEASE OR INJURY	26B. DATES OF TREATMENT	26C. NAME, NUMBER OR LOCATION OF HOSPITAL, FIRST-AID STATION, DRESSING STATION OR INFIRMARY	26D. ORGANIZATION AT TIME SICKNESS, DISEASE OR INJURY WAS INCURRED

LIST CIVILIAN PHYSICIANS AND HOSPITALS WHERE YOU WERE TREATED FOR ANY SICKNESS, INJURY OR DISEASE SHOWN IN ITEM 26A, BEFORE, DURING OR SINCE YOUR SERVICE, AND ANY MILITARY HOSPITALS SINCE YOUR LAST DISCHARGE

27A. NAME	27B. PRESENT ADDRESS	27C. DISABILITY	27D. DATE

LIST PERSONS OTHER THAN PHYSICIANS WHO KNOW ANY FACTS ABOUT ANY SICKNESS, DISEASE OR INJURY SHOWN IN ITEM 26A, WHICH YOU HAD BEFORE, DURING OR SINCE YOUR SERVICE

28A. NAME	28B. PRESENT ADDRESS	28C. DISABILITY	28D. DATE

IF YOU CLAIM TO BE TOTALLY DISABLED (Complete Items 29A through 32E)

29A. ARE YOU NOW EMPLOYED?	29B. IF YOU WERE SELF-EMPLOYED BEFORE BECOMING TOTALLY DISABLED, WHAT PART OF THE WORK DID YOU DO?
29C. DATE YOU LAST WORKED	29D. IF YOU ARE STILL SELF-EMPLOYED WHAT PART OF THE WORK DO YOU DO NOW?

30A. EDUCATION (Circle highest year completed)	30B. NATURE OF AND TIME SPENT IN OTHER EDUCATION AND TRAINING
1 2 3 4 5 6 7 8 (GRADE SCHOOL) 1 2 3 4 (HIGH SCHOOL) 1 2 3 4 (COLLEGE)	

LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, FOR ONE YEAR BEFORE YOU BECAME TOTALLY DISABLED

31A. NAME AND ADDRESS OF EMPLOYER	31B. KIND OF WORK	31C. MONTHS WORKED	31D. TIME LOST FROM ILLNESS	31E. TOTAL EARNINGS

LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, SINCE YOU BECAME TOTALLY DISABLED

32A. NAME AND ADDRESS OF EMPLOYER	32B. KIND OF WORK	32C. MONTHS WORKED	32D. TIME LOST FROM ILLNESS	32E. TOTAL EARNINGS

NET WORTH OF VETERANS AND DEPENDENTS (See attached Instructions for Items 33A to 33E inclusive)

NOTE: Items 33A through 33E should be completed ONLY if you are applying for non-service-connected pension.

ITEM NO.	SOURCE	AMOUNTS				
		VETERAN	SPOUSE	NAME OF CHILD(REN)		
33A.	STOCKS, BONDS, BANK DEPOSITS	\$	\$	\$	\$	\$
33B.	REAL ESTATE (Do not include residence)					
	OTHER PROPERTY					
33D.	TOTAL DEBTS					
33E.	NET WORTH	\$	\$	\$	\$	\$

INCOME RECEIVED AND EXPECTED FROM ALL SOURCES

NOTE: Items 34A through 39B should be completed ONLY if you are applying for non-service-connected pension.

34A. HAVE YOU OR YOUR SPOUSE APPLIED OR ARE YOU RECEIVING OR ENTITLED TO RECEIVE ANY BENEFITS AT THE SOCIAL SECURITY ADMINISTRATION (OTHER THAN SSI) OR RAILROAD RETIREMENT BOARD? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "Yes," complete Items 34B through 34F as applicable)</i>	34B. MONTHLY AMOUNT <i>(Include Medicare Deduction)</i>		34C. BEGINNING DATE	34D. DATE YOU EXPECT BENEFITS TO BEGIN
	VETERAN \$	SPOUSE \$		
34E. WILL YOU OR YOUR SPOUSE APPLY FOR EITHER BENEFIT DURING THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO		34F. DATE OF INTENTION TO APPLY		
		VETERAN	SPOUSE	

35A. HAVE YOU OR YOUR SPOUSE APPLIED FOR OR ARE YOU RECEIVING OR ENTITLED TO RECEIVE ANNUITY OR RETIREMENT BENEFITS OR ENDOWMENT INSURANCE FROM ANY OTHER SOURCE?
 YES NO *(If "Yes," complete Items 35B through 35E, as applicable)*

35B. MONTHLY AMOUNT	35C. BEGINNING DATE	35D. DATE OF INTENTION TO APPLY	35E. SOURCE OF BENEFIT
VETERAN \$			
SPOUSE \$			

	SOURCE OF VETERAN AND DEPENDENTS INCOME <i>(Specify source for Items 36F, 37F and 38F "ALL OTHER INCOME" in Item 40, "REMARKS")</i>	AMOUNT OF INCOME				
		VETERAN	SPOUSE	NAME OF CHILD/REN		
		\$	\$	\$	\$	\$
36. AMOUNT RECEIVED FROM JAN 1 TO THE DATE YOU SIGN THIS STATEMENT	A. EARNINGS					
	B. SOCIAL SECURITY (GREEN CHECK)					
	C. OTHER ANNUITIES AND RETIREMENTS					
	D. DIVIDENDS AND INTEREST, ETC.					
	E. SUPPLEMENTAL SECURITY INCOME (GOLD CHECK)					
	F. ALL OTHER INCOME					
37. AMOUNT EXPECTED FROM DATE YOU SIGN THIS STATEMENT TO END OF CALENDAR YEAR	A. EARNINGS					
	B. SOCIAL SECURITY (GREEN CHECK)					
	C. OTHER ANNUITIES AND RETIREMENTS					
	D. DIVIDENDS AND INTEREST, ETC.					
	E. SUPPLEMENTAL SECURITY INCOME (GOLD CHECK)					
	F. ALL OTHER INCOME					
38. AMOUNT EXPECTED FOR THE NEXT CALENDAR YEAR	A. EARNINGS					
	B. SOCIAL SECURITY (GREEN CHECK)					
	C. OTHER ANNUITIES AND RETIREMENTS					
	D. DIVIDENDS AND INTEREST, ETC.					
	E. SUPPLEMENTAL SECURITY INCOME (GOLD CHECK)					
	F. ALL OTHER INCOME					

39A. GROSS AMOUNT OF FINAL PAY RECEIVED \$

39B. DATE FINAL PAY WAS RECEIVED

40. REMARKS *(Identify your statements by their applicable item number. If additional space is required, attach separate sheet and identify your statements by their item numbers)*

NOTE: Filing of this application constitutes a waiver of military retired pay in the amount of any VA compensation to which you may be entitled. See instructions for Items 14A and 14 D inclusive, Retired Pay.

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION - I certify that the foregoing statements are true and complete to the best of my knowledge and belief. I CONSENT that any physician, surgeon, dentist or hospital that has treated or examined me for any purpose, or that I have consulted professionally, may furnish to the VETERANS ADMINISTRATION any information about myself, and I waive any privilege which renders such information confidential.

41. DATE SIGNED _____ 42. SIGNATURE OF CLAIMANT
SIGN HERE

NOTE: Signature made by mark must be witnessed by two persons to whom the person making the statement is personally known, and the signatures and addresses of such witnesses must be shown.

43A. SIGNATURE OF WITNESS _____ 44A. SIGNATURE OF WITNESS

43B. ADDRESS OF WITNESS _____ 44B. ADDRESS OF WITNESS

PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

APPENDIX 3. STATEMENT OF INCOME AND NET WORTH

Form Approved
OMB No. 76-RO481

VETERANS ADMINISTRATION		1. VA FILE NO.		
STATEMENT OF INCOME AND NET WORTH - DISABILITY		C.		
IMPORTANT: Read attached instruction sheet before completing this form. All items should be answered fully. If your answer to any item is "none," write "NONE," for additional space use Item 13, "REMARKS," or attach a separate sheet indicating numbers to which items apply.				
2. NAME OF VETERAN (First, middle, last)		3. SOCIAL SECURITY NO. OF VETERAN		
4. NAME OF SPOUSE (First, middle, last)		5. SOCIAL SECURITY NO. OF SPOUSE		
PART I - RETIREMENT AND/OR ANNUITY BENEFITS				
6. INDICATE WHICH OF THE FOLLOWING YOU OR YOUR SPOUSE MAY BE ENTITLED TO RECEIVE THIS YEAR OR NEXT BY PLACING "V" FOR YOURSELF OR "S" FOR YOUR SPOUSE IN THE APPROPRIATE BOX, OR "B" IF BOTH OF YOU ARE TO RECEIVE THAT ANNUITY INCOME		8. INCOME FROM SOCIAL SECURITY OR RAILROAD RET.	VETERAN SPOUSE	
<input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> RAILROAD RETIREMENT <input type="checkbox"/> U.S. ARMED FORCES <input type="checkbox"/> NONE		A. MONTHLY PAYMENT	\$ \$	
NOTE: If you or your spouse has applied or will soon apply for any benefit checked in Item 6, specify the type in either Item 7A or 7B and date(s) in Item 7C.		B. NO. MEDICARE DEDUCTIONS (If any)	+ +	
7A. WILL SOON APPLY FOR	7B. HAVE APPLIED FOR	7C. DATE		
		C. TOTAL MONTHLY ENTITLEMENT (Sum of Item 8A and 8B)	\$ \$	
PART II - ANNUAL INCOME				
ITEM NO.	SOURCE	AMOUNT OF INCOME		NAME OF CHILD/REN
		VETERAN	SPOUSE	
AMOUNT RECEIVED LAST YEAR				
9A	EARNINGS	\$	\$	\$
9B	SOCIAL SECURITY (GREEN CHECK)			
9C	OTHER ANNUITIES AND RETIREMENTS			
9D	DIVIDENDS, INTEREST, ETC.			
9E	SUPPLEMENTAL SECURITY INCOME (GOLD CHECK)			
9F	ALL OTHER INCOME (Specify source(s). If additional space is needed, continue in Item 13, "Remarks")			
AMOUNT RECEIVED AND EXPECTED THIS YEAR				
10A	EARNINGS			
10B	SOCIAL SECURITY (GREEN CHECK)			
10C	OTHER ANNUITIES AND RETIREMENTS			
10D	DIVIDENDS, INTEREST, ETC.			
10E	SUPPLEMENTAL SECURITY INCOME (GOLD CHECK)			
10F	ALL OTHER INCOME (Specify source(s). If additional space is needed, continue in Item 13, "Remarks")			
AMOUNT EXPECTED NEXT YEAR				
11A	EARNINGS			
11B	SOCIAL SECURITY (GREEN CHECK)			
11C	OTHER ANNUITIES AND RETIREMENTS			
11D	DIVIDENDS, INTEREST, ETC.			
11E	SUPPLEMENTAL SECURITY INCOME (GOLD CHECK)			
11F	ALL OTHER INCOME (Specify source(s). If additional space is needed, continue in Item 13, "Remarks")			
IMPORTANT - THIS STATEMENT IS NOT VALID UNLESS SIGNED ON REVERSE				

VA FORM 21-6897
MAY 1980

EXISTING STOCKS OF VA FORM 21-6897, NOV 1976,
WILL BE USED.

INSTRUCTIONS FOR COMPLETING INCOME STATEMENT

READ VERY CAREFULLY, DETACH, AND RETAIN THIS SHEET FOR YOUR FUTURE REFERENCE. ANSWER ALL QUESTIONS FULLY OR ACTION ON YOUR CLAIM MAY BE DELAYED.

- A. **PRIVACY ACT INFORMATION** - No benefits may be paid under this program unless this form is completed and returned as required by existing law (38 U.S.C. 506). The information requested by this form is considered relevant and necessary to determine the maximum benefits to which you are entitled. The information submitted may be disclosed outside the Veterans Administration only as permitted by law. Disclosure of Social Security number(s) of those for whom benefits are claimed is requested under the authority of Title 38, U.S.C. and is mandatory as a condition to receipt of pension (38 CFR 1.575). Social Security numbers will be used in the administration of veterans' benefits in the identification of veterans or persons claiming or receiving Veterans Administration benefits and their records, and may be used to verify Social Security entitlement (including amounts payable) with the Social Security Administration and, for other purposes where authorized by both Title 38, U.S.C. and the Privacy Act of 1974 (5 U.S.C. 552a), or, where required by another statute.
- B. **CUSTODIANS AND GUARDIANS** - If you are making this statement as a "Custodian" or "Guardian" of a veteran who is incompetent or incapable of acting in his/her own behalf, furnish information applying to the veteran and his/her spouse, not yourself.
- C. **RETIREMENT AND/OR ANNUITY BENEFITS (PART I)** - Check the type (Item 6) of any retirement or annuity benefits you or your spouse receive or expect to receive during this or the next calendar year. Enter the *annual* amounts in Part II. In Item 8 report the *monthly* amount of any retirement or disability social security (green check) or railroad retirement benefits you or your spouse receive.
- D. **ANNUAL INCOME (PART II)** - The total amount of all income received and expected should be reported for all persons for whom benefits are claimed. Include as income all amounts received and/or expected as severance pay or other accrued payment of any kind, or of any source. If income from two or more sources should be reported on the same line, list each amount separately and clearly indicate the source on a separate sheet of paper.
- E. **JOINT INCOME** - If you and your spouse receive income from dividends, interest, rents, investments or operation of a business, profession or farm, which you own jointly, report one-half of the income as yours and one-half as your spouse's income.
- F. **NET WORTH (PART III)** - Net worth is the market value of all interest or rights in any kind of property other than the ordinary personal effects necessary for daily living (such as an automobile, clothing, or furniture and the dwelling (single family unit) used as a principal residence). If you and your spouse own any such other property jointly, one-half of the market value of these holdings should be reported for each of you.
- G. **PROMPT NOTICE:** Notify us immediately if there is any change in the income or net worth for you or for those for whom you receive benefits, and of any change in your marital or dependency status (Resulting changes in rates of benefits may be effective immediately. In some cases an overpayment may result which is subject to recovery.)

APPENDIX 4. RATES OF PAYMENT

IMPROVED PENSION ANNUAL RATES AND PRIOR PENSION LAWS INCOME LIMITS							
Effective Dates	1-1-79	6-1-79	6-1-80	6-1-81	6-1-82	12-1-83	12-1-84
VETERANS							
No Dependents	3,550	3,902	4,460	4,960	5,328	5,515	5,709
One Dependent	4,651	5,112	5,844	6,499	6,980	7,225	7,478
VETERAN -- AID AND ATTENDANCE							
No Dependents	5,680	6,243	7,136	7,936	8,524	8,823	9,132
One Dependent	6,781	7,453	8,519	9,474	10,176	10,533	10,902
VETERAN - HOUSEBOUND							
No Dependents	4,430	4,770	5,453	6,064	6,513	6,741	6,977
One Dependent	5,441	5,980	6,836	7,602	8,165	8,451	8,747
VETERAN MARRIED TO VETERAN							
No A & A or Housebound	4,651	5,112	5,844	6,449	6,980	7,225	7,478
One A & A	6,781	7,543	8,519	9,474	10,176	10,533	10,902
Both A & A	8,911	9,794	11,195	12,499	13,371	13,839	14,324
One Housebound	5,441	5,980	6,836	7,602	8,165	8,451	8,747
Both Housebound	6,231	6,848	7,828	8,705	9,350	9,678	10,017
One A & A, One Housebound	7,571	8,321	9,511	10,577	11,360	11,758	12,170
EACH ADDITIONAL DEPENDENT	600	660	755	840	903	935	968
WWI AND MEXICAN BORDER SVC ADD	800	880	1,006	1,119	1,202	1,245	1,289
WIDOWER							
No Dependents	2,379	2,615	2,989	3,324	3,570	3,695	3,825
One Dependent	3,116	3,425	3,915	4,354	4,677	4,841	5,011
WIDOWER -- AID AND ATTENDANCE							
No Dependents	3,806	4,143	4,782	5,318	5,712	5,912	6,119
One Dependent	4,543	4,993	5,707	6,347	6,817	7,056	7,303
WIDOWER -- HOUSEBOUND							
No Dependents	2,908	3,196	3,654	4,064	4,365	4,518	4,677
One Dependent	3,645	4,006	4,579	5,092	5,469	5,661	5,860
EACH ADDITIONAL DEPENDENT	600	660	755	840	903	935	968
CHILDREN							
One Child	600	660	755	840	903	935	968
Each Additional Child	600	660	755	840	903	935	968
NOTE: EFF. 12/1/83 IMPROVED PENSION RATES ARE ROUNDED DOWN TO THE NEAREST WHOLE DOLLAR							
306 PENSION INCOME LIMITS							
Veteran or Widow/er Only	4,038	4,438	5,073	5,642	6,060	6,273	6,493
Veteran or Widow/er w/dependents	5,430	5,968	6,822	7,587	8,149	8,435	8,731
Child	3,299	3,626	4,145	4,610	4,952	5,126	5,306
306 PENSION SPOUSE EXCLUSION	1,285	1,413	1,616	1,797	1,930	1,998	2,068
"OLD LAW" PENSION INCOME LIMITS							
Veteran or Widow/er Only	3,534	3,884	4,440	4,938	5,304	5,490	5,683
Veteran or Widow/er w/dependents	5,098	5,603	6,405	7,123	7,651	7,919	8,197
Child	3,534	3,884	4,440	4,938	5,304	5,490	5,683
VSD VISUAL FILE 12/1/84 B-11 (Replaces B-11 12/1/83)							

SECTION 306 PENSION

VETERAN ONLY (No Dependents)		
Income Not Over	Each \$1 Decrement	Monthly Rate
\$300	NONE	\$197
400	0.03	194
500		191
600		187
700	0.04	183
800	0.05	178
900		173
1,000	0.06	167
1,100		161
1,200	0.07	154
1,300		147
1,400		140
1,500		133
1,600		126
1,700		119
1,800	0.08	111
1,900		103
2,000		95
2,100		87
2,200		79
2,300		71
2,400		63
2,500		55
2,600		47
2,700		39
2,800		31
2,900		23
3,000	15	
3,100	7	
3,124	5.08	
3,125 TO 3,770	NONE	5

NOTE: For age 78 or over multiply rate arrived at above by 1.25.

	Regular Rate	Age 78 Rate
If A&A Add	\$165	\$206.25
If H/B Add	61	76.25

VETERANS WITH DEPENDENTS				
Income Not Over	Each \$1 Decrement	Veteran, 1 Dependent	Monthly Rate Veteran, 2 Dependents	Veteran, 3 Dependents
\$500	NONE	\$212	\$217	\$222
600	0.02	210	215	220
700		208	213	218
800	0.03	205	210	215
900		202	207	212
1,000		199	204	209
1,100	0.04	195	200	205
1,200		191	196	201
1,300		187	192	197
1,400		183	188	193
1,500		179	184	189
1,600		175	180	185
1,700		171	176	181
1,800		167	172	177
1,900	0.05	163	168	173
2,000		159	164	169
2,100		154	159	164
2,200		149	154	159
2,300	0.06	144	149	154
2,400		139	144	149
2,500		134	139	144
2,600		129	134	139
2,700		124	129	134
2,800		119	124	129
2,900		114	119	124
3,000		109	114	119
3,100	0.07	103	108	113
3,200		97	102	107
3,300	0.08	90	95	100
3,400		83	88	93
3,500		76	81	86
3,600		69	74	79
3,700	0.08	61	66	71
3,800		53	58	63
3,900		45	50	55
4,000		37	42	47
4,100		29	34	39
4,200		21	26	31
4,300		13	18	23
4,400		5	10	15
4,462	SEE FOOTNOTES	5	5.04	10.04
4,463		5 ^a	5 ^b	9.96
4,500		5	5	7
4,524		5	5	5.08
4,525		5	5	5 ^c
TO 5,070		5	5	5

a. No decrement if income from \$4,000 to \$5,070.
b. No decrement if income from \$4,463 to \$5,070.
c. No decrement if income from \$4,525 to \$5,070.

VSD VISUAL FILE 7-15-81
B-12

VA Regional Office
P.O. Box 1437
St. Petersburg, FL 33731

SECTION 306 PENSION

WIDOW(ER) ONLY (No Children)		
Income Not Over	Each \$1 Decrement	Monthly Rate
\$300	NONE	\$133
400		132
500	0.01	131
600		130
700		127
800	0.03	124
900		121
1,000	0.04	117
1,100		113
1,200		108
1,300		103
1,400		98
1,500	0.05	93
1,600		88
1,700		83
1,800		78
1,900		72
2,000		66
2,100		60
2,200		54
2,300	0.06	48
2,400		42
2,500		36
2,600		30
2,700		24
2,800		18
2,900	0.07	11
2,985		5.05
2,986 TO 3,770	NONE	5.00

CHILDREN ONLY (No Widow/er) INCOME LIMIT \$3,080 (Unearned)		
Total Dependency Code	Total	Each Child
1C 81	\$61.00	\$61.00
2C 82	87.00	43.50
3C 83	113.00	37.66
4C 84	139.00	34.75
5C 85	165.00	33.00
6C 86	191.00	31.83
7C 87	217.00	31.00
8C 88	243.00	30.37
9C 89	269.00	29.88
Each Add'l Child	26.00	

WIDOW(ER) WITH 1 CHILD		
Income Not Over	Each \$1 Decrement	Monthly Rate^{1,2}
\$700	NONE	\$159
800		158
900	0.01	157
1,000		156
1,100		155
1,200		153
1,300		151
1,400	0.02	149
1,500		147
1,600		145
1,700		142
1,800		139
1,900		136
2,000	0.03	133
2,100		130
2,200		127
2,300		124
2,400		121
2,500		117
2,600	0.04	113
2,700		109
2,800		105
2,900		101
3,000		96
3,100		91
3,200		86
3,300	0.05	81
3,400		76
3,500		71
3,600		66
3,700		61
3,701 TO 5,070	NONE	61

1. If entitled to aid and attendance add \$79 to the monthly rates shown.
2. Add \$26 for each additional child.

VSD VISUAL FILE 7-15-81
B-13

VA Regional Office
P.O. Box 1437
St. Petersburg, FL 33731

“OLD LAW” PENSION MONTHLY RATES

VETERAN		SURVIVING SPOUSE	
Housebound	\$78.75	With 1 Child	\$50.40
Aid and Attendance	100.00	Each Additional Dependent	63.00
	135.45	Aid and Attendance (add to above)	7.56
SURVIVING CHILDREN (No Surviving Spouse)			50.00
One Child	\$27.30		
Two Children	40.95		
Three Children	54.60		
Each Additional Child	7.56		
(Total Payment Shared Equally)			

SPANISH-AMERICAN WAR PENSION MONTHLY RATES

VETERAN -- 90 DAYS OR MORE SERVICE		\$101.59
Aid and Attendance		135.45
VETERAN -- 70 TO 89 DAYS SERVICE		67.75
Aid and Attendance		88.04
SURVIVING SPOUSE ONLY		70.00
If Spouse During Veteran's Service		75.00
With Veteran's Children -- Each Child Add		8.13
Entitled to Aid and Attendance Add		79.00
NO SURVIVING SPOUSE, ONE CHILD		73.13
Each Additional Child Add		8.13

* * * * *

SOCIAL SECURITY FACTORS

NEW MONTHLY RATE (Effective 6-1-82) = Old Rate x 1.074
OLD MONTHLY RATE (Before 6-1-82) = New Rate x 0.9311
1982 ANNUAL = New Rate x 11.5866
1982 ANNUAL = Old Rate x 12.444

VSD VISUAL FILE 2-15-83
B-14
(replaces B-14 7-15-81)

APPENDIX 5. HOPE SURVEY RESPONSE FORM

Veterans Administration

Department of Veterans Benefits
Washington, D.C. 20420

Dear VA Beneficiary:

May we introduce you to Project Hope.

Recently, the Department of Health and Human Services awarded a grant to the Center for Health Affairs to Project Hope. They will conduct a study of what has been termed "constant attendance allowances." The VA's two separate allowances called housebound and aid and attendance are the only known public programs in the United States which fit the definition of "constant attendance allowances." The additional monies we might pay are for those whose disabilities may keep them essentially confined to their household or for those who need the rather constant care of other persons.

Through the results of this study, the VA as well as other public or private agencies will better understand the existing programs and will be able to develop future policies which support persons who are severely disabled and may have limited income. We at the VA are cooperating fully with Project Hope and wholeheartedly endorse the study.

As a part of the study, representatives of Project Hope wish to visit with some of the people who are currently receiving housebound or aid and attendance benefits as a part of their nonservice-connected disability pension or survivors' pension. You are one of the persons they may wish to visit.

Your participation is strictly voluntary and will not affect in any way the benefits you receive. All information relating to income, personal care, etc. will be kept in strict confidence. Project Hope representatives will clearly identify themselves, will limit the interview in the home as much as possible, and will use the information only to help all of us more fully understand the benefits and their use.

Will you please consider being a participant? Our understanding of the physical and financial needs of our beneficiaries will help us better structure future programs and benefits in such a way that they best serve the people they are designed to serve.

Thank you for reading this letter and assisting in this important study.

Department of Veterans Benefits
Veterans Administration



THE PROJECT HOPE HEALTH SCIENCES EDUCATION CENTER
Millwood, Virginia 22646/(703) 837-2100

April 1, 1985

Dear Friend:

Project HOPE was best known in the early 1960s for the S.S. HOPE, the world's first peacetime hospital ship. Today, with the support of the Veterans Administration (VA), the Project HOPE Center for Health Affairs is working to find ways to better meet the needs of older Americans. An important part of our work is a study which will involve personal interviews with participants in the VA Housebound and Aid and Attendance Allowance Program as well as selected persons who provide care for these participants. We would greatly appreciate your cooperation by volunteering to be interviewed in your home for approximately one hour by a HOPE Center staff member. Your interview responses will be kept strictly confidential--the VA and other government agencies will not have access to information on any one person.

Participation in this study is strictly voluntary; however, your cooperation is very important because we need to interview a large number of veterans receiving either the Aid and Attendance or Housebound Allowance. Through your cooperation we will be able to help other older Americans by applying what we learn from this study to better meet their needs. Please fill out the enclosed response form and mail it back to Project HOPE by April 27, 1985. Use the enclosed envelope for return; no stamp is needed. We greatly appreciate your cooperation.

Sincerely,

John M. Grana, Ph.D.
Project Director/Senior Policy Analyst
Center for Health Affairs

JMG/BKS
Enclosure

Board of Directors: W.H. Conzen, Chairman; Eugene R. Black, Herbert J. Bloom, D.D.S., Mrs. Edward N. Cole, J. Edward Day, W.L. Henry, L.W. Lehr, Irwin Lerner, Edwin A. Locke, Jr., Donald S. MacNaughton, Mrs. Emil Mosbacher, Jr., John O'Neil, J. Donald Rauth, Mrs. John B. Rogan, Richard R. Shinn, Lester S. Sinness, C. Joseph Stetler, James Stewart, William B. Walsh, M.D., Richard J. Whalen, Foster B. Whitlock, Joseph D. Williams, Philip Young, Eugene M. Zuckert. Officers: William B. Walsh, M.D., President; Edwin A. Locke, Jr., Vice President; W.L. Henry, Treasurer; J. Edward Day, Secretary.

PROJECT HOPE SURVEY RESPONSE FORM

Name _____ Telephone Number (____) _____
(Last, First)

Address _____
Street City/State Zipcode

I will participate in the study. Yes
No

1. Which allowance are you receiving?

Aid and Attendance Allowance
Housebound Allowance

2. How long have you been in the program? _____ (years/months)

3. Do you live in a nursing home? Yes
No

4. Do you live alone? Yes
No

a) If no, who lives with you? _____

b) If yes, is there someone who helps you with day-to-day activities?

Yes
No

5. Please write down the name, telephone number, and address of the main person who helps you with daily activities, chores, errands, etc.

Name (Last, First)

Street City/State Zipcode

(____) _____
Telephone Number

We will be interviewing people during the weeks of _____.
Please indicate what time periods during the day are best for you to be interviewed and what days of the week would be more convenient. (Check all that apply)

A. ___ Sunday ___ Monday ___ Tuesday ___ Wednesday
___ Thursday ___ Friday ___ Saturday

B. ___ 8am-10am ___ 10am-12 noon ___ 12 noon-2pm
___ 2pm-4pm ___ 4pm-6pm

APPENDIX 6. SURVEY INSTRUMENTS

Sample Person Code: _____
Interviewer Code: _____

SECTION A - FUNCTIONAL STATUS

SECTION A

PART 1 - ACTIVITIES OF DAILY LIVING (ADL)

- I'm going to ask you a series of questions related to your ability to take care of yourself.

- 1a. During the past week, that is, since last (day), did any person help you eat?
- 1 Yes
 - 2 No (SKIP to 2A)
 - 3 Did not eat at all (CIRCLE code 1 in c.c. item 12 and skip 2A)
- b. Did someone feed you?
- 1 Yes (SKIP to d)
 - 2 No
- c. Did someone help you cut your meat or butter your bread?
- 1 Yes
 - 2 No
- d. How often did you receive help - most of the time, some of the time, or only occasionally?
- 1 Most of the time
 - 2 Some of the time
 - 3 Only occasionally
- e. About how long have you had help eating - PROBE as necessary.
CODE for longest.
- (Is it less than 3 mos. or more than 3 mos.?)
 - (Is it less than 6 mos. or more than 6 mos.?)
 - (Is it less than 1 year or more than 1 year?)
 - (Is it less than 5 yrs. or more than 5 yrs.?)
- 1 Less than 3 months
2 3 months to less than 6 months
3 6 months to less than 1 year
4 1 year to less than 5 years
5 5 years or over
- CIRCLE code 1
in c.c. item 12

2a. Since last (day), did any person help you get in or out of bed (or didn't you get out of bed at all for any reason whatever)?

- 1 Yes
- 2 No (SKIP to 3a)
- 3 Did not get out of bed at all (SKIP to 2d)

b. How often did you receive help - most of the time, some of the time, or only occasionally?

- 1 Most of the time
- 2 Some of the time
- 3 Only occasionally

c. About how long have you had help to get in or out of bed? PROBE as necessary. CODE for longest.

- 1 Less than 3 months
 - 2 3 mos. to less than 6 mos.
 - 3 6 mos. to less than 1 year
 - 4 1 year to less than 5 years
 - 5 5 years or over
- CIRCLE code 2 in c.c. item 12 (SKIP to 3a)

d. About how long have you been unable to get out of bed? PROBE as necessary.

- 1 Less than 3 months
 - 2 3 mos. to less than 6 mos.
 - 3 6 mos. to less than 1 year
 - 4 1 year to less than 5 years
 - 5 5 years or over
- CIRCLE codes 3 and 5 in c.c. item 12. (SKIP to 5a.)

3a. Since last (day), did any person help you get around inside with or without special equipment (or didn't you get around inside at all)?

- 1 Yes
- 2 No
- 3 Did not get around inside at all (CIRCLE code 4 and 5 in c.c. item 12 and SKIP to 4a)

b. Which, if any, of the following special equipment do you use to help you get around inside?

- 1 Wheelchair
- 2 Walker
- 3 Cane
- 4 Other (specify) _____
- 5 None (SKIP to 4a)

c. (IF wheelchair circled ask) Are you able to get around inside without the wheelchair?

- 1 Yes
- 2 No (CIRCLE code 6 c.c. item 12)



d. How often did you receive help/use special equipment to get around inside? Most of the time, some of the time or occasionally?

- 1 Most of the time
- 2 Some of the time
- 3 Only occasionally

e. About how long have you had help/used special equipment to get around inside?

- 1 Less than 3 months
- 2 3 mos. to less than 6 mos.
- 3 6 mos. to less than 1 year
- 4 1 year to less than 5 years
- 5 5 years or over

CIRCLE code 4 in c.c. item 12.

4a. The next questions are about dressing, that is, getting and putting on clothes that you wear during the day. Since last (day), did any person usually help you to get dressed (or didn't you dress at all)?

- 1 Yes
- 2 No (SKIP to 5a)
- 3 Did not dress at all (CIRCLE code 7 in c.c. item 12 and SKIP to 5a.)

b. Did someone put on all your clothes for you.

- 1 Yes
- 2 No

c. How often did you receive help in getting dressed? Most of the time, some of the time, or only occasionally?

- 1 Most of the time
- 2 Some of the time
- 3 Only occasionally

d. About how long have you had help dressing? PROBE as necessary. CODE for longest.

- 1 Less than 3 months
- 2 3 mos. to less than 6 mos.
- 3 6 mos. to less than 1 year
- 4 1 year to less than 5 years
- 5 5 years or over

CIRCLE code 7 in c.c. item 12

5a. Since last (day), did any person help you bathe, or were you unable to bathe at all?

- 1 Yes
- 2 No (SKIP to 6a)
- 3 Unable to bathe (CIRCLE code 8 in c.c. item 12 and SKIP to 6a)

b. Did someone bathe you?

- 1 Yes
- 2 No

c. How often did you receive help bathing?
Most of the time, some of the time, or
only occasionally?

- 1 Most of the time
- 2 Some of the time
- 3 Only occasionally

d. About how long have you had help to bathe?
PROBE as necessary. CODE for longest.

- 1 Less than 3 months
- 2 3 mos. to less than 6 mos.
- 3 6 mos. to less than 1 year
- 4 1 year to less than 5 years
- 5 5 years or over

CIRCLE code 8 in
c.c. item 12.

6a. Since last (day), did any person help you
get to the bathroom or use the toilet, or
didn't you use the toilet at all?

- 1 Yes
- 2 No (SKIP to 6d)
- 3 Did not use the toilet at all
(SKIP to 6d)

b. How often did you receive help? Most of
the time, some of the time, or only
occasionally? PROBE as necessary. CODE
for longest.

- 1 Most of the time
- 2 Some of the time
- 3 Only occasionally

c. About how long have you had help using the
toilet? PROBE as necessary. CODE for
longest.

- 1 Less than 3 months
- 2 3 mos. to less than 6 mos.
- 3 6 mos. to less than 1 year
- 4 1 year to less than 5 years
- 5 5 years or over

CIRCLE code 9 in
c.c. item 12.

d. Do you use a device such as a urinary
catheter or colostomy bag?

- 1 Yes
- 2 No (SKIP to 6g)

e. Do you take care of it by yourself, or
does someone help you take care of it?

- 1 Self care
With help

f. About how long have you been using it?
PROBE as necessary. CODE for longest.

- Less than 3 months
2 3 mos. to less than 6 mos.
3 6 mos. to less than 1 year
4 1 year to less than 5 years
5 5 years or over

CIRCLE code 9 in
c.c. item 12

g. During the past week, have you sometimes had trouble controlling your bladder or bowels, so that you accidentally wet or soiled yourself--either day or night?

- 1 Yes
2 No (SKIP to 7)

h. About how long have you had this problem?

- 1 Less than 3 months
2 3 months to less than 6 months
3 6 months to 1 year
4 1 year to less than 5 years
5 5 years or over

7. For which of these things do you use special equipment?

- 1 Eating
2 Getting in/out of bed
4 Getting around inside
7 Dressing
8 Bathing
9 Using bathroom and toileting

CIRCLE, if not circled,
appropriate
item(s) in
c.c. item 12

**CHECK ITEM A.1 REFER TO C.C. ITEM 12

- 1 Code 3 and/or 5 circled (SKIP TO 8a)
2 All others (SKIP TO 8b)

8a. You said that you did not get around inside at all. What is the name of the person who helps you MOST with daily activities such as dressing, bathing, and getting to the bathroom?

FILL Control Card items 14a, b(0), and c
in column A.

8b. You said that you have help in (REFER TO CIRCLED ADL items from c.c. 12). What is the name of the person who helps you MOST with that/those things?

FILL Control Card items 14a, b(0), and c in column A.

c. Is he/she paid to help you?

FILL Control Card item 14d in column A.

d. Who else helps you with that/those things?

REASK until no more helpers named.
FILL Control Card items 14a, b(0), c, and d in all cases.

SECTION A

PART 2 - INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) AND HELPERS

Now I'm going to ask you some questions about your ability to do chores and other activities.

**CHECK ITEM A.2--REFER to Control Card Item 12

- 1 Code 3 and/or code 5 circled (SKIP to 8a)
- 2 Code 6 circled (SKIP to 2a)
- 3 All others

1a. Do you usually do heavy work around the house such as moving furniture, scrubbing floors, or washing windows?

- 1 Yes (SKIP to 2a)
- 2 No

b. If you had to do heavy work around the house, could you do it?

- 1 Yes (SKIP to 2a)
- 2 No

c. What is the reason you cannot do heavy work around the house--Is that because of a disability or health problem, or is there some other reason?

- 1 Disability or health problem (including old age)
- 2 Other

CIRCLE code 1
in c.c. 13.

2a. Do you usually do light work around the house such as straightening up, putting things away, or washing dishes?

- 1 Yes (SKIP to 3a)
- 2 No

b. If you had to do light work around the house, could you do it?

- 1 Yes (SKIP to 3a)
- 2 No

CIRCLE code 2
in c.c. item 13

- 1 Disability or health problem (including old age)
- 2 Other reason

c. What is the reason you cannot do light work around the house--is that because of a disability or health problem, or is there some other reason?

- 1 Yes (SKIP to 4a)
- 2 No

3a. Do you usually do your own laundry?

- 1 Yes (SKIP to 4a)
- 2 No

b. If you had to do your own laundry, could you do it?

CIRCLE code 3
in c.c. item 13

- 1 Disability or health problem (including old age)
- 2 Other reason

c. What is the reason you cannot do your own laundry--is that because of a disability or health problem, or is there some other reason?

- 1 Yes (SKIP to 5a)
- 2 No

4a. Do you usually prepare your own meals?

- 1 Yes (SKIP to 5a)
- 2 No

b. If you had to prepare your own meals, could you do it?

CIRCLE code 4
in c.c. 13

- 1 Disability or health problem (including old age)
- 2 Other reason (Specify): _____

c. What is the reason you cannot prepare your own meals--is that because of a disability or health problem, or is there some other reason?

- 1 Yes (SKIP to 6a)
- 2 No

5a. Do you usually shop for groceries, that is, go to the store, select the items, and get them home?

<p>c. What is the reason you cannot shop for groceries--is that because of a disability or health problem or is there some other reason?</p>	<p>Disability or health problem (including old age) 2 Other reason</p>	<p>CIRCLE code 6 in c.c. item 13</p>
<p>6a. Do you get around outside at all, either with help or without help?</p>	<p>1 Yes 2 No (SKIP to 6c)</p>	
<p>b. When you go outside, does someone usually help you?</p>	<p>1 Yes 2 No (SKIP to 7a)</p>	
<p>c. If you had to get around outside without help, could you do it?</p>	<p>1 Yes (SKIP to 7a) 2 No</p>	
<p>d. What is the reason you do not get around outside--is it because of a disability or health problem, or is there some other reason?</p>	<p>1 Disability or health problem (including old age) 2 Other reason</p>	<p>CIRCLE code 6 in c.c. item 13</p>
<p>7a. How do you USUALLY go places outside of walking distance? CIRCLE only one.</p>	<p>1 Car 2 Van 3 Taxi 4 Bus 5 Other public transportation 6 Other (Specify) _____ 7 Does not travel at all (SKIP to 8a)</p>	
<p>b. If you had to go places outside of walking distance by yourself, could you do it?</p>	<p>1 Yes 2 No</p>	

CIRCLE code 7
in c.c. item 13

1 Disability or health problem
2 Other reason

c. Is the reason you do not go places outside of walking distance by yourself because of a disability or health problem, or is there some other reason?

1 Yes (SKIP to 9)
2 No

8a. Do you usually manage your own money by yourself, including things like keeping track of bills or handling cash?

1 Yes (SKIP to 9)
2 No

b. If you had to manage your own money, could you do it?

CIRCLE code 8
in c.c. item 13

1 Disability or health problem (including old age)
2 Other reason

c. Is the reason you cannot manage your own money because of a disability or health problem, or is there some other reason?

1 Yes (CIRCLE code 9 c.c. item 13)
2 No
3 Does not take medicine at all

9. Does someone usually help you take your medicine?

1 Code 3 and/or 5 circled (SKIP TO 10a)
2 All Others (SKIP TO 10b)

**CHECK ITEM A.3 REFER TO C.C. ITEM 12

10a. You mentioned that you do not get around inside. Who regularly helps you most with activities such as housework, laundry, and shopping?
REFER TO ITEMS CHECKED IN C.C. ITEM 13.
FILL C.C. ITEM 14a, b (1-9), and c
IN APPROPRIATE (OR FIRST AVAILABLE)
HELPER COLUMN.
SKIP TO 10c.

10b. You mentioned that you can not
(REFER to items
checked in c.c. item 13). Who regularly
helps you most with this/these
activity?

FILL C.C. ITEM 14a, b (1-9), and c
IN APPROPRIATE (OR FIRST AVAILABLE)
HELPER COLUMN.

10c. Is he/she paid to help you?

FILL C.C. ITEM 14d IN APPROPRIATE
HELPER COLUMN.

**CHECK ITEM A.4--REFER to Control Card Item 14d (ALL COLUMNS).
IF no helpers are paid, SKIP to CHECK ITEM A.5.

11a. You said that (name of paid helper[s]) helps you. Did you decide that you needed this help, or did someone
else decide?

- 1 Self _____
- 2 Other (Specify) _____

b. Did you choose the person who helps you or did someone else choose?

- 1 Self _____
- 2 Other (Specify) _____

c. Did you decide how much help you would receive or did someone else decide?

- 1 Self _____
- 2 Other (Specify) _____

**CHECK ITEM A.5--REFER to Control Card, item 12
1 If all codes (excluding 3, 5, 6) circled (SKIP to 13)
2 All others

12a. Are there any activities you are now doing which you would like or need help with?
(RECORD IN COLUMN I BELOW)

Anything else?

COLUMN I: ACTIVITY

A No activity mentioned (CIRCLE and SKIP to Section A, Part 3)

B
C
D
E

12b. What is the reason for not getting help?

- 1 Could not afford assistance
- 2 Could afford assistance, but could not find it
- 3 Other (Record Verbatim)

(RECORD REASON IN COLUMN II, BELOW, BESIDE APPROPRIATE ACTIVITY)

COLUMN II: REASON

B
C
D
E

Notes:

SECTION A

PART 3 - HELPERS

Now I'm going to ask you about the people who give you help.

REFER TO C.C. ITEM 14a. IF 2 OR LESS HELPERS ARE INDICATED, ENTER NAME(S) IN COLUMN(S) A (AND B). IF MORE THAN 2 HELPERS ARE INDICATED, ASK A:

_____ A _____ B

A. Of the helpers you mentioned, which two help you the most? RECORD NAMES IN COLUMNS A AND B.

Name of person/organization _____
Name of person/organization _____

You mentioned that _____ helps you.

Person A

1a. During the past week, how many days were there when _____ helped you because of your disability or health problem?

1 _____ Days
2 None

b. Thinking about all of the things _____ does for you because of your disability, about how many extra hours does he/she spend helping you on an average day? _____ hours/day

Person B

1 _____ Days
2 None

_____ hours/day

A

Name _____

- 1 Less than 3 mos.
- 2 3 mos. to less than 6 mos.
- 3 6 mos. to less than 1 year
- 4 1 year to less than 5 years
- 5 5 years or over

Relatives

- 1 Spouse
- 2 Father
- 3 Mother
- 4 Son
- 5 Daughter
- 6 Brother
- 7 Sister
- 8 Son-in-law
- 9 Daughter-in-law
- 10 Other male relative
- 11 Other female relative

- Others
- 12 Male friend
- 13 Female friend
- 14 Someone hired
- 15 Someone from helping organization
- 16 Someone else -

- 1 Less than 3 mos.
- 2 3 mos. to less than 6 mos.
- 3 6 mos. to less than 1 year
- 4 1 year to less than 5 years
- 5 5 years or over

Relatives

- 1 Spouse
- 2 Father
- 3 Mother
- 4 Son
- 5 Daughter
- 6 Brother
- 7 Sister
- 8 Son-in-law
- 9 Daughter-in-law
- 10 Other male relative
- 11 Other female relative

- Others
- 12 Male friend
- 13 Female friend
- 14 Someone hired
- 15 Someone from helping organization
- 16 Someone else -

c. For how long has ... helped you because of your disability or health problem?

d. IF obvious, code without asking.

You mentioned that ... helps you. Is ... a relative, friend someone you hired to help you, someone from a helping organization, or someone else?

If "relative," ASK "how is ... related to you?"

CIRCLE only one

IF caregiver present, or proxy, SKIP to f.

How would you rate your satisfaction with your helper. (How satisfied, satisfied, ...)

- 1 Very Satisfied
- 2 Satisfied
- 3 Somewhat Satisfied

- 1 Very Satisfied
- 2 Satisfied
- 3 Somewhat Satisfied

B

Name _____

B

Name _____

A

Name _____

f. REFER to Control Card item 14d.
IF not paid help, SKIP to next helper. IF last helper, SKIP to Section B, Part 1

g. How much is _____ paid?
(ENTER amount and CIRCLE unit of time.)

1 \$ _____ .00 (hour/week/month)
2 Don't know

1 \$ _____ .00 (hour/week/month)
2 Don't know

h. How much will you yourself pay for the help that you got from ... during (previous month)?

1 \$ _____ .00 (hour/week/month)
2 0__ Nothing

1 \$ _____ .00 (hour/week/month)
2 0__ Nothing

i. Will insurance, Medicare, Medicaid, or anyone else, including any members of your family, end up paying any of the charge for this?

1 Yes (GO to j on next page)
2 No (SKIP to next helper.)
IF last helper, SKIP to 1 Section B, Part 1.

1 Yes (SKIP to j on next page)
2 No (SKIP to 1, Section B, Part 1)

J. Who will end up paying?
Anyone else?
CIRCLE all that apply.

A

Name _____

- 1 Insurance
- 2 Medicare
- 3 Medicaid

4 Household member(s)
Name _____

5 Child(ren) not in
HH
Name _____

Other nonhousehold members

- 6 ___ Father
- 7 ___ Mother
- 8 ___ Son-in-law
- 9 ___ Daughter-in-law
- 10 ___ Brother
- 11 ___ Sister
- 12 ___ Other male relative
- 13 ___ Other female relative
- 14 ___ Male friend
- 15 ___ Female friend
- 16 ___ Other (Specify) _____

17 ___ DK

SKIP to next helper. IF last helper, SKIP Section B,

B

Name _____

- 1 Insurance
- 2 Medicare
- 3 Medicaid

4 Household member(s)
Name _____

5 Child(ren) not in
HH
Name _____

Other nonhousehold members

- 6 ___ Father
- 7 ___ Mother
- 8 ___ Son-in-law
- 9 ___ Daughter-in-law
- 10 ___ Brother
- 11 ___ Sister
- 12 ___ Other male relative
- 13 ___ Other female relative
- 14 ___ Male friend
- 15 ___ Female friend
- 16 ___ Other (Specify) _____

17 ___ DK

SECTION B - OTHER FUNCTIONING

SECTION B

PART 1 - COMMUNICATIONS AND SOCIAL ACTIVITIES

Now I'm going to ask some questions about social activities.

1. Is there a telephone in this house/apartment?
(CODE WITHOUT ASKING IF OBVIOUS)
- 1 Yes
2 No

****CHECK ITEM B.J.L. (REFER to Control Card item 8a):**
1 Sample person lives alone
2 Sample person lives with other persons (SKIP to 3a)

- 2a. Does anyone phone or check on you regularly just to make sure you are all right?
- 1 Yes
2 No (SKIP to c)

- b. Who regularly does this?
Anyone else?
REASK until answer is "No one else."
- | Person | First | Second | Third | Fourth | Fifth | Sixth |
|-------------------------------------|-------|--------|-------|--------|-------|-------|
| 1. Daughter | 1 | 1 | 1 | 1 | 1 | 1 |
| 2. Son | 2 | 2 | 2 | 2 | 2 | 2 |
| 3. Other relatives | 3 | 3 | 3 | 3 | 3 | 3 |
| 4. Neighbor | 4 | 4 | 4 | 4 | 4 | 4 |
| 5. Friend | 5 | 5 | 5 | 5 | 5 | 5 |
| 6. Person from helping organization | 6 | 6 | 6 | 6 | 6 | 6 |
| 7. Other | 7 | 7 | 7 | 7 | 7 | 7 |

- c. Do you NEED someone to phone or check on you regularly just to make sure you are all right?
- 1 Yes
2 No

3a. Now I have some questions about being in touch with your relatives and friends. First, I'd like to ask about your relatives (including any children) who don't live here.

Do you have any relatives with whom you keep in touch - either by visiting or by telephone?

1 Yes
2 No (SKIP to 4a)

b. SHOW FLASHCARD A
(Not counting your relatives who live here) how many times in the past month did you see your relatives (including your children)?
CODE all relatives' visits combined.

1 None, once, or twice
2 Three to five times
3 Six to ten times
4 Eleven to twenty-nine times
5 Thirty or more times

c. SHOW FLASHCARD A
In the past month, how often did you speak with your relatives on the telephone?

1 None, once, or twice
2 Three to five times
3 Six to ten times
4 Eleven to twenty-nine times
5 Thirty or more times

4a. (You've told me about your relatives.) Now I want to ask about your friends. Do you have any friends, including neighbors you consider as friends, whom you keep in touch with - either by visiting or by telephone?

1 Yes
2 No (SKIP to 5a)

- b. How many times in the past month did you see your friends.
 - 1 None, once, or twice
 - 2 Three to five times
 - 3 Six to ten times
 - 4 Eleven to twenty-nine times
 - 5 Thirty or more times

- c. In the past month, how often did you speak with your friends on the telephone?
 - 1 None, once, or twice
 - 2 Three to five times
 - 3 Six to ten times
 - 4 Eleven to twenty-nine times
 - 5 Thirty or more times

- 5. How often do you usually watch television?
 - 1 Everyday
 - 2 At least one day a week
 - 3 Less than once a week

- 6. How often do you usually listen to the radio?
 - 1 Everyday
 - 2 At least one day a week
 - 3 Less than once a week

- 7. How often do you usually listen to a tape recorder or record player?
 - 1 Everyday
 - 2 At least one day a week
 - 3 Less than once a week

- 8. Do you have any pets?
 - 1 Yes
 - 2 No

- 9. During the past week, did you -
 - a. Read a book, magazine, or newspaper?
 - 1 Yes
 - 2 No
 - b. Work on a hobby, like painting, sewing, or arts and crafts, or

**CHECK ITEM B.2 (REFER TO c.c. item 12) 1 Item 3 and/or 5 circled (SKIP to Section B, Part 2)
2 All others

10. During the past month did you -

a. Go to religious services? 1 Yes
2 No

b. Attend a meeting of a civic, religious, professional, or recreational club or organization? 1 Yes
2 No

11a. Do you regularly go to a senior center or an adult day/care center? 1 Yes
2 No (SKIP to d)

b. Do you receive any health services or therapy at the center? 1 Yes
2 No

c. Does this center provide you with transportation between the center and your home? 1 Yes
2 No

d. Do you now regularly eat meals (in a senior center or in some other place) with a special meal program for older people? 1 Yes
2 No

Notes:

SECTION B

PART 2 - LIFE SATISFACTION

Now I'm going to ask some questions about life satisfaction.

**CHECK ITEM B.3--Respondent is -
1 Sample person
2 Proxy (SKIP to Section C, Condition List)

1. Compared to other persons your age, would you say that your health is excellent, good, fair, or poor?

- 1 Excellent
- 2 Good
- 3 Fair
- 4 Poor

2. Compared to last year, would you say that your health is better, worse, or about the same?

- 1 Better
- 2 Worse
- 3 About the same

**CHECK ITEM B.4 (REFER to c.c. item 12)
1 Item 3 and/or 5 circled (SKIP to CHECK ITEM B.6)
2 All others

3. How often do you avoid doing things because you do not have enough energy to do them--would you say all of the time, most of the time, some of the time, once in a while, or never?

- 1 All of the time
- 2 Most of the time
- 3 Some of the time
- 4 Once in a while
- 5 Never

**CHECK ITEM B.5
1 Sample person alone during interview
2 Other persons present (SKIP to Question 5)

4. Sometimes people feel that they have nobody to tell their troubles to. Would you say you feel this way most of the time, some of the time, or hardly ever?

- 1 Most of the time
- 2 Some of the time
- 3 Hardly ever
- 4 Never

5. Generally speaking, how satisfied are you with your life now as a whole--would you say you are very satisfied, satisfied, or not satisfied?
- 1 Very satisfied
2 Satisfied
3 Not satisfied

Notes:

SECTION - CONDITION LJSI

Now I'm going to ask about some health problems or conditions some people have.

1a. Are you missing any fingers,
a hand, or an arm?

- 1 Yes
- 2 No (SKIP to 2a)

b. What are you missing?
CIRCLE all that apply.

- Entire arm
- 1 Left
- 2 Right
- 3 Both

- Lower arm
- 1 Left
- 2 Right
- 3 Both

- Hand only
- 1 Left
- 2 Right
- 3 Both

- Fingers only
- 1 Left hand
- 2 Right hand
- 3 Both hands

2a. Are you missing any toes, a foot
or a leg?

- 1 Yes
- 2 No (SKIP to 3)

b. What are you missing?
CIRCLE all that apply.

Entire leg
1 Left
2 Right
3 Both

Lower leg
1 Left
2 Right
3 Both

Foot only
1 Left
2 Right
3 Both

Toes only
1 Left foot
2 Right foot
3 Both feet

3. Do you usually see well enough
to read ordinary newspaper with
glasses or contact lenses if you
wear them?

1 Yes
2 No

****CHECK UJEM.C.1--Respondent is**

- 1 Sample person (SKIP to 6)**
- 2 Proxy**

4a. Is . . . 's speech understandable to most people?

- 1 Yes (SKIP to 5a)**
- 2 No**

b. How does . . . usually make himself/herself understood? CIRCLE only one.

- 1 Writing**
 - 2 Standard sign language**
 - 3 Gestures, grunts, or some other motion**
 - 4 Some other way (Specify)**
-

5a. Does . . . usually hear and understand what is being said to him/her without difficulty?

- 1 Yes (SKIP to 6)**
- 2 No**

b. What means does . . . usually use to understand what is being said to him/her? CIRCLE only one.

- 1 Reading written materials or lip reading**
 - 2 Standard sign language**
 - 3 Gestures, grunts, or some other motion**
 - 4 Some other way (Specify)**
-

6. Now I'm going to read you a list of medical conditions. Do you NOW have any of the following:

a. Rheumatism or arthritis? 1 Yes
2 No

b. Paralysis? 1 Yes
2 No

c. Other permanent numbness or stiffness (besides paralysis/rheumatism or arthritis)? 1 Yes
2 No

d. Multiple sclerosis? 1 Yes
2 No

e. Cerebral palsy? 1 Yes
2 No

f. Epilepsy? 1 Yes
2 No

g. Parkinson's disease? 1 Yes
2 No

h. Glaucoma? 1 Yes
2 No

i. Diabetes? 1 Yes
2 No

J. Cancer? 1 Yes
2 No

k. Frequent constipation? 1 Yes
2 No

l. Frequent trouble sleeping? 1 Yes
2 No

m. Frequent severe headaches? 1 Yes
2 No

n. Obesity or are you overweight? 1 Yes
2 No

o. Arteriosclerosis or hardening of the arteries? 1 Yes
2 No

**CHECK ITEM C.2--Respondent is - 1 Sample person (SKIP to 7)
2 Proxy

p. Mental retardation? 1 Yes
2 No

q. Senility 1 Yes
2 No

7. Have you had any of the following in the LAST 12 months:

a. A heart attack? 1 Yes 2 No

b. Any other heart problem? 1 Yes 2 No

c. Hypertension or high blood pressure? 1 Yes 2 No

d. A stroke? 1 Yes 2 No

e. Circulation trouble in your arms or legs? 1 Yes 2 No

f. Pneumonia? 1 Yes 2 No

g. Bronchitis? 1 Yes 2 No

h. Flu? 1 Yes 2 No

i. Emphysema? 1 Yes 2 No

j. Asthma? 1 Yes 2 No

k. A broken hip?

1 Yes
2 No

l. Other broken bones?

1 Yes
2 No

Notes:

SECTION D - HEALTH INSURANCE

Now I have some questions about your health insurance coverage.

1. There is a national program called Medicare which pays for health care for persons 65 years of age or older and for certain disabled persons.

a. During the past 12 months, have you received health care which has been paid for by Medicare?
1 Yes
2 No
3 DK

b. Are you now covered by MEDICARE?
1 Yes
2 No
3 DK

2. There is a national program called Medicaid which pays for health care for persons in need. (In this state it is also called [Name]).

a. During the past 12 months, have you received health care which has been or will be paid for by Medicaid (or name)?
1 Yes
2 No
3 DK

b. Do you NOW have a Medicaid (or name) card?
1 Yes
2 No

3. We are interested in all kinds of private health insurance plans except those which pay only for accidents.

a. Are you now covered by any other public or private health insurance plan which pays any part of a hospital, doctor's or surgeon's bill?
 1 Yes
 2 No (SKIP to Section E, 1a)

b. What is the name of the plan? Any other plan?

Plan 1	Plan 2	Plan 3
Name	Name	Name

c. Does this (name) plan pay any part of hospital expenses?

1 Yes	1 Yes	1 Yes
2 No	2 No	2 No

d. Does this (name) plan pay any part of doctors' or surgeons' bills for operations? REASK c and d if more than one plan.

1 Yes	1 Yes	1 Yes
2 No	2 No	2 No

Notes:

SECTION E - MEDICAL PROVIDERS AND PRESCRIPTION MEDICINES

Now I have some questions about your use of health care services.

1a. Have you EVER been a patient in a nursing home, convalescent or rest home?
 1 Yes
 2 No (SKIP to e)

b. How many times?
 ___ Times

c. When were you admitted (the last time/the time before that)?
 Last time
 Month Year
 ___ 19__

Next to last time
 Month Year
 ___ 19__

Time before that
 Month Year
 ___ 19__

d. How long were you in the nursing home (that time)?
 REASK c and d if more than one time.
 ___ Days
 or
 ___ Months

___ Days
 or
 ___ Months

___ Days
 or
 ___ Months

e. Are you now on a waiting list to go into a nursing home?
 1 Yes
 2 No

2a. Have you been a patient in a hospital overnight or longer, in the last 12 months?
 1 Yes
 2 No (SKIP to 3a)

b. How many times?
 ___ Time(s)

c. When were you admitted (the last time/the time before that)?

Last time	Next to last time	Time before last
Month Year	Month Year	Month Year
-- -- 19-- --	-- -- 19-- --	-- -- 19-- --

d. How long were you in the hospital (that time)?

-- -- Days	-- -- Days	-- -- Days
or	or	or
-- -- Months	-- -- Months	-- -- Months

REASK c and d if more than one time.

3a. In the last month, that is, since (date 1 month ago), did you see a physical therapist, an occupational therapist, or a speech, or a hearing therapist (not counting when you were in the hospital)?

1 Yes
2 No (SKIP to 4a)

b. Which of these therapists did you see? Anyone else? CIRCLE all that apply.

Physical	Occupational	Speech	Hearing
1	2	3	4

c. How many times did you see (item b therapist) in the last month?

-- -- Times	-- -- Times	-- -- Times	-- -- Times
-------------	-------------	-------------	-------------

d. Did you see this therapist in your home or somewhere else? REASK c and d for each type of therapist seen.

1 At home	1 At home	1 At home
2 Somewhere else	2 Somewhere else	2 Somewhere else
3 Both	3 Both	3 Both

e. How much will you yourself end up paying for (that visit/all those visits)? CIRCLE only one PROBE for dollar amount.

\$ _____ .00 Percent

0 Nothing
1 Included with other charges

f. Will insurance, Medicare, Medicaid, or anyone else, including any members of your family, end up paying any of the charges for (that visit/all those visits)?

- 1 Yes (SKIP to 3h)
- 2 No

**CHECK ITEM E.1--REFER to Items 3e and 3f, above

- 1 Sample person paid nothing AND no one else will pay
- 2 All others (SKIP to 4a)

g. Why was there no charge? CIRCLE all that apply.

- 1 One general fee/blanket charge (HMO)
- 2 Group practice prepayment/Health Maintenance Organization (SKIP to 4a)
- 3 Welfare/public assistance
- 4 Private organization/charity
- 5 Federal, state, or city hospital, clinic, or health department (including Veterans Administration hospital)
- 6 Professional courtesy
- 7 Other (Specify) _____

h. Who will end up paying?
Anyone else?
CIRCLE all that apply.

- 1 Insurance
- 2 Medicare
- 3 Medicaid
- 4 Household member(s) - (Specify)

Name _____

- 5 Child(ren) of sample person
(nonhousehold members) - (Specify)

Name	Items

Other nonhousehold members

- 6 Father
- 7 Mother
- 8 Son-in-law
- 9 Daughter-in-law
- 10 Brother
- 11 Sister
- 12 Other male relative
- 13 Other female relative
- 14 Male friend
- 15 Female friend
- 16 Other (Specify)

4a. In the last month, that is, since (date 1 month ago), did you discuss any personal problems with a psychiatrist, psychologist, or any other mental health professional?

- 1 Yes
- 2 No (SKIP to 5a)

b. How many times have you seen one of these mental health professionals in the last month? 1 Times

c. How much will you yourself end up paying for (that visit/all those visits)?
CIRCLE only one
PROBE for dollar amount

- \$.00 Percent
- 0 Nothing
- 1 Included with other charges

d. Will insurance, Medicare, Medicaid, or anyone else, including any member of your family, end up paying any of the charge for (that visit/all those visits)?

- 1 Yes (SKIP to 4f)
- 2 No

**CHECK ITEM E.2--REFER to Items 4c & 4d

- 1 Sample person paid nothing AND no one else will pay
- 2 All others (SKIP to 5a)

4e. Why was there no charge? CIRCLE all that apply

- 1 One general fee/blanket charge
 - 2 Group practice prepayment/Health Maintenance Organization (HMO)
 - 3 Welfare/public assistance
 - 4 Private organization/charity
 - 5 Federal, State, or city hospital clinic, or health department (including VA hospital)
 - 6 Professional courtesy
 - 7 Other (Specify) _____
- (SKIP to 5a)

4f. Who will end up paying?
Anyone else?
CIRCLE all that apply

- 1 Insurance
- 2 Medicare
- 3 Medicaid
- 4 Household member(s) - (Specify)

Name _____

- 5 Child(ren) of sample person
(nonhousehold members) -(Specify)

Name _____

Other nonhousehold members

- 6 Father
- 7 Mother
- 8 Son-in-law
- 9 Daughter-in-law
- 10 Brother
- 11 Sister
- 12 Other male relative
- 13 Other female relative
- 14 Male friend
- 15 Female friend
- 16 Other (Specify)

5a. In the last month, that is, since (date 1 month ago), did you receive care from a dentist, foot doctor, optometrist, or chiropractor?

1 Yes
2 No (SKIP to 6a)

b. Which of these did you see? Anyone else? CIRCLE all that apply

Dentist 1 Foot doctor 2 Optometrist 3 Chiropractor 4

c. How many times did you see (item b person) in the last month?

Times <u>1</u>	Times <u>1</u>	Times <u>1</u>
----------------	----------------	----------------

d. Did you see (item b person) in your home or somewhere else? REASK c & d for each type of medical person seen.

1 At home	1 At home	1 At home
2 Somewhere else	2 Somewhere else	2 Somewhere else
3 Both	3 Both	3 Both

6a. In the last month, that is, since (date 1 month ago), did you go to an emergency room or hospital clinic when you did NOT stay overnight? (Do not include any visits you have already told me about.)

1 Yes
2 No (SKIP to 7a)

b. How many times did you go in the last month?

Time(s) 1

Notes

7a. (Not counting any visits you've already told me about.) In the last month, that is, since (date 1 month ago), did you receive medical care in a doctor's office? (Do NOT count doctors seen in a hospital emergency room or hospital clinic, or while a patient in the hospital.)

1 Yes
2 No (SKIP to 8a)

b. How many times did you receive care in a doctor's office in the last month? _____ Time(s)

8a. In the last month, that is, since (date 1 month ago), did you see a doctor in your home? (Do NOT count any visits you already told me about.)

1 Yes
2 No (SKIP to 9)

b. How many times did you see a doctor in your home in the last month? _____ Time(s)

9. Do you have a regular source of medical care, like a family doctor, a clinic, or some other medical person or place?

1 Yes
2 No

10a. In the last month, that is, since 1 Yes
(date 1 month ago), did you receive 2 No (SKIP to CHECK ITEM E.3)
nursing services at home from
someone such as a visiting nurse,
home health aide, or nurse's aide?

b. Who provided these nursing services
to you?

IF PREVIOUSLY MENTIONED HELPER,
CIRCLE b (10) IN APPROPRIATE COLUMN.
IF NEW HELPER, FILL IN ITEMS 14a, b(10),
AND ASK 14c AND d.

c. You said that you receive nursing services.

1) Who decided that you would get nursing services?

1 Self 2 Other (Specify) _____

11) Who chose the person that provides nursing services for you?

1 Self 2 Other (Specify) _____

111) Who chose how much nursing services you received?

1 Self 2 Other (Specify) _____

**CHECK ITEM E.3--Respondent is --

- 1 Sample person
- 2 Proxy (SKIP to 12a)

11a. In the last month, did you have any health problem or condition about which you would have liked to see a doctor or other medical person, but did not?

- 1 Yes
- 2 No - (SKIP to 12a)

b. What is the reason that you didn't see a doctor or other medical person? Any other reason? RECORD verbatim response below; then CIRCLE all that apply.

- 1 Financial
- 2 Time
- 3 Availability of a doctor
- 4 Transportation
- 5 Not free to leave
- 6 Problem not serious
- 7 Afraid to find out what's wrong
- 8 Weather
- 9 Other reason(s)

12a. In the last month, that is, since (date 1 month ago), how many prescription medicines were bought or obtained for you?

- 1 Number of prescription medicines
- 0 None (SKIP to Section F)

b. How much will you yourself end up paying for (this/these) prescription(s)? CIRCLE only one. PROBE for dollar amount.

- \$ _____ .00
- _____ Percent
- 0 Nothing
- 1 Included with other charges

c. Will insurance, Medicaid or anyone else, including any members of your family, end up paying any of the charge for (this/these) prescription(s)?

- 1 Yes (SKIP to 12e.)
- 2 No

**CHECK ITEM E.4 (REFER to Question 12b and 12c, above)

- 1 Sample person paid nothing AND no one else will pay
- 2 All others (SKIP to Section F)

d. Why was there no charge?
Any other reason?
CIRCLE all that apply

- 1 One general fee/blanket charge
- 2 Group practice prepayment/
Health Maintenance Organization
(HMO)
- 3 Welfare/public assistance
- 4 Private organization/charity
- 5 Federal, state, or city hospital,
clinic, or health department
(including veterans hospital)
- 6 Professional courtesy
- 7 Other (Specify) _____

(SKIP
to
Section F)

12e. Who will end up paying?
Anyone else?
CIRCLE all that apply.

- 1 Insurance
- 2 Medicaid
- 3 Household member(s) - (Specify)

Name _____

4 Child(ren) of sample person
(nonhousehold members) - (Specify)

Name _____

Other nonhousehold members

- 5 Father
- 6 Mother
- 7 Son-in-law
- 8 Daughter-in-law
- 9 Brother
- 10 Sister
- 11 Other male relative
- 12 Other female relative
- 13 Male friend

SECTION F - MILITARY SERVICE AND SOCIODEMOGRAPHIC INFORMATION

Now, I'm going to ask you some questions about your military service and other background information.

- 1a. What is your date of birth? ___-___-___
- 2a. Are you a veteran or surviving spouse?
1 Veteran
2 Surviving spouse (SKIP to 2c)
- b. Do you have a disability related to your service in the Armed Forces of the United States?
1 Yes
2 No
- c. During what years did you (your spouse) serve in the Armed Forces? ___ to ___ period
_____ Check here if this includes WWI (April 5, 1917 - November 12, 1918 or April 5, 1917 - April 1, 1920 for service in Russia.)
- d. 1) Do you have (a spouse or any children counted as dependents for the VA pension)?
1) Yes
2) No (SKIP to e)
- 1) How many dependents do you have? ___
_____ years
or _____ months
- e. How long have you been receiving a VA pension?
1 Housebound
2 Aid and attendance
3 DK
- f. Are you receiving housebound or aid and attendance allowance?
1 Housebound
2 Aid and attendance
3 DK

3. SHOW FLASHCARD B
What is your racial or ethnic
background?
CIRCLE only one.

- 1 White
- 2 Hispanic
- 3 Black
- 4 Asian
- 5 Other (Specify) _____
- 6 DK

**CHECK_ITEM_E.1--CIRCLE type of area

- 1 Open country/not a farm
- 2 Farm
- 3 City/town/village (under 50,000)
- 4 City (50,000 - 250,000)
- 5 Suburb of large city
- 6 Large city (over 250,000)

**CHECK_ITEM_E.2--CIRCLE type of
living quarters

- 1 Detached house
- 2 Duplex or row house
- 3 Apartment
- 4 Room in hotel/motel
- 5 Room in rooming or boarding house
- 6 Rented room in private house
- 7 Trailer (permanent)
- 8 Trailer (mobile)
- 9 Other (Specify) _____

**CHECK_ITEM_E.3--Respondent is --

- 1 Sample person
- 2 Proxy (SKIP to 5)

4. All things considered, how
satisfied are you with the place
in which you are living - would
you say that you are very
satisfied, satisfied, or not
satisfied?

- 1 Very satisfied
- 2 Satisfied
- 3 Not satisfied

5. (If obvious, CIRCLE without asking.) 1 Yes
Is this place part of a building 2 No
or community intended for older
or retired, or disabled persons?

Now I have some questions about your income.

- 6a. During the last month, that is, in 1 Yes
the month of (previous month), did 2 No (SKIP to 7)
you receive Social Security benefits
(green checks) or Railroad Retirement
benefits?

b. How much did you receive in \$ _____ .00
(previous month)?
1 Ref.
2 DK

7. How much did you receive in \$ _____ .00
Veterans' Administration pension 1 Ref.
or compensation in 2 DK
(previous month)?

- 8a. During (previous month), did you 1 Yes
receive any other retirement, 2 No (SKIP to 9a)
pension, or annuity income?

b. How much did you receive in \$ _____ .00
(previous month)?
1 Ref.
2 DK

- 9a. Did you or any members of your 1 Yes
family who live here receive 2 No (SKIP to 10a)
food stamps in (previous month)?

b. What was the value of the stamps
received? \$ _____ .00
1 Ref.
2 DK

10a. During the last 12 months, did you receive any other kind of regular income that you have not already told me about?

1 Yes
2 No (SKIP to 10d)

b. What kind of income was it? _____

c. How much did you receive in the last 12 months?

\$ _____ .00

1 Ref.
2 DK

d. Other than income, did you receive any other support on a regular basis?

1 Yes
2 No (SKIP to 11a)

e. What kind of support?
RECORD VERBATIM _____

- 11a. SHOW FLASHCARD C
- Which category on this card represents your total combined income before deductions during the LAST 12 months?
- Include money from jobs, net income from business or farm, pensions, dividends, interest, net income from rent, Social Security payments, and any other money income you received.
- | | |
|-----------------------|------------------------|
| 01 Under \$3,000 | 13 \$25,000 - \$29,999 |
| 02 \$3,000 - \$ 3,999 | 14 30,000 - 39,999 |
| 03 4,000 - 4,999 | 15 40,000 - 49,999 |
| 04 5,000 - 5,999 | 16 50,000 or more |
| 05 6,000 - 6,999 | 17 Refused |
| 06 7,000 - 7,999 | 18 DK |
| 07 8,000 - 8,999 | |
| 08 9,000 - 9,999 | |
| 09 10,000 - 11,999 | |
| 10 12,000 - 14,999 | |
| 11 15,000 - 19,999 | |
| 12 20,000 - 24,999 | |

**CHECK ITEM F.4--REFER to Control Card Item 8. Sample person lives

1 Alone or with other non-related persons (SKIP to 12)
2 With other related persons

- 13 \$25,000 - \$29,999
- 14 30,000 - 39,999
- 15 40,000 - 49,999
- 16 50,000 or more
- 17 Refused
- 18 DK

- 01 Under \$3,000
- 02 \$3,000 - \$ 3,999
- 03 4,000 - 4,999
- 04 5,000 - 5,999
- 05 6,000 - 6,999
- 06 7,000 - 7,999
- 07 8,000 - 8,999
- 08 9,000 - 9,999
- 09 10,000 - 11,999
- 10 12,000 - 14,999
- 11 15,000 - 19,999
- 12 20,000 - 24,999

Vehicles
 None

b. SHOW FLASHCARD 3
 Which category on this card represents the total combined income before deductions during the LAST 12 months for you and all members of your family who live with you? Include money from jobs, net income from business or farm, pensions, dividends, interest, net income from rent, Social Security payments, and any other money income received by you (and all members of your family).

12. How many vehicles, including cars, vans, trailers, motorcycles, or other vehicles are owned by you (and all members of your family who live with you)?

13a. Are your living quarters owned or being bought by someone in your household?
 1 Yes (SKIP to 16a)
 2 No

b. Are your living quarters rented for cash or occupied without payment of cash rent?
 1 Rented for cash
 2 Occupied without payment of cash rent (SKIP to Section G, Question 1)

14. About how much is the rent each month?
 \$ _____ .00

15. In whose name is this house/
apartment rented?
CIRCLE all that apply.

Household Member(s) - (Specify
Name)

(SKIP to Section G,
Question 1)

Child(ren) of Sample Person
(nonhousehold members - Specify Name)

_____ Other nonhousehold member(s) (CHECK HERE)

16a. What is the present value of
this home (and lot/farm),
that is, about how much would
it bring if you sold it on
today's market?
CIRCLE only one.

- 1 Under \$20,000
- 2 \$ 20,000 - \$34,999
- 3 35,000 - 49,999
- 4 50,000 - 74,999
- 5 75,000 - 99,999
- 6 100,000 - 149,999
- 7 150,000 or more

b. Is there a mortgage or other
indebtedness on this home
(and lot/farm) at the present
time?

Yes
No (SKIP to 17)

c. About how much is still owed?

\$ _____ .00

d. About how much is your monthly
mortgage payment?

\$ _____ .00

16. Who owns this (house/apartment)?
Anyone else?
CIRCLE all that apply

Household Member(s) - (Specify Name)

Child(ren) of Sample Person
(Nonhousehold Members - Specify Name)

Other nonhousehold member(s)

Notes:

SECTION G -- VA PENSION

Now I would like to ask you some questions regarding your VA pension.

****CHECK ITEM G.1--REFER to Section F, Question 7, page 45.
IF VA pension is less than \$50/month, SKIP to 2a.**

1a. SHOW FLASHCARD D
Does the VA Pension you receive help to pay for
the following items:

- 1 Housing/Utilities
- 2 Food
- 3 Social Activities/Entertainment
- 4 Clothing
- 5 Nonprescription Drugs
- 6 Transportation
- 7 Household Appliances
- 8 Home Health Care
- 9 Homemaker Services
- 10 Health Care Supplies and Equipment
- 11 Other Support Services (specify) _____

SKIP to 2 if item 8, 9, or 10 is not circled.

IF item 8 is circled, ask 1b.
IF item 9 is circled, ask 1c.
IF item 10 is circled, ask 1d.

b. You mentioned that the VA pension helps you pay for home health care. What type of home health care does it help you purchase?

- 1 Nursing Care
- 2 Other (Specify)

c. You mentioned that the VA pension helps you pay for homemaker services. What type(s) of services does it help you to purchase?

- 1 Meal preparation
- 2 Shopping
- 3 Light housework
- 4 Heavy housework
- 5 Laundry
- 6 Other (Specify)

d. You mentioned that the VA pension helps you to pay for health care supplies and equipment. What type(s) of health care supplies and equipment does it help you to purchase?

- 1 special utensils or dishes to help you eat
- 2 special clothing or equipment to help you dress
- 3 special underwear
- 4 walker
- 5 cane
- 6 wheelchair
- 7 railing
- 8 other (Specify)

2a. Is the VA pension amount sufficient to meet the costs of dealing with your disability?

- 1 Yes (SKIP to CHECK ITEM G.3)
- 2 No (VERBATIM)

b. If not, how much more money in VA pension would you require?

- 1 _____ .00 (mo./yr.)
- 2 Ref.
- 3 DK

**CHECK_ITEM_G.3--REFER to Control Card Item 14.
Were any ADL helpers reported?

- 1 Yes
- 2 No GO to Control Card Item 5 and record end time.

As part of this research, we may want to speak to the helper(s) you have told me about. Of course, everything (he/she/they) tell(s) us will be kept completely confidential.

— Statement was read - CHECK HERE, GO to Control Card Item 5 and record end time.

Notes:

SECTION H - INTERVIEWER OBSERVATIONS

- **CHECK JIEM.H.1--CIRCLE only one
- 1 Sample person answered all questions (SKIP to 2)
- 2 Proxy answered all questions - Answer 1 only
- 3 Both sample person and proxy answered all questions - Answer 1 and 2

1. What is the proxy's name(s)?

Person No.
Name _____

Person No.
Name _____

2. Did the sample person show any sign of confusion at any time during the interview, such as difficulty in remembering dates, places, or other things?

1 Yes - (Specify)

2 No

Notes: _____

CONTROL CARD

1. Site Code _____
2. Interviewer Code _____
3. Sample Person (SP) Code _____
4. Name (SP) _____
Telephone Number (_____) _____
5. Interview Date _____ AM
Beginning Time (from PERSONAL INTERVIEW, p.2) _____ PM
AM
Ending Time (from end of SP interview) _____ PM

INTRODUCTION (TELEPHONE)

Hello, I am _____ from Project HOPE. We are conducting an evaluation of the Veterans Administration's Housebound and Aid and Attendance Allowance Program. Several (weeks/months) ago we contacted you about this survey and you agreed to participate. I would like to thank you for your cooperation, and arrange an interview time. I'll be in the area on (day/time), would this be a convenient time to visit you?

Date: _____
Time: _____

BOX 1: IF SP IS UNABLE TO COMMUNICATE, A PROXY CAN BE INTERVIEWED. THE PROXY SHOULD LIVE WITH THE SP AND HAVE PRIMARY RESPONSIBILITY FOR HIS OR HER CARE

PROXY NAME: _____
RELATION TO SP: _____

6. What is (your/the) exact address?

- 7a. Do you have a service organization who has power of attorney or who represents you with the Veterans Administration?

Yes (specify) _____ No _____

- b. Are you a member of a national service organization (NSO)?

Yes (specify) _____ No _____

- c. (Ask if member of Veterans of Foreign Wars or Paralyzed Veterans of America):

If possible, would you like a representative from your NSO to be present during our interview?

Yes _____ No _____

Thank you again for all your help and cooperation. I look forward to talking with you on (date/time). I will show you my Project HOPE identification card upon my arrival at your home.

Date of phone call: _____
Time: _____

INTRODUCTION (PERSONAL INTERVIEW)

Beginning Time _____ AM
_____ PM

Hello. I am _____ from Project HOPE. I have an appointment with _____. Here is my identification card. Are you _____? I spoke with you on _____ about our survey of veterans and their dependents who participate in the Veterans Administration's Housebound and Aid and Attendance Allowance program. Thank you again for your help and cooperation. Let's begin our interview.

SAMPLE PERSON (SP) CODE _____

BEGINNING

B. HOUSEHOLD ROSTER

What are the names of all persons who usually live or stay here? (INCLUDE members of immediate household and/or relatives living in housing unit.)

(START with name of sample person)

(LIST name(s) below.)

RELATIONSHIP TO SAMPLE PERSON

What is ...'s relationship to (name of sample person)? Examples: wife, parent, sister, cousin, uncle, lodger, lodger's son, etc.

- 1-sample person
- 2-spouse
- 3-son/daughter
- 4-son/daughter-in-law
- 5-parent
- 6-parent-in-law
- 7-brother/sister
- 8-brother/sister-in-law
- 9-grandchild
- 10-other relative
- 11-employee
- 12-other nonrelative (Enter code)

Sample Person

GO TO 9

SEX

ASK If not appar. Is male or female?

ASK How old is ...?

ASK e-h IF 15 OR OLDER

ASK (Enter Code) Bc Bf Bg Bh

ASK What is the highest grade or yr. of reg. school... has ever attended?

ASK Does ... usually work 30 hrs. a week or more?

ASK (SEE Codes) Bf Bg Bh

ASK (Enter Code) Bc Bf Bg Bh

EDUCATION: 0-Never attended, preschool, or kindergarten
 01-12-1st grade through 12th grade or equivalent
 21-1st (freshman) year of college or equivalent
 22-2nd (sophomore) year of college or equivalent
 23-3rd (junior) year of college or equivalent
 24-4th (senior) year of college or equivalent
 31-1 year of graduate school
 32-2 or more years of graduate school

9. ASK - I have listed (READ names in item Bc.) - Have I missed anyone? (If "yes", enter name in item Bc and ask item Bf for each person. If "no", ask Bc-Bh.)

Circle Y=Yes N=No
 Y N

IF no other persons, SKIP to c.c. item 10.

10. CHILDREN OF SAMPLE PERSON (Nonhousehold members) - ASK 11a-d FOR EACH CHILD.
 How I have some questions about your children who are not living with you. Do you have any living children who are not members of your household? This would include natural, adopted, or stepchildren.

- 1 Yes-FILL items as instructed above: THEN GO TO SP-SURVEY AND CONDUCT INTERVIEW
- 2 No-GO TO SP-SURVEY AND CONDUCT INTERVIEW

11. What are the names of all your living children who are not members of this household? Anyone else?	SEX (ASK if not apparent) Is ... male or female?	AGE How old is ...?	When did you last see ...? 1-Today or yesterday 2-2-7 days ago 3-8-30 days ago 4-During last yr. but more than 30 days ago 5-More than 1 yr. ago (Enter code) d
a	b	c	d
Last First M.	Male Female		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		
	1 2		

12. Activities of Daily Living (ADL)
 (To be filled in during survey.
 Circle item when indicated.)

- 1 Eating
- 2 Getting in/out of bed
- 3 Didn't get out of bed at all
- 4 Getting around inside
- 5 Did not get around inside at all
- 6 Confined to wheelchair
- 7 Dressing
- 8 Bathing
- 9 Getting to the bathroom or using the toilet

13. Instrumental Activities of Daily Living (IADL).
 (To be filled in during survey.
 Circle item when indicated.)

- 1 Doing heavy work
- 2 Doing light work
- 3 Doing laundry
- 4 Preparing meals
- 5 Shopping for groceries
- 6 Getting around outside
- 7 Going places outside of walking distance
- 8 Managing Money
- 9 Taking medicine

A		B		D	
a. Name of helper/organization					
b. Type of help (Circle all that apply)	b. Type of help (Circle all that apply)	b. Type of help (Circle all that apply)	b. Type of help (Circle all that apply)	b. Type of help (Circle all that apply)	b. Type of help (Circle all that apply)
0 ADL IADL 1-3 Doing housework/laundry 4 Preparing meals 5 Shopping for groceries 6 Help getting around outside 7 Going places outside of walking distance 8 Managing money 9 Helping take medicine 10 Nursing services	0 ADL IADL 1-3 Doing housework/laundry 4 Preparing meals 5 Shopping for groceries 6 Help getting around outside 7 Going places outside of walking distance 8 Managing money 9 Helping take medicine 10 Nursing services	0 ADL IADL 1-3 Doing housework/laundry 4 Preparing meals 5 Shopping for groceries 6 Help getting around outside 7 Going places outside of walking distance 8 Managing money 9 Helping take medicine 10 Nursing services	0 ADL IADL 1-3 Doing housework/laundry 4 Preparing meals 5 Shopping for groceries 6 Help getting around outside 7 Going places outside of walking distance 8 Managing money 9 Helping take medicine 10 Nursing services	0 ADL IADL 1-3 Doing housework/laundry 4 Preparing meals 5 Shopping for groceries 6 Help getting around outside 7 Going places outside of walking distance 8 Managing money 9 Helping take medicine 10 Nursing services	0 ADL IADL 1-3 Doing housework/laundry 4 Preparing meals 5 Shopping for groceries 6 Help getting around outside 7 Going places outside of walking distance 8 Managing money 9 Helping take medicine 10 Nursing services
Enter address and telephone when asking OB, page 5 or 6.	Enter address and telephone when asking OB, page 5 or 6.	Enter address and telephone when asking OB, page 5 or 6.	Enter address and telephone when asking OB, page 5 or 6.	Enter address and telephone when asking OB, page 5 or 6.	Enter address and telephone when asking OB, page 5 or 6.
c. Number and street					
City	City	City	City	City	City
State	State	State	State	State	State
Zip code					
Area Code					
Number	Number	Number	Number	Number	Number
DK Refused					
d. Paid Help (circle)					
1 Yes					
2 No					

FOR ADDITIONAL HELPERS, RECORD ADDITIONAL HELPERS FORM

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

RETURN TO:

Office of Disability, Aging and Long-Term Care Policy (DALTCP) Home
[\[http://aspe.hhs.gov/office_specific/daltcp.cfm\]](http://aspe.hhs.gov/office_specific/daltcp.cfm)

Assistant Secretary for Planning and Evaluation (ASPE) Home
[\[http://aspe.hhs.gov\]](http://aspe.hhs.gov)

U.S. Department of Health and Human Services Home
[\[http://www.hhs.gov\]](http://www.hhs.gov)