



California Department of Health Care Services
California Partnership For Long-Term Care
P.O. Box 997413
Mailstop 4100
Sacramento, CA 95899-7413

Dear Policyholder:

Your insurance company has reported that you recently purchased a long-term care insurance policy approved by the California Partnership for Long-Term Care. As the Acting Director of the California Partnership for Long-Term Care and on behalf of the California Department of Health Care Services, I would like to thank you for purchasing a California Partnership long-term care insurance policy. Additionally, I am writing to ask for your assistance in helping us evaluate the California Partnership program by completing and mailing back the enclosed **confidential** survey.

The California Partnership is an innovative program that has national significance, and we are especially interested in individuals such as you, who have decided to participate in the Partnership by purchasing a Partnership policy. The enclosed survey will provide essential information which will help us to properly evaluate the California Partnership program and develop improved plans for providing and financing long-term care services for Californians.

I realize that some of the information we are requesting is of a sensitive nature. However, I want to assure you that the information we are seeking will be used for research purposes only. *All information will be held in strict confidence.* Information that we report will be of a statistical nature only. Please answer the questions as honestly and completely as possible. If you are unable or prefer not to answer certain questions, you may leave them blank. Please return the survey in the enclosed self-addressed, postage pre-paid envelope to the California Partnership.

If you have any questions regarding this survey, please call me at (916) 552-8990. If you have questions concerning your policy, please contact your agent. Thank you for your participation.

Sincerely,

A handwritten signature in cursive script that reads "Brenda Bufford".

Brenda Bufford, Director
California Partnership for
Long-Term Care

Enclosures

PS: If you decided not to keep your policy (dropped it) please check this box . If you were not accepted for coverage, please check this box and return this letter in the postage pre-paid envelope.



CALIFORNIA PARTNERSHIP FOR
LONG-TERM CARE

CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE BASELINE SURVEY

Thank you for taking a few minutes to answer this survey. Your answers will be used for research purposes only. ***Any information you provide will be held in strict confidence.***

SECTION ONE

Your answers to the first set of questions will provide us with background information on people who purchase long-term care insurance policies which were approved by the **California Partnership for Long-Term Care**.

1. What is your date of birth? Month: _____ Day: _____ Year: _____
2. What is your sex? (Check the correct box.) Male Female
3. What is your current marital status? (Check ONE box.) Married Divorced
 Single Widowed Domestic Partner Legally Separated
4. a. What is your ethnicity? (Check ONE box.)
 White /Euro American Japanese Korean Asian Indian Guamanian
 African American Chinese Vietnamese Thai Samoan
 Filipino Cambodian Hawaiian American Indian Eskimo
 Aleut Other: _____
- b. If Hispanic or Latino, which of the following ethnicities best identify you?
 Mexican/Mexican American/Chicano(a) Puerto Rican Cuban Other: _____
5. What are your current living arrangements? (Check ALL that apply.)
 Live alone Live with nonrelatives Live with spouse Live with unmarried partner
 Live with other relatives Live with children Children live with me
6. How many people live in your household (including you)? _____
7. If you have living adult children, how many of them live within one hour's travel distance from you? _____

SECTION TWO

Now we would like to ask you some questions about the Partnership Long-Term Care Insurance Policy you just purchased.

- 8. Were you considering purchasing long-term care insurance before you heard about the California Partnership for Long-Term Care? *(Check ONE box.)* Yes No
- 9. Did the California Partnership for Long-Term Care influence your decision to purchase long-term care insurance? *(Check ONE box.)* Yes No
- 10. Would you have purchased long-term care insurance in the absence of the Partnership? *(Check ONE box.)* Yes No
- 11. If you are married, did your spouse also purchase a long-term care insurance policy? *(Check ONE box.)* Yes No
 Not married
- 12. Do you currently have more than one long-term care insurance policy for yourself? (Include any and all long-term care policies, whether or not Medi-Cal asset protection is provided by the policy.) *(Check ONE box.)* Yes No
- 13. Why did you decide to purchase long-term care insurance? *(Check ALL that apply.)*
 - To pay for services I might need in the future.
 - To financially protect my spouse/family in case I need long-term care someday.
 - To protect my assets.
 - To avoid needing Medi-Cal.
 - As an alternative to transferring assets to qualify for Medi-Cal.
 - My children recommended I purchase long-term care insurance.
 - Others recommended I purchase long-term care insurance.
 - Avoid reliance for care on my spouse/family members.
 - After reviewing information received from the Partnership or an insurance agent.
 - Other: _____

14. In selecting your policy, how important was each of the following? *(Check ONE box for each category.)*

	Very Important	Important	Not Important	Not Offered To Me
State "seal of approval"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medi-Cal asset protection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More affordable premiums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coverage for home and community services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coverage for case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No requirement that you be hospitalized before benefits are paid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advice of insurance agent or financial planner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumer information provided by The California Partnership	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION THREE

Now we would like to ask you a few questions about your health. We want to know whether people who purchase long-term care insurance have particular health problems.

15. Compared to other persons your age, would you say your health is: *(Check ONE box.)*

- Excellent Good Fair Poor

16. Is there any physical condition, illness, or health problem for which you are being treated now or were treated any time within the last SIX MONTHS?

(Check ONE box.)

- Yes No

17. Below is a list of health conditions. For each condition, *please check if yes, leave blank if no:*

COLUMN 1: If you have ever been diagnosed or been treated by a member of the medical profession for any of the following conditions.

COLUMN 2: If you have the condition now.

	HAD IT IN THE PAST?	HAVE IT NOW?
	YES	YES
Arthritis, rheumatism, or gout	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory illness (i.e., asthma, chronic bronchitis, TB, emphysema)	<input type="checkbox"/>	<input type="checkbox"/>
Eye disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (i.e., high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition (i.e., heart attack, congestive heart failure, angina)	<input type="checkbox"/>	<input type="checkbox"/>
Circulation problems in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, thyroid, or other hormone or endocrine problems	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or intestinal disorder (i.e., ulcer, gall bladder, polyps, colitis)	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (including leukemia)	<input type="checkbox"/>	<input type="checkbox"/>
Stroke or brain hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>
Nerve or muscle disorder	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or other blood problems	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's disease or serious memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Hip fracture	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of the spine, disk, or joints	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or mental/psychiatric conditions	<input type="checkbox"/>	<input type="checkbox"/>
Liver or kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/drug dependency	<input type="checkbox"/>	<input type="checkbox"/>

18. BECAUSE OF A DISABILITY OR HEALTH PROBLEM, do you RECEIVE help from another person for any of the following activities? (Check ONE box for each activity.)

	RECEIVE HELP	NO HELP
Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>
Shopping for groceries	<input type="checkbox"/>	<input type="checkbox"/>
Doing routine household chores	<input type="checkbox"/>	<input type="checkbox"/>
Managing money	<input type="checkbox"/>	<input type="checkbox"/>
Doing laundry	<input type="checkbox"/>	<input type="checkbox"/>
Taking medications	<input type="checkbox"/>	<input type="checkbox"/>
Getting to places out of walking distance	<input type="checkbox"/>	<input type="checkbox"/>
Using the telephone	<input type="checkbox"/>	<input type="checkbox"/>
Taking a bath or shower	<input type="checkbox"/>	<input type="checkbox"/>
Getting dressed	<input type="checkbox"/>	<input type="checkbox"/>
Getting in and out of a bed or chair	<input type="checkbox"/>	<input type="checkbox"/>
Using the toilet	<input type="checkbox"/>	<input type="checkbox"/>
Feeding yourself	<input type="checkbox"/>	<input type="checkbox"/>
Maintaining control of your bowel/bladder function	<input type="checkbox"/>	<input type="checkbox"/>
Getting around inside the house	<input type="checkbox"/>	<input type="checkbox"/>

19. Which of the following activities are you ABLE to do without help? (Check ONE box for each activity.)

	NOT ABLE TO DO	ABLE TO DO
Walk up and down one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>
Go to a movie, to church/synagogue, to meeting, or to visit friends	<input type="checkbox"/>	<input type="checkbox"/>
Do heavy work around the house, like shoveling snow or washing walls	<input type="checkbox"/>	<input type="checkbox"/>
Walk half a mile (about eight ordinary blocks)	<input type="checkbox"/>	<input type="checkbox"/>

20. During the **past six months**, how many times were you admitted as a patient **IN A HOSPITAL** and stayed at least **OVERNIGHT**? _____

21. During the **past six months**, how many times did you use **AN EMERGENCY ROOM** at a hospital? _____

22. During the **past six months**, how many times did you visit **A MEDICAL DOCTOR OR CLINIC**, not counting emergency room care or overnight hospital stays? _____

SECTION FOUR

Next we would like to know how well our information programs are working. The following questions ask you about the educational and promotional activities of the California Partnership for Long-Term Care.

23. How did you hear about the California Partnership for Long-Term Care? *(Check ALL that apply.)*

- Relative or spouse
- My employer
- Radio, television, or newspaper advertisement
- Newspaper article
- Radio or television news or talk shows
- California Partnership brochures
- Attended a Partnership group presentation
- Received counseling from a volunteer with the Department of Aging (HICAP)
- Insurance company literature or presentation
- Insurance agent
- Through my work with the insurance industry
- Financial advisor, planner or attorney
- I never heard of the Partnership until I received this survey
- Other: _____

24. How did you find out specific information about the long-term insurance policy you decided to purchase? *(Check ALL that apply.)*

- Relative or spouse
- California Partnership for Long-Term Care office
- Insurance company literature or presentation
- Insurance agent
- Through my work with the insurance industry
- Financial advisor, planner, or attorney
- My employer
- Other: _____

SECTION FIVE

Now we have a few questions about your income and assets. We do not want to know any specific dollar amounts. We just want to know whether people who purchase insurance have, on average, different levels of income or assets than people who do not.

25. What category best describes the total MONTHLY income—before taxes—in your household? (Include: wages, salaries, social security income, pensions, retirement benefits, veterans benefits, public assistance, investment income, rental income, and cash contributions from relatives or friends.) (Check ONE box.)

- | | |
|--|--|
| <input type="checkbox"/> Less than \$1,000 per month | <input type="checkbox"/> Between \$3,000 and \$3,999 per month |
| <input type="checkbox"/> Between \$1,000 and \$1,999 per month | <input type="checkbox"/> Between \$4,000 and \$4,999 per month |
| <input type="checkbox"/> Between \$2,000 and \$2,999 per month | <input type="checkbox"/> \$5,000 or more per month |

26. How many people are supported by this income (including you)? _____

27. What category best describes the total value of your assets? **DO NOT INCLUDE your home or your car.** DO INCLUDE bank accounts, stocks, bonds, investment or business property, and the cash value of any life insurance.) (Check ONE box.)

- | | |
|--|--|
| <input type="checkbox"/> Less than \$10,000 | <input type="checkbox"/> Between \$40,000 and \$49,999 |
| <input type="checkbox"/> Between \$10,000 and \$14,999 | <input type="checkbox"/> Between \$50,000 and \$99,999 |
| <input type="checkbox"/> Between \$15,000 and \$19,999 | <input type="checkbox"/> Between \$100,000 and \$199,999 |
| <input type="checkbox"/> Between \$20,000 and \$24,999 | <input type="checkbox"/> Between \$200,000 and \$349,999 |
| <input type="checkbox"/> Between \$25,000 and \$29,999 | <input type="checkbox"/> \$350,000 or more |
| <input type="checkbox"/> Between \$30,000 and \$39,999 | |

28. Do you own your own home or condominium? Yes No

29. If yes, what is the approximate present value of your home or condominium? \$ _____

30. What is the approximate equity you have on your home or condominium? \$ _____

That completes the survey. THANK YOU VERY MUCH FOR YOUR TIME AND COOPERATION.

PRIVACY STATEMENT

The information requested in this survey is in conformance with California Code of Regulations, Title 22, Section 58052(c)(2)(D), "Consent and Authorization to Release Information," which you read and signed as a condition for purchase of a California Partnership long-term care insurance policy. This information will be held in strict confidence and used for research purposes only and to aid the California Partnership for Long-Term Care in its evaluation of the Partnership policies and the State's Partnership program. Please mail the completed survey to the California Partnership for Long-Term Care, in the enclosed preaddressed and postage prepaid return envelope.