

National Post-acute and Long-term Care Study

2024 Adult Day Services Center Questionnaire

The Centers for Disease Control and Prevention conducts the National Post-acute and Long-term Care Study (NPALS). Please complete this questionnaire about the adult day services center at the location listed below.

- If this adult day services center is associated with another adult day services center or is part of a facility or campus that offers multiple levels of care, please answer only for the adult day services portion operating at the location listed below.
- Please consult records and other staff as needed to answer questions.
- If you need assistance or have questions, go to https://www.cdc.gov/nchs/npals/index.htm or call 1-855-500-1435.
- Thank you for taking the time to complete this questionnaire.

CASE ID
DIRECTOR'S NAME OR "CURRENT DIRECTOR"
FACILITY NAME, LICENSE NUMBER
FACILITY PHYSICAL STREET ADDRESS
CITY, ST ZIP

Please provide your contact information. Your information may be used for contact related to participation in current and future NPALS waves and will be kept confidential. PLEASE PRINT

Your name	First	Last
	Name	Name Name
Your work telephone		
number, with extension		Ext.
Your work e-mail address		
Your job title		

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Background Information

	Background Information	5.	What is the <u>maximum</u> number of particip allowed at this adult day services center a	at this	
1.	What is the type of ownership of this adult day services center? MARK ONLY ONE ANSWER Private—nonprofit Private—for profit Publicly traded company or limited liability company (LLC) Government—federal, state, county, or local Is this adult day services center	6.	location? This may be called the allowable capacity and is usually determined by law code but may also be a program decision. If none, enter "0." Maximum number of participants allowed Is this center owned by a person, group, organization that owns or manages two cadult day services centers? This may inclucorporate chain.	daily or by f or or or mor mor	
	MARK YES OR NO IN EACH ROW		○ Yes		
	Yes No		○ No		
	a. licensed or certified by your State specifically to provide adult day services, or accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)?	7.	Which one of the following best describes participant needs that the services of this are designed to meet? MARK ONLY ONE ONLY social/recreational needs—NO health/medical needs	cente	
	b. authorized or otherwise set up to participate in Medicaid (Medicaid state plan, Medicaid waiver, or Medicaid		 PRIMARILY social/recreational needs a health/medical needs EQUALLY social/recreational needs an 		MI
	managed care) or part of a Program of All-inclusive Care for the Elderly (PACE)?		health/medical needs PRIMARILY health/medical needs and	SOME	<u>:</u>
	If you answered "No" to both 2a <u>and</u> 2b, skip to question 37		social/recreational needs ONLY health/medical needs—NO social/recreational needs		
3.	What is the total number of participants <u>currently</u> <u>enrolled at</u> this adult day services center? Include all participants on this center's roster, no matter how frequently they attend, if they are receiving services at their residence or virtually (on-line or by telephone), if they share an enrollment spot, or if the center has temporarily closed or suspended services. If none, enter "0." Number of participants	8.	Of this center's revenue from paid partici about what percentage comes from each following sources? Your entries should add 100%. Enter "0" for any sources that do n a. Medicaid (include revenue from Medicaid state plans, Medicaid waivers, Medicaid managed care, or California regional centers) b. Medicare (include Medicare Advantage and Traditional or Original Medicare)	of the d up to	:
\rightarrow	If you answered "0," skip to question 37		c. Older Americans Act/Title III		%
4.	Based on a typical week, what is the approximate		d. Veteran's Administration		%
	average number of participants this adult day services center serves daily, either at this physical		e. Other federal, state, or local government		%
	location, at the participant's residence, or virtually (on-line or by telephone)? If none, enter "0."		f. Out-of-pocket payment by the participant or family]%
	Average daily attendance of participants		g. Private insurance		%
			h. Other source		%
			TOTAL		%
			NOTE: Your entries should add up to	100%.	

No → Skip to question 11 No → Skip to question 11 In which of the following diagnoses, conditions, or disabilities does this center specialize? MARK YES OR NO IN EACH ROW	accounting or billing purposes, does this services center use Electronic Health Rec		t day		or dis	cipants with particular dissabilities? Yes No → Skip to question 13				,
Electronic Health Records system support electronic Health Information exchange with each of the following providers? Do not include faxing. MARK YES OR NO IN EACH ROW Yes No a. Physician b. Pharmacy c. Hospital d. Skilled nursing facility, nursing home, or inpatient rehabilitation facility e. Other long-term care provider 13. In the last 12 months, did this center use any of the following types of telehealth tools to assess, diagnose, monitor, or treat participants? WARK YES, NO, OR DON'T KNOW IN EACH ROW Don't Know a. Telephone audio b. Videoconference software with audio (e.g., Zoom, Webex, FaceTime) Does this center have the following infection control policies and practices? MARK YES OR NO IN EACH ROW Yes No a. Have a written Emergency Operations Plan that is specific to or includes pandemic response b. Have a designated staff member or consultant responsible for coordinating the infection control program c. Offer annual influenza vaccination to participants d. Offer COVID-19 vaccination to all employees or contract staff e. Offer COVID-19 vaccination to all employees or contract staff g. Screen participants daily for infection (e.g., screen for fever or respiratory symptoms) if an outbreak occurs l. Impose restrictions on family, relatives, visitors, volunteers, or non-essential consultant personnel (e.g., barbers, delivery personnel) entering the building if an outbreak occurs	── Yes○ No → Skip to question 11				→ 12.	conditions, or disabilitie	s does t	his ce		
each of the following providers? Do not include faxing. MARK YES OR NO IN EACH ROW Yes No a. Physician b. Pharmacy c. Hospital d. Skilled nursing facility, nursing home, or inpatient rehabilitation facility e. Other long-term care provider 13. In the last 12 months, did this center use any of the following types of telehealth tools to assymment of the following	Electronic Health Records system su	appo					other			_
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a. Physician b. Pharmacy c. Hospital d. Skilled nursing facility, nursing home, or inpatient rehabilitation facility e. Other long-term care provider e. Other long-term care provider 13. In the last 12 months, did this center use any of the following types of telehealth tools to assess, which was monitor, or treat participants? MARK YES, NO, OR DON'T KNOW IN EACH ROW 14. Telephone audio b. Videoconference software with audio (e.g., Zoom, Webex, FaceTime) Does this center have the following infection control policies and practices? MARK YES OR NO IN EACH ROW A. Have a written Emergency Operations Plan that is specific to or includes pandemic response b. Have a designated staff member or consultant responsible for coordinating the infection control program c. Offer annual influenza vaccination to participants d. Offer annual influenza vaccination to all employees or contract staff e. Offer COVID-19 vaccination to all employees or contract staff g. Screen participants daily for infection (e.g., screen for fever or respiratory symptoms) if an outbreak occurs h. Limit hours or temporarily close this center if an outbreak occurs i. Impose restrictions on family, relatives, visitors, volunteers, or non-essential consultant personnel (e.g., barbers, delivery personnel) entering the building if an outbreak occurs	ROW	Voc	No			c. Multiple sclerosis			0	0
b. Pharmacy c. Hospital d. Skilled nursing facility, nursing home, or inpatient rehabilitation facility e. Other long-term care provider 13. In the last 12 months, did this center use any of the following types of telehealth tools to assess, diagnose, monitor, or treat participants? MARK YES, NO, OR DON'T KNOW IN EACH ROW Ves No a. Telephone audio b. Videoconference software with audio (e.g., Zoom, Webex, FaceTime) Does this center have the following infection control policies and practices? MARK YES OR NO IN EACH ROW Ves No a. Have a written Emergency Operations Plan that is specific to or includes pandemic response b. Have a designated staff member or consultant responsible for coordinating the infection control program c. Offer annual influenza vaccination to participants d. Offer annual influenza vaccination to all employees or contract staff e. Offer COVID-19 vaccination to all employees or contract staff g. Screen participants daily for infection (e.g., screen for fever or respiratory symptoms) if an outbreak occurs h. Limit hours or temporarily close this center if an outbreak occurs i. Impose restrictions on family, relatives, visitors, volunteers, or non-essential consultant personnel (e.g., barbers, delivery personnel) entering the building if an outbreak occurs	a Physician					d. Parkinsons disease			0	0
C. Hospital d. Skilled nursing facility, nursing home, or inpatient rehabilitation facility e. Other long-term care provider 13. In the last 12 months, did this center use any of the following types of telehealth tools to assess, diagnose, monitor, or treat participants? MARK YES, NO, OR DON'T KNOW IN EACH ROW Ves No a. Telephone audio b. Videoconference software with audio (e.g., Zoom, Webex, FaceTime) Does this center have the following infection control policies and practices? MARK YES OR NO IN EACH ROW A. Have a written Emergency Operations Plan that is specific to or includes pandemic response b. Have a designated staff member or consultant responsible for coordinating the infection control program c. Offer annual influenza vaccination to participants d. Offer annual influenza vaccination to all employees or contract staff e. Offer COVID-19 vaccination to all employees or contract staff g. Screen participants daily for infection (e.g., screen for fever or respiratory symptoms) if an outbreak occurs h. Limit hours or temporarily close this center if an outbreak occurs ii. Impose restrictions on family, relatives, visitors, volunteers, or non-essential consultant personnel (e.g., barbers, delivery personnel) entering the building if an outbreak occurs						e. Severe mental illness			0	0
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j. Masking if an outbreak occurs	a. Have a written Emergency Operations P b. Have a designated staff member or con program c. Offer annual influenza vaccination to pa d. Offer annual influenza vaccination to all e. Offer COVID-19 vaccination to participa f. Offer COVID-19 vaccination to all emplo g. Screen participants daily for infection (e outbreak occurs	Plan t sulta articip l emp nts oyees e.g., s	chat is int res pants oloyee s or co	specific to consible s or cont ntract st for feve	s and so or in for co	ith audio (e.g., Zoom, Yebex, FaceTime) practices? MARK YES OR includes pandemic responsion ordinating the infection of the control of the	NO IN E	Yes O O O O O	NA CO	0
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3

11. Is this a specialized center that serves only

8087124347

9. An Electronic Health Record (EHR) is a

Services Offered

5.	Services currently offered by this center car residence, or virtually (on-line or by telepho	n include services offered a one). For each service listed	t this physical location, at display the below, MARK ALL THAT A	a participant's APPLY IN EACH ROV
	This adult day services center	Provides the service by paid center employees or Arranges for the service to be provided by outside service providers	Refers participants or family to outside service providers	Does not provide, arrange, or refer for this service
	a. <u>Hospice or palliative care</u> services			0
	b. <u>Social work services</u> —provided by licensed social workers or persons with a bachelor's or master's degree in social work, and may include an array of services such as psychosocial assessment, individual or group counseling, support groups, and referral services			0
	c. Mental or behavioral health services—target participants' mental, emotional, psychological, or psychiatric well-being and may include diagnosing, describing, evaluating, and treating mental conditions			0
	d. <u>Therapy services</u> —physical, occupational, or speech therapies			0
	e. <u>Pharmacy services</u> —including filling of or delivery of prescriptions			0
	f. <u>Dietary and nutritional services</u> — including meal pickup or delivery			0
	g. <u>Skilled nursing services</u> —must be performed by an RN, LPN, or LVN and are medical in nature			0
	h. Transportation services for <u>medical or</u> <u>dental appointments</u>			0
	i. Daily round trip transportation services to or from this center			0
	j. Routine and emergency dental services by a licensed dentist			0
	k. <u>Home health care</u> —medical, therapeutic, and other health care services to help with post-acute and chronic illnesses			0
	I. <u>Home care</u> —assistance with completing self-care, activities of daily living, and instrumental activities of daily living such as housekeeping, errands, and appointments			0

Participant Profile

When answering questions 16-26, include all participants on this center's roster, no matter how frequently they attend, if they are receiving services at their residence or virtually (on-line or by telephone), if they share an enrollment spot, or if the center has temporarily closed or suspended services.

 Of the participants <u>currently enro</u> center, what is the age breakdow any categories with no participant 	n? Enter "0" for	18.	Of the participants <u>currently enrolled</u> what is the gender identity breakdow for any categories with no participant	wn? Enter "0"
	Number of Participants			Number of Participants
a. Under 65 years			a. Male	
b. 65–74 years			b. Female	
c. 75–84 years			c. Transgender, non-binary, or another gender	
d. 85 years or older			TOTAL	
TOTAL			NOTE: Total should be the same as t participants provided in ques	
NOTE: Total should be the same of participants provided i 7. Of the participants <u>currently enrolly</u> what is the racial-ethnic breakdow	n question 3. led at this center,	19.	Of the participants <u>currently enrolled</u> about how many have been diagnost the following conditions? <u>Enter "0" for categories with no participants</u> .	ed with each o or any
participant only once. If a non-Hispo falls under more than one category	anic participant			Number of Participants
them in the "Two or more races" co	tegory.		a. Alzheimer disease or other dementias	
	Number of Participants		b. Arthritis	
a. Hispanic or Latino, of any race			c. Asthma	
b. Two or more races, not Hispan	ic		d. Chronic kidney disease	
or Latino c. Middle eastern or North Africa	n,		e. COPD (chronic bronchitis or emphysema)	
not Hispanic or Latino d. American Indian or Alaska			f. Depression	
Native, not Hispanic or Latino			g. Diabetes	
d. Asian, not Hispanic or Latino f. Black, not Hispanic or Latino			h. Heart disease (for example, congestive heart failure, coronary or ischemic heart disease, heart	
g. Native Hawaiian or Other Pacif Islander, not Hispanic or Latino			i. High blood pressure or	
h. White, not Hispanic or Latino			hypertension j. Intellectual or developmental disability	
i. Some other category reported in this center's system			k. Osteoporosis	
j. Not reported (race and ethnicit unknown)	ty	20.	As best you know, of the participants enrolled at this center, about how m	
ТОТА			treated in a hospital emergency department of the last 90 days? If none, enter "0."	
NOTE: Total should be the same a participants provided in qu			Number of participants	

21.	As best you know, of the participants <u>currently</u> <u>enrolled</u> at this center, about how many were discharged from an overnight hospital stay in the <u>last 90 days</u> ? Exclude trips to the hospital emergency department that did not result in an overnight hospital stay. If none, enter "0."	25.	from and the partic about ho usual res following	ce refers to needing an other person, or use of cipants <u>currently enrolly</u> w many now need <u>anyidence or this center</u> is activities? Enter "0" for the content of the cont	assistive devices. Of lled at this center, y assistance at their n each of the
	Number of participants		·	·	Number of Participants
22.	During the <u>last 30 days</u> , for how many of the participants <u>currently enrolled at</u> this adult day		a. With t	ransferring in and out o	
	services center did Medicaid pay for some or all of their services received at this center? Please include		b. With e	eating, like cutting up fo	ood
	any participants that received funding from a Medicaid state plan, Medicaid waiver, Medicaid		c. With o	dressing	
	managed care, or California regional center. If none, enter "0."		d. With b	oathing or showering	
	Number of participants		e. With u	using the bathroom ing)	
23.	In the <u>last 12 months</u> , how many coronavirus disease (COVID-19) cases did this center have among participants? If none, enter "0."		this in walker	ocomotion or walking– cludes using a cane, r, or wheelchair and/or rom another person	
→	Number of COVID-19 cases If you answered "0", skip to question 25	26.	enrolled	ou know, of the partic at this center, about h O days? Include falls th	ow many had a fall ir
	▶24. Of the COVID-19 cases in your center in the last 12 months, how many cases resulted in each of the following? Enter "0" if none or select don't know if you do not know the number. Number of COVID-19 Cases a. Hospitalization b. Death		injured, a participal fall per po more tha during th or rehabi	off-site, whether or no and whether or not anyon the fall or caught them. articipant who fell, ever n one time. If one of you e last 90 days, but is cu litation facility, please i ant. If no participants ha	one saw the Please just count one Please just count one In the participant fell pur participants fell pur participants fell pur participants fell include that person in ad a fall, enter "0."
	Staff	Profi	ile		
27.	An individual is considered an <u>employee</u> if the center behalf. For <u>each</u> staff type below, indicate how many <u>currently</u> has. Include employees who work at this physor by telephone). Enter "0" for any categories with no	/ <u>full-ti</u> sical lo	<mark>me emplo</mark> cation, at a	yees and part-time em	ployees this center
	a. Registered nurses (RNs)			Time Employees	Time Employees
	b. Licensed practical nurses (LPNs) / licensed vocationa	I nurse	s (LVNs)		
	 c. Certified nursing assistants, nursing assistants, home home care aides, personal care aides, personal care medication technicians or medication aides 	health	aides,		
	d. Social workers—licensed social workers or persons v or master's degree in social work	vith a b	achelor's		
	e. Activities directors or activities staff				
		6			5159124344

	out are not directly employed by the cent contract or agency staff? Include contract strictually (on-line or by telephone). Yes No -> Skip to question 30		ho w	ork at i			
	29. For <u>each</u> staff type below, indicate h agency staff this center <u>currently</u> has Enter "0" for any categories with no	Do no	ot inc	clude in	dividual.		
	Effect o for any categories with no	contra	ct oi	agene	y Stain.	Number of Full-Time Contract or Agency Staff	Number of Part-Time Contract or Agency Staff
	a. Registered nurses (RNs)						
	b. Licensed practical nurses (LPNs) / li (LVNs)	censed	lvoc	ational	nurses		
	c. Certified nursing assistants, nursing aides, home care aides, personal ca assistants, and medication technici	are aide	es, pe	ersonal	care		
	d. Social workers—licensed social workers—bachelor's or master's degree in so		•	sons w	ith a		
	e. Activities directors or activities staf	f					
home	ext series of questions asks about <u>aide emp</u> health aides, home care aides, personal ca cation aides. Contract workers are not to be	ire aide	s, pe	ersonal			
		•• • •			inswers.		n technicians or
ti	Does this center offer the following benefime aide employees? MARK YES OR NO IN EACH ROW				How m	nany hours of training	does this center requiesch of the following?
ti N	ime aide employees? MARK YES OR NO IN EACH ROW	Yes I	ull-		How m	nany hours of training mployees to have for	does this center requiesch of the following?
ti N	ime aide employees?	Yes I			How maide er Enter "	nany hours of training mployees to have for	does this center required.
ti N a b	ime aide employees? MARK YES OR NO IN EACH ROW . Health insurance for the employee only b. Health insurance that includes family	Yes I	No O		How maide er Enter " a. Initia prov	nany hours of training in ployees to have for or of training of training all training prior to widing care tinuing education, on-	does this center required.
ti N a. b	ime aide employees? MARK YES OR NO IN EACH ROW . Health insurance for the employee only . Health insurance that includes family coverage . Dental, vision, or prescription drug	Yes I	No O		How maide er Enter " a. Initia prov	nany hours of training imployees to have for of training of training all training prior to viding care tinuing education, oning, or on-the-job	does this center required or the following?
a. b c. d	ime aide employees? MARK YES OR NO IN EACH ROW . Health insurance for the employee only . Health insurance that includes family coverage . Dental, vision, or prescription drug benefits . Life insurance . A pension, a 401(k), or a 403(b)	Yes I	No O		How maide er Enter " a. Initia provide. Congoin	nany hours of training imployees to have for of training of training all training prior to viding care tinuing education, oning, or on-the-job	does this center required or the following?
a. b c. d e f.	ime aide employees? MARK YES OR NO IN EACH ROW . Health insurance for the employee only coverage . Dental, vision, or prescription drug benefits . Life insurance . A pension, a 401(k), or a 403(b) . Paid childcare, childcare subsidies, or assistance . Paid personal time off, vacation time, or	Yes 1	No O O O O O	32.	How maide er Enter " a. Initia provious Congoin train Does the lifting a	nany hours of training imployees to have for o o'' if no hours of train all training prior to o'iding care itinuing education, oning on on-the-job hing is center provide assaides, belts, trapeze be	does this center required of the following? ing are required. Number of hours istive devices, such as ars, or other assistive
a. b c. d e f.	ime aide employees? MARK YES OR NO IN EACH ROW . Health insurance for the employee only coverage . Dental, vision, or prescription drug benefits . Life insurance . A pension, a 401(k), or a 403(b) . Paid childcare, childcare subsidies, or assistance . Paid personal time off, vacation time, or sick leave	Yes I	No	32.	a. Initia provide train	nany hours of training imployees to have for of training if no hours of training all training prior to widing care itinuing education, oning education, oning its center provide assaides, belts, trapeze benent, to your aide eming participants who care	does this center required of the following? ing are required. Number of hours
a. b. c. d. e. f.	ime aide employees? MARK YES OR NO IN EACH ROW . Health insurance for the employee only b. Health insurance that includes family coverage . Dental, vision, or prescription drug benefits l. Life insurance c. A pension, a 401(k), or a 403(b) c. Paid childcare, childcare subsidies, or assistance c. Paid personal time off, vacation time, or sick leave c. Overtime pay	Yes I	No	32.	a. Initia provide their or lifting a equipment or lifting a equipmen	nany hours of training imployees to have for of training if no hours of training all training prior to widing care itinuing education, oning education, oning its center provide assaides, belts, trapeze benent, to your aide eming participants who care	does this center required of the following? ing are required. Number of hours istive devices, such as ars, or other assistive ployees when moving
a. b c. d e f. g.	ime aide employees? MARK YES OR NO IN EACH ROW . Health insurance for the employee only coverage . Dental, vision, or prescription drug benefits . Life insurance . A pension, a 401(k), or a 403(b) . Paid childcare, childcare subsidies, or assistance . Paid personal time off, vacation time, or sick leave	Yes I O I O I O I O I O I O I O I O I O I	No	32.	a. Initia provide train	nany hours of training imployees to have for of training if no hours of training all training prior to widing care itinuing education, oning education, oning its center provide assaides, belts, trapeze benent, to your aide eming participants who care	does this center required of the following? ing are required. Number of hours istive devices, such as ars, or other assistive ployees when moving

•					ining										
34.	How often does this jobs? Include any true MARK ONLY ONE RE	aining	offer	ed w			ning an	aiue una ai	y training offer	cu sirici	e uiue.	s stui	ted v	VOIKIII	g.
								Training i always offered	Training i offered occasional or as need	Tı ly offe	aining ered ra or nev	arely		n't Kn	ow
	a. Discussing particip families	ant ca	re wi	th pa	articiį	oants'		0	0		0			0	
	b. Dementia care							0	0		0			0	
	c. Working with part abusive	icipant	s tha	it act	out	or are		0	0		0			0	
	d. Preventing person	al inju	ries a	t wo	rk			\circ	0		\bigcirc			\bigcirc	
	e. End of life issues (advance care planning and help families cope with grief)f. Relating to participants of different cultures or				help	0	0		0			0			
	ethnicities, or with	differ	ent v	alue	s or b	eliefs		0	0		0			0	
	g. Infection control (personal protectiv						g)	0	0		0			0	
con	tract staff. We then in	vited t	he so	ample	ed dii	rect co	are wor	kers to com	formation for t plete a question ould you have a	naire b	y mai	l or w	veb.		atior
con	tract staff. We then in	you to ou have direct	parti ve acc care de us r dire	icipat cess t emp s with	te in a to the bloye h this are en	rect co a future follo es? If	re wing yes,	36. W	plete a questio	ccess to e <u>contr</u> us with	o the fact stands this contra	follow aff? If	ving i yes, mation	inform would	
con	If we were to invite of DCW Study, would you would you be able to	you to ou have direct o provi act you Have Acces	parti ve aco care de us r dire e ss?	icipaticess to employees with ect ca	te in a to the bloye h this are en	a future follo es? If mploy le to vide?	re wing yes,	36. W for be	plete a question ould you have a your direct can able to provide	ccess to e control us with t care c	o the fact state that this contra	follow aff? If infori	ving i yes, mations ff?	inform would on to le to vide?	
con	If we were to invite of DCW Study, would y information for your would you be able to information to contain	you to you have direct p provi act you Hav Acces	parti ve acc care de us r dire e ss?	icipaticess to employees with ect ca	te in a to the bloye h this are en	a future folloes? If the mploy le to vide?	re wing yes,	36. W for be co	plete a question ould you have a your direct can able to provide ntact your direc	ccess to e contr us with t care c	o the fact stands on tra	follow aff? If infor ct sta	ving if yes, matic	inform would on to le to vide? Yes	
con	If we were to invite of DCW Study, would y information for your would you be able to information to contain	you to ou hav direct provi act you Hav Acces	partive accide using directions. Yes	icipaticess to employees with ect ca	te in a to the bloye h this are en	a future follo es? If somploy le to vide?	re wing yes,	36. W for be co	plete a question ould you have a your direct can able to provide ntact your direct	ccess to e control us with t care c	o the fact state that this contra	followaff? If information in the state of th	ving if yes, matic	inform would on to	
con	If we were to invite DCW Study, would y information for your would you be able to information to contains. Full name b. Mailing address	you to ou have direct provi act you Acces No Questio	partive accide using the service accidents of the service accidents of the service accidents of the service accidents. Yes	icipaticess to employ switches with the ect can be employed by the ect can be expected by the expected	te in a to the bloge h this are en O	a future follo es? If somploy le to vide? Yes Control of the contr	re worn wing yes, vees?	36. W for be co	plete a question ould you have a your direct can able to provide ntact your direct ull name Mailing address mail address	ccess to e control us with t care c	o the fact state that this contract veess?	followaff? If information in the state of th	ving if yes, matic ff? Ab Proposition O	inform would on to	