Patient _____ Identifier _____ Date _____

LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 3.00

PATIENT ASSESSMENT FORM - EXPIRED

Section A Administrative Information

A0050. Type of Record

Enter Code ☐

1. **Add new assessment/record**
2. **Modify existing record**
3. **Inactivate existing record**

A0100. Facility Provider Numbers. Enter Code in boxes provided.

A. National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐

B. CMS Certification Number (CCN): ☐☐☐☐☐☐☐☐☐☐☐☐

C. State Medicaid Provider Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0200. Type of Provider

Enter Code ☐

3. **Long-Term Care Hospital**

A0210. Assessment Reference Date

Observation end date: ☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A0220. Admission Date

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A0250. Reason for Assessment

Enter Code ☐☐

01. **Admission**
10. **Planned discharge**
11. **Unplanned discharge**
12. **Expired**

A0270. Discharge Date. This is the date of death.

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Section A Administrative Information

Patient Demographic Information

A0500. Legal Name of Patient

A. First name:

B. Middle initial:

C. Last name:

D. Suffix:

A0600. Social Security and Medicare Numbers

A. Social Security Number: ___ – ___ – ____

B. Medicare number (or comparable railroad insurance number)**:**

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

A0800. Gender

Enter Code

1. **Male**
2. **Female**

A0900. Birth Date

__ – __ – ____

Month Day Year

A1000. Race/Ethnicity

Check all that apply

- ☐ **A. American Indian or Alaska Native**
- ☐ **B. Asian**
- ☐ **C. Black or African American**
- ☐ **D. Hispanic or Latino**
- ☐ **E. Native Hawaiian or Other Pacific Islander**
- ☐ **F. White**

Section A Administrative Information

A1400. Payer Information

↓ Check all that apply	
☐	**A. Medicare** (traditional fee-for-service)
☐	**B. Medicare** (managed care/Part C/Medicare Advantage)
☐	**C. Medicaid** (traditional fee-for-service)
☐	**D. Medicaid** (managed care)
☐	**E. Workers' compensation**
☐	**F. Title programs** (e.g., Title III, V, or XX)
☐	**G. Other government** (e.g., TRICARE, VA, etc.)
☐	**H. Private insurance/Medigap**
☐	**I. Private managed care**
☐	**J. Self-pay**
☐	**K. No payor source**
☐	**X. Unknown**
☐	**Y. Other**

Section J Health Conditions

J1800. Any Falls Since Admission

Enter Code ☐

Has the patient **had any falls since admission?**

0. **No** → *Skip to Z0400. Signature of Persons Completing the Assessment*
1. **Yes** → *Continue to J1900. Number of Falls Since Admission*

J1900. Number of Falls Since Admission

CODING:
0. None
1. One
2. Two or more

↓ Enter Codes in Boxes	
☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
☐	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that submitting false information may subject my organization to a 2% reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Assessment Completion

A. Signature:

B. LTCH CARE Data Set Completion Date:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year