

Outcome and Assessment Information Set (OASIS-B1)

Items to be Used at Specific Time Points

<u>Start of Care</u> -----	Home Health Patient Tracking Sheet, M0080-M0826
Start of care—further visits planned	
<u>Resumption of Care</u> -----	M0080-M0826
Resumption of care (after inpatient stay)	
<u>Follow-Up</u> -----	M0080-M0110, M0230-M0250, M0390, M0420, M0440, M0450, M0460, M0470, M0474, M0476, M0488, M0490, M0520-M0550, M0650-M0700, M0800, M0826
Recertification (follow-up) assessment	
Other follow-up assessment	
<u>Transfer to an Inpatient Facility</u> -----	M0080-M0100, M0830-M0855, M0890-M0906
Transferred to an inpatient facility—patient not discharged from an agency	
Transferred to an inpatient facility—patient discharged from agency	
<u>Discharge from Agency — Not to an Inpatient Facility</u>	
Death at home -----	M0080-M0100, M0906
Discharge from agency -----	M0080-M0100, M0200-M0220, M0250, M0280-M0380, M0410-M0820, M0830-M0880, M0903-M0906

Note: For items M0640-M0800, please note special instructions at the beginning of the section.

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

(M0090) Date Assessment Completed:

___/___/___
month day year

(M0100) This Assessment is Currently Being Completed for the Following Reason:

Start/Resumption of Care

- ☐ 1 – Start of care—further visits planned
☐ 3 – Resumption of care (after inpatient stay)

Follow-Up

- ☐ 4 – Recertification (follow-up) reassessment [Go to M0110]
☐ 5 – Other follow-up [Go to M0110]

Transfer to an Inpatient Facility

- ☐ 6 – Transferred to an inpatient facility—patient not discharged from agency [Go to M0830]
☐ 7 – Transferred to an inpatient facility—patient discharged from agency [Go to M0830]

Discharge from Agency — Not to an Inpatient Facility

- ☐ 8 – Death at home [Go to M0906]
☐ 9 – Discharge from agency [Go to M0200]

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?

- ☐ 1 - Early
- ☐ 2 - Later
- ☐ UK - Unknown
- ☐ NA - Not Applicable: No Medicare case mix group to be defined by this assessment.

At follow-up go to M0230

DEMOGRAPHICS AND PATIENT HISTORY

(M0175) From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days?
(Mark all that apply.)

- ☐ 1 - Hospital
- ☐ 2 - Rehabilitation facility
- ☐ 3 - Skilled nursing facility
- ☐ 4 - Other nursing home
- ☐ 5 - Other (specify) _____
- ☐ NA - Patient was not discharged from an inpatient facility **[If NA, go to M0200]**

(M0180) Inpatient Discharge Date (most recent):

____/____/____
month day year

- ☐ UK - Unknown

(M0190) List each **Inpatient Diagnosis** and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no surgical, E-codes, or V-codes):

	<u>Inpatient Facility Diagnosis</u>	<u>ICD-9-CM</u>
a.	_____	(____.____)
b.	_____	(____.____)

(M0200) Medical or Treatment Regimen Change Within Past 14 Days: Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days?

- ☐ 0 - No **[If No, go to M0220; if No at Discharge, go to M0250]**
- ☐ 1 - Yes

(M0210) List the patient's **Medical Diagnoses** and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical, E-codes, or V-codes)::

	<u>Changed Medical Regimen Diagnosis</u>	<u>ICD-9-CM</u>
a.	_____	(____.____)
b.	_____	(____.____)
c.	_____	(____.____)
d.	_____	(____.____)

(M0220) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

- ☐ 1 - Urinary incontinence
- ☐ 2 - Indwelling/suprapubic catheter
- ☐ 3 - Intractable pain
- ☐ 4 - Impaired decision-making
- ☐ 5 - Disruptive or socially inappropriate behavior
- ☐ 6 - Memory loss to the extent that supervision required
- ☐ 7 - None of the above
- ☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
- ☐ UK - Unknown

M0230/240/246 Diagnoses, Severity Index, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2) . Rate each condition (Column 2) using the severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) V codes (for M0230 or M0240) or E codes (for M0240 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V code is reported in place of a case mix diagnosis, then optional item M0246 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group.

Code each row as follows:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the severity of the condition listed in Column 1 using the following scale:

- 0 - Asymptomatic, no treatment needed at this time
- 1 - Symptoms well controlled with current therapy
- 2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
- 3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
- 4 - Symptoms poorly controlled; history of re-hospitalizations

Column 3: (OPTIONAL) If a V code reported in any row in Column 2 is reported in place of a case mix diagnosis, list the appropriate case mix diagnosis (the description and the ICD-9-CM code) in the same row in Column 3. Otherwise, leave Column 3 blank in that row.

Column 4: (OPTIONAL) If a V code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M0230) Primary Diagnosis & (M0240) Other Diagnoses		(M0246) Case Mix Diagnoses (OPTIONAL)	
(1)	(2)	(3)	(4)
	ICD-9-CM and severity rating for each condition	Complete only if a V code in Column 2 is reported in place of a case mix diagnosis.	Complete only if the V code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM / Severity Rating	Description/ ICD-9-CM	Description/ ICD-9-CM
(M0230) Primary Diagnosis	(V codes are allowed)	(V or E codes NOT allowed)	(V or E codes NOT allowed)
a. _____	a. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	a. _____ (____ . ____)	a. _____ (____ . ____)
(M0240) Other Diagnoses	(V or E codes are allowed)	(V or E codes NOT allowed)	(V or E codes NOT allowed)
b. _____	b. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	b. _____ (____ . ____)	b. _____ (____ . ____)
c. _____	c. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	c. _____ (____ . ____)	c. _____ (____ . ____)
d. _____	d. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	d. _____ (____ . ____)	d. _____ (____ . ____)
e. _____	e. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	e. _____ (____ . ____)	e. _____ (____ . ____)
f. _____	f. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	f. _____ (____ . ____)	f. _____ (____ . ____)

(M0250) Therapies the patient receives at home: **(Mark all that apply.)**

- ☐ 1 - Intravenous or infusion therapy (excludes TPN)
- ☐ 2 - Parenteral nutrition (TPN or lipids)
- ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 - None of the above

(M0260) Overall Prognosis: BEST description of patient's overall prognosis for recovery from this episode of illness.

- ☐ 0 - Poor: little or no recovery is expected and/or further decline is imminent
- ☐ 1 - Good/Fair: partial to full recovery is expected
- ☐ UK - Unknown

(M0270) Rehabilitative Prognosis: BEST description of patient's prognosis for functional status.

- ☐ 0 - Guarded: minimal improvement in functional status is expected; decline is possible
- ☐ 1 - Good: marked improvement in functional status is expected
- ☐ UK - Unknown

(M0280) Life Expectancy: (Physician documentation is not required.)

- ☐ 0 - Life expectancy is greater than 6 months
- ☐ 1 - Life expectancy is 6 months or fewer

(M0290) High Risk Factors characterizing this patient: **(Mark all that apply.)**

- ☐ 1 - Heavy smoking
- ☐ 2 - Obesity
- ☐ 3 - Alcohol dependency
- ☐ 4 - Drug dependency
- ☐ 5 - None of the above
- ☐ UK - Unknown

LIVING ARRANGEMENTS

(M0300) Current Residence:

- ☐ 1 - Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/significant other)
- ☐ 2 - Family member's residence
- ☐ 3 - Boarding home or rented room
- ☐ 4 - Board and care or assisted living facility
- ☐ 5 - Other (specify) _____

(M0340) Patient Lives With: **(Mark all that apply.)**

- ☐ 1 - Lives alone
- ☐ 2 - With spouse or significant other
- ☐ 3 - With other family member
- ☐ 4 - With a friend
- ☐ 5 - With paid help (other than home care agency staff)
- ☐ 6 - With other than above

SUPPORTIVE ASSISTANCE

(M0350) Assisting Person(s) Other than Home Care Agency Staff: **(Mark all that apply.)**

- ☐ 1 - Relatives, friends, or neighbors living outside the home
- ☐ 2 - Person residing in the home (EXCLUDING paid help)
- ☐ 3 - Paid help
- ☐ 4 - None of the above [If None of the above, go to M0390]
- ☐ UK - Unknown [If Unknown, go to M0390]

(M0360) Primary Caregiver taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff):

- ☐ 0 - No one person [If No one person, go to M0390]
- ☐ 1 - Spouse or significant other
- ☐ 2 - Daughter or son
- ☐ 3 - Other family member
- ☐ 4 - Friend or neighbor or community or church member
- ☐ 5 - Paid help
- ☐ UK - Unknown [If Unknown, go to M0390]

(M0370) How Often does the patient receive assistance from the primary caregiver?

- ☐ 1 - Several times during day and night
- ☐ 2 - Several times during day
- ☐ 3 - Once daily
- ☐ 4 - Three or more times per week
- ☐ 5 - One to two times per week
- ☐ 6 - Less often than weekly
- ☐ UK - Unknown

(M0380) Type of Primary Caregiver Assistance: (Mark all that apply.)

- ☐ 1 - ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
- ☐ 2 - IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances)
- ☐ 3 - Environmental support (housing, home maintenance)
- ☐ 4 - Psychosocial support (socialization, companionship, recreation)
- ☐ 5 - Advocates or facilitates patient's participation in appropriate medical care
- ☐ 6 - Financial agent, power of attorney, or conservator of finance
- ☐ 7 - Health care agent, conservator of person, or medical power of attorney
- UK - Unknown

SENSORY STATUS

(M0390) Vision with corrective lenses if the patient usually wears them:

- ☐ 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- ☐ 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

(M0400) Hearing and Ability to Understand Spoken Language in patient's own language (with hearing aids if the patient usually uses them):

- ☐ 0 - No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation.
- ☐ 1 - With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice.
- ☐ 2 - Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance.
- ☐ 3 - Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, additional time.
- ☐ 4 - Unable to hear and understand familiar words or common expressions consistently, or patient nonresponsive.

(M0410) Speech and Oral (Verbal) Expression of Language (in patient's own language):

- ☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- ☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- ☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- ☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- ☐ 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
- ☐ 5 - Patient nonresponsive or unable to speak.

(M0420) Frequency of Pain interfering with patient's activity or movement:

- ☐ 0 - Patient has no pain or pain does not interfere with activity or movement
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time

(M0430) Intractable Pain: Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?

- ☐ 0 - No
- ☐ 1 - Yes

INTEGUMENTARY STATUS

(M0440) Does this patient have a **Skin Lesion** or an **Open Wound**? This excludes "OSTOMIES."

- ☐ 0 - No [If No, go to **M0490**]
- ☐ 1 - Yes

(M0445) Does this patient have a **Pressure Ulcer**?

- ☐ 0 - No [If No, go to **M0468**]
- ☐ 1 - Yes

(M0450) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.)

Pressure Ulcer Stages		Number of Pressure Ulcers				
a)	Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.	0	1	2	3	4 or more
b)	Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.	0	1	2	3	4 or more
c)	Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.	0	1	2	3	4 or more
d)	Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.)	0	1	2	3	4 or more
e)	In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes					

(M0460) [At follow-up, skip to M0470 if patient has no pressure ulcers]

Stage of Most Problematic (Observable) Pressure Ulcer:

- ☐ 1 - Stage 1
- ☐ 2 - Stage 2
- ☐ 3 - Stage 3
- ☐ 4 - Stage 4
- ☐ NA - No observable pressure ulcer

(M0464) Status of Most Problematic (Observable) Pressure Ulcer:

- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable pressure ulcer

(M0468) Does this patient have a **Stasis Ulcer**?

- ☐ 0 - No [If No, go to **M0482**]
- ☐ 1 - Yes

(M0470) Current Number of Observable Stasis Ulcer(s):

- ☐ 0 - Zero
- ☐ 1 - One
- ☐ 2 - Two
- ☐ 3 - Three
- ☐ 4 - Four or more

(M0474) Does this patient have at least one **Stasis Ulcer that Cannot be Observed** due to the presence of a nonremovable dressing?

- ☐ 0 - No
- ☐ 1 - Yes

(M0476) [At follow-up, skip to M0488 if patient has no stasis ulcers]

Status of Most Problematic (Observable) Stasis Ulcer:

- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable stasis ulcer

(M0482) Does this patient have a **Surgical Wound**?

- ☐ 0 - No [If No, go to **M0490**]
- ☐ 1 - Yes

(M0484) Current Number of (Observable) Surgical Wounds: (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.)

- ☐ 0 - Zero
- ☐ 1 - One
- ☐ 2 - Two
- ☐ 3 - Three
- ☐ 4 - Four or more

(M0486) Does this patient have at least one **Surgical Wound that Cannot be Observed** due to the presence of a nonremovable dressing?

- ☐ 0 - No
- ☐ 1 - Yes

(M0488) [At follow-up, skip to M0490 if patient has no surgical wounds]

Status of Most Problematic (Observable) Surgical Wound:

- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable surgical wound

RESPIRATORY STATUS

(M0490) When is the patient dyspneic or noticeably **Short of Breath**?

- ☐ 0 - Never, patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

(M0500) **Respiratory Treatments** utilized at home: **(Mark all that apply.)**

- ☐ 1 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continually or at night)
- ☐ 3 - Continuous positive airway pressure
- ☐ 4 - None of the above

ELIMINATION STATUS

(M0510) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient on prophylactic treatment
- ☐ UK - Unknown

(M0520) **Urinary Incontinence or Urinary Catheter Presence:**

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [If No, go to M0540]
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) [Go to M0540]

(M0530) When does **Urinary Incontinence** occur?

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - During the night only
- ☐ 2 - During the day and night

(M0540) **Bowel Incontinence Frequency:**

- ☐ 0 - Very rarely or never has bowel incontinence
- ☐ 1 - Less than once weekly
- ☐ 2 - One to three times weekly
- ☐ 3 - Four to six times weekly
- ☐ 4 - On a daily basis
- ☐ 5 - More often than once daily
- ☐ NA - Patient has ostomy for bowel elimination
- ☐ UK - Unknown

(M0550) **Ostomy for Bowel Elimination:** Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?

- ☐ 0 - Patient does not have an ostomy for bowel elimination.
- ☐ 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
- ☐ 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M0560) Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)

- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ☐ 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

(M0570) When Confused (Reported or Observed):

- ☐ 0 - Never
- ☐ 1 - In new or complex situations only
- ☐ 2 - On awakening or at night only
- ☐ 3 - During the day and evening, but not constantly
- ☐ 4 - Constantly
- ☐ NA - Patient nonresponsive

(M0580) When Anxious (Reported or Observed):

- ☐ 0 - None of the time
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time
- ☐ NA - Patient nonresponsive

(M0590) Depressive Feelings Reported or Observed in Patient: (Mark all that apply.)

- ☐ 1 - Depressed mood (e.g., feeling sad, tearful)
- ☐ 2 - Sense of failure or self reproach
- ☐ 3 - Hopelessness
- ☐ 4 - Recurrent thoughts of death
- ☐ 5 - Thoughts of suicide
- ☐ 6 - None of the above feelings observed or reported

(M0610) Behaviors Demonstrated at Least Once a Week (Reported or Observed): (Mark all that apply.)

- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

(M0620) Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):

- ☐ 0 - Never
- ☐ 1 - Less than once a month
- ☐ 2 - Once a month
- ☐ 3 - Several times each month
- ☐ 4 - Several times a week
- ☐ 5 - At least daily

(M0630) Is this patient receiving **Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?**

- ☐ 0 - No
- ☐ 1 - Yes

ADL/IADLs

For M0640-M0800, complete the "Current" column for all patients. For these same items, complete the "Prior" column only at start of care and at resumption of care; mark the level that corresponds to the patient's condition 14 days prior to start of care date (M0030) or resumption of care date (M0032). In all cases, record what the patient is *able to do*.

(M0640) Grooming: Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

- | Prior | Current | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Grooming utensils must be placed within reach before able to complete grooming activities. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - Someone must assist the patient to groom self. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - Patient depends entirely upon someone else for grooming needs. |
| <input type="checkbox"/> | | UK - Unknown |

(M0650) Ability to Dress Upper Body (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- | Prior | Current | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - Someone must help the patient put on upper body clothing. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - Patient depends entirely upon another person to dress the upper body. |
| <input type="checkbox"/> | | UK - Unknown |

(M0660) Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

- | Prior | Current | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to obtain, put on, and remove clothing and shoes without assistance. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - Patient depends entirely upon another person to dress lower body. |
| <input type="checkbox"/> | | UK - Unknown |

(M0670) Bathing: Ability to wash entire body. **Excludes grooming (washing face and hands only).**

- | Prior | Current | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to bathe self in <u>shower or tub</u> independently. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - With the use of devices, is able to bathe self in shower or tub independently. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - Able to bathe in shower or tub with the assistance of another person:
(a) for intermittent supervision or encouragement or reminders, <u>OR</u>
(b) to get in and out of the shower or tub, <u>OR</u>
(c) for washing difficult to reach areas. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - Participates in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4 - <u>Unable</u> to use the shower or tub and is bathed in <u>bed or bedside chair</u> . |
| <input type="checkbox"/> | <input type="checkbox"/> | 5 - Unable to effectively participate in bathing and is totally bathed by another person. |
| <input type="checkbox"/> | | UK - Unknown |

(M0680) Toileting: Ability to get to and from the toilet or bedside commode.

- | Prior | Current | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to get to and from the toilet independently with or without a device. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance). |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4 - Is totally dependent in toileting. |
| <input type="checkbox"/> | | UK - Unknown |

(M0690) Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

Prior	Current	
<input type="checkbox"/>	<input type="checkbox"/>	0 - Able to independently transfer.
<input type="checkbox"/>	<input type="checkbox"/>	1 - Transfers with minimal human assistance or with use of an assistive device.
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Unable</u> to transfer self but is able to bear weight and pivot during the transfer process.
<input type="checkbox"/>	<input type="checkbox"/>	3 - Unable to transfer self and is <u>unable</u> to bear weight or pivot when transferred by another person.
<input type="checkbox"/>	<input type="checkbox"/>	4 - Bedfast, unable to transfer but is able to turn and position self in bed.
<input type="checkbox"/>	<input type="checkbox"/>	5 - Bedfast, unable to transfer and is <u>unable</u> to turn and position self.
<input type="checkbox"/>		UK - Unknown

(M0700) Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Prior	Current	
<input type="checkbox"/>	<input type="checkbox"/>	0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
<input type="checkbox"/>	<input type="checkbox"/>	1 - Requires use of a device (e.g., cane, walker) to walk alone <u>or</u> requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
<input type="checkbox"/>	<input type="checkbox"/>	2 - Able to walk only with the supervision or assistance of another person at all times.
<input type="checkbox"/>	<input type="checkbox"/>	3 - Chairfast, <u>unable</u> to ambulate but is able to wheel self independently.
<input type="checkbox"/>	<input type="checkbox"/>	4 - Chairfast, unable to ambulate and is <u>unable</u> to wheel self.
<input type="checkbox"/>	<input type="checkbox"/>	5 - Bedfast, unable to ambulate or be up in a chair.
<input type="checkbox"/>		UK - Unknown

(M0710) Feeding or Eating: Ability to feed self meals and snacks. **Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.**

Prior	Current	
<input type="checkbox"/>	<input type="checkbox"/>	0 - Able to independently feed self.
<input type="checkbox"/>	<input type="checkbox"/>	1 - Able to feed self independently but requires: (a) meal set-up; <u>OR</u> (b) intermittent assistance or supervision from another person; <u>OR</u> (c) a liquid, pureed or ground meat diet.
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack.
<input type="checkbox"/>	<input type="checkbox"/>	3 - Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.
<input type="checkbox"/>	<input type="checkbox"/>	4 - <u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
<input type="checkbox"/>	<input type="checkbox"/>	5 - Unable to take in nutrients orally or by tube feeding.
<input type="checkbox"/>		UK - Unknown

(M0720) Planning and Preparing Light Meals (e.g., cereal, sandwich) or reheat delivered meals:

Prior	Current	
<input type="checkbox"/>	<input type="checkbox"/>	0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; <u>OR</u> (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
<input type="checkbox"/>	<input type="checkbox"/>	1 - <u>Unable</u> to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
<input type="checkbox"/>	<input type="checkbox"/>	2 - Unable to prepare any light meals or reheat any delivered meals.
<input type="checkbox"/>		UK - Unknown

(M0730) Transportation: Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway).

Prior	Current	
<input type="checkbox"/>	<input type="checkbox"/>	0 - Able to independently drive a regular or adapted car; <u>OR</u> uses a regular or handicap-accessible public bus.
<input type="checkbox"/>	<input type="checkbox"/>	1 - Able to ride in a car only when driven by another person; <u>OR</u> able to use a bus or handicap van only when assisted or accompanied by another person.
<input type="checkbox"/>	<input type="checkbox"/>	2 - <u>Unable</u> to ride in a car, taxi, bus, or van, and requires transportation by ambulance.
<input type="checkbox"/>		UK - Unknown

(M0740) Laundry: Ability to do own laundry -- to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand.

Prior Current

- | | | | |
|--------------------------|--------------------------|----|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 | - (a) Able to independently take care of all laundry tasks; <u>OR</u>
(b) Physically, cognitively, and mentally able to do laundry and access facilities, <u>but</u> has not routinely performed laundry tasks in the past (i.e., prior to this home care admission). |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 | - Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 | - <u>Unable</u> to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation. |
| <input type="checkbox"/> | | UK | - Unknown |

(M0750) Housekeeping: Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.

Prior Current

- | | | | |
|--------------------------|--------------------------|----|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 | - (a) Able to independently perform all housekeeping tasks; <u>OR</u>
(b) Physically, cognitively, and mentally able to perform <u>all</u> housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this home care admission). |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 | - Able to perform only <u>light</u> housekeeping (e.g., dusting, wiping kitchen counters) tasks independently. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 | - Able to perform housekeeping tasks with intermittent assistance or supervision from another person. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 | - <u>Unable</u> to consistently perform any housekeeping tasks unless assisted by another person throughout the process. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4 | - Unable to effectively participate in any housekeeping tasks. |
| <input type="checkbox"/> | | UK | - Unknown |

(M0760) Shopping: Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.

Prior Current

- | | | | |
|--------------------------|--------------------------|----|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 | - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; <u>OR</u>
(b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission). |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 | - Able to go shopping, but needs some assistance:
(a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; <u>OR</u>
(b) <u>Unable</u> to go shopping alone, but can go with someone to assist. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 | - <u>Unable</u> to go shopping, but is able to identify items needed, place orders, and arrange home delivery. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 | - Needs someone to do all shopping and errands. |
| <input type="checkbox"/> | | UK | - Unknown |

(M0770) Ability to Use Telephone: Ability to answer the phone, dial numbers, and effectively use the telephone to communicate.

Prior Current

- | | | | |
|--------------------------|--------------------------|----|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 | - Able to dial numbers and answer calls appropriately and as desired. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 | - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 | - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 | - Able to answer the telephone only some of the time or is able to carry on only a limited conversation. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4 | - <u>Unable</u> to answer the telephone at all but can listen if assisted with equipment. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5 | - Totally unable to use the telephone. |
| <input type="checkbox"/> | <input type="checkbox"/> | NA | - Patient does not have a telephone. |
| <input type="checkbox"/> | | UK | - Unknown |

MEDICATIONS

(M0780) Management of Oral Medications: Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

Prior Current

- | | | | | |
|--------------------------|--------------------------|----|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 | - | Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 | - | Able to take medication(s) at the correct times if:
(a) individual dosages are prepared in advance by another person; <u>OR</u>
(b) given daily reminders; <u>OR</u>
(c) someone develops a drug diary or chart. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 | - | <u>Unable</u> to take medication unless administered by someone else. |
| <input type="checkbox"/> | <input type="checkbox"/> | NA | - | No oral medications prescribed. |
| <input type="checkbox"/> | | UK | - | Unknown |

(M0790) Management of Inhalant/Mist Medications: Patient's ability to prepare and take all prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes all other forms of medication (oral tablets, injectable and IV medications).**

Prior Current

- | | | | | |
|--------------------------|--------------------------|----|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 | - | Able to independently take the correct medication and proper dosage at the correct times. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 | - | Able to take medication at the correct times if:
(a) individual dosages are prepared in advance by another person, <u>OR</u>
(b) given daily reminders. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 | - | <u>Unable</u> to take medication unless administered by someone else. |
| <input type="checkbox"/> | <input type="checkbox"/> | NA | - | No inhalant/mist medications prescribed. |
| <input type="checkbox"/> | | UK | - | Unknown |

(M0800) Management of Injectable Medications: Patient's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

Prior Current

- | | | | | |
|--------------------------|--------------------------|----|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 | - | Able to independently take the correct medication and proper dosage at the correct times. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 | - | Able to take injectable medication at correct times if:
(a) individual syringes are prepared in advance by another person, <u>OR</u>
(b) given daily reminders. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 | - | <u>Unable</u> to take injectable medications unless administered by someone else. |
| <input type="checkbox"/> | <input type="checkbox"/> | NA | - | No injectable medications prescribed. |
| <input type="checkbox"/> | | UK | - | Unknown |

EQUIPMENT MANAGEMENT

(M0810) Patient Management of Equipment (includes ONLY oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies): Patient's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**

- | | | | |
|--------------------------|----|---|---|
| <input type="checkbox"/> | 0 | - | Patient manages all tasks related to equipment completely independently. |
| <input type="checkbox"/> | 1 | - | If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment. |
| <input type="checkbox"/> | 2 | - | Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task. |
| <input type="checkbox"/> | 3 | - | Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment. |
| <input type="checkbox"/> | 4 | - | Patient is completely dependent on someone else to manage all equipment. |
| <input type="checkbox"/> | NA | - | No equipment of this type used in care [If NA, go to M0826] |

(M0820) Caregiver Management of Equipment (includes ONLY oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies): Caregiver's ability to set up, monitor, and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**

- ☐ 0 - Caregiver manages all tasks related to equipment completely independently.
- ☐ 1 - If someone else sets up equipment, caregiver is able to manage all other aspects.
- ☐ 2 - Caregiver requires considerable assistance from another person to manage equipment, but independently completes significant portions of task.
- ☐ 3 - Caregiver is only able to complete small portions of task (e.g., administer nebulizer treatment, clean/store/dispose of equipment or supplies).
- ☐ 4 - Caregiver is completely dependent on someone else to manage all equipment.
- ☐ NA - No caregiver
- ☐ UK - Unknown

THERAPY NEED

(M0826) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

- (_ _ _) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).
- ☐ NA - Not Applicable: No case mix group defined by this assessment.

EMERGENCY CARE

(M0830) Emergent Care: Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? **(Mark all that apply.)**

- ☐ 0 - No emergent care services **[If no emergent care, go to M0855]**
- ☐ 1 - Hospital emergency room (includes 23-hour holding)
- ☐ 2 - Doctor's office emergency visit/house call
- ☐ 3 - Outpatient department/clinic emergency (includes urgicenter sites)
- ☐ UK - Unknown **[If UK, go to M0855]**

(M0840) Emergent Care Reason: For what reason(s) did the patient/family seek emergent care? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Nausea, dehydration, malnutrition, constipation, impaction
- ☐ 3 - Injury caused by fall or accident at home
- ☐ 4 - Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)
- ☐ 5 - Wound infection, deteriorating wound status, new lesion/ulcer
- ☐ 6 - Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain)
- ☐ 7 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 8 - GI bleeding, obstruction
- ☐ 9 - Other than above reasons
- ☐ UK - Reason unknown

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(M0855) To which Inpatient Facility has the patient been admitted?

- ☐ 1 - Hospital **[Go to M0890]**
- ☐ 2 - Rehabilitation facility **[Go to M0903]**
- ☐ 3 - Nursing home **[Go to M0900]**
- ☐ 4 - Hospice **[Go to M0903]**
- ☐ NA - No inpatient facility admission

(M0870) Discharge Disposition: Where is the patient after discharge from your agency? **(Choose only one answer.)**

- ☐ 1 - Patient remained in the community (not in hospital, nursing home, or rehab facility)
- ☐ 2 - Patient transferred to a noninstitutional hospice [**Go to M0903**]
- ☐ 3 - Unknown because patient moved to a geographic location not served by this agency [**Go to M0903**]
- ☐ UK - Other unknown [**Go to M0903**]

(M0880) After discharge, does the patient receive health, personal, or support **Services or Assistance**? **(Mark all that apply.)**

- ☐ 1 - No assistance or services received
- ☐ 2 - Yes, assistance or services provided by family or friends
- ☐ 3 - Yes, assistance or services provided by other community resources (e.g., meals-on-wheels, home health services, homemaker assistance, transportation assistance, assisted living, board and care)

Go to M0903

(M0890) If the patient was admitted to an acute care **Hospital**, for what **Reason** was he/she admitted?

- ☐ 1 - Hospitalization for emergent (unscheduled) care
- ☐ 2 - Hospitalization for urgent (scheduled within 24 hours of admission) care
- ☐ 3 - Hospitalization for elective (scheduled more than 24 hours before admission) care
- ☐ UK - Unknown

(M0895) Reason for Hospitalization: (Mark all that apply.)

- ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Injury caused by fall or accident at home
- ☐ 3 - Respiratory problems (SOB, infection, obstruction)
- ☐ 4 - Wound or tube site infection, deteriorating wound status, new lesion/ulcer
- ☐ 5 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 6 - GI bleeding, obstruction
- ☐ 7 - Exacerbation of CHF, fluid overload, heart failure
- ☐ 8 - Myocardial infarction, stroke
- ☐ 9 - Chemotherapy
- ☐ 10 - Scheduled surgical procedure
- ☐ 11 - Urinary tract infection
- ☐ 12 - IV catheter-related infection
- ☐ 13 - Deep vein thrombosis, pulmonary embolus
- ☐ 14 - Uncontrolled pain
- ☐ 15 - Psychotic episode
- ☐ 16 - Other than above reasons

Go to M0903

(M0900) For what **Reason(s)** was the patient **Admitted** to a **Nursing Home**? **(Mark all that apply.)**

- ☐ 1 - Therapy services
- ☐ 2 - Respite care
- ☐ 3 - Hospice care
- ☐ 4 - Permanent placement
- ☐ 5 - Unsafe for care at home
- ☐ 6 - Other
- ☐ UK - Unknown

(M0903) Date of Last (Most Recent) Home Visit:

___/___/___
month day year

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

___/___/___
month day year