

MINIMUM DATA SET (MDS) - Version 3.0 **RESIDENT ASSESSMENT AND CARE SCREENING** *Nursing Home and Swing Bed Tracking (NT/ST) Item Set*

Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code

Type of provider

1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction to prior comprehensive** assessment
06. **Significant correction to prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay

07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
- Not PPS Assessment**
99. **Not PPS** assessment

Enter Code

C. PPS Other Medicare Required Assessment - OMRA

0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2

0. **No**
1. **Yes**

Enter Code

E. Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent admission?

0. **No**
1. **Yes**

Enter Code

F. Entry/discharge reporting

01. **Entry** record
10. **Discharge** assessment-return not anticipated
11. **Discharge** assessment-return anticipated
12. **Death in facility** record
99. **Not entry/discharge** record

Section A**Identification Information****A0410. Submission Requirement**

Enter Code

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident**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

- | | |
|--------------------------|---|
| <input type="checkbox"/> | A. American Indian or Alaska Native |
| <input type="checkbox"/> | B. Asian |
| <input type="checkbox"/> | C. Black or African American |
| <input type="checkbox"/> | D. Hispanic or Latino |
| <input type="checkbox"/> | E. Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> | F. White |

A1200. Marital Status

Enter Code

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

Section A Identification Information

A1300. Optional Resident Items

A. Medical record number:

B. Room number:

C. Name by which resident prefers to be addressed:

D. Lifetime occupation(s) - put "/" between two occupations:

A1600. Entry Date (date of this admission/reentry into the facility)

— —
Month Day Year

A1700. Type of Entry

Enter Code

1. **Admission**
2. **Reentry**

A1800. Entered From

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
99. **Other**

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

— —
Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
08. **Deceased**
99. **Other**

Section A

Identification Information

A2400. Medicare Stay

<div>Enter Code</div> <div></div>	<div>A. Has the resident had a Medicare-covered stay since the most recent entry?</div> <div>0. No → Skip to X0100, Type of Record</div> <div>1. Yes → Continue to A2400B, Start date of most recent Medicare stay</div> <div>B. Start date of most recent Medicare stay:</div> <div> <div>—</div> <div>—</div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div>C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:</div> <div> <div>—</div> <div>—</div> <div>Month</div> <div>Day</div> <div>Year</div> </div>
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Section X**Correction Request****X0100. Type of Record**

Enter Code <input type="text"/>	1. Add new record → Skip to Z0500, Signature of RN Assessment Coordinator 2. Modify existing record → Continue to X0150, Type of Provider 3. Inactivate existing record → Continue to X0150, Type of Provider
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Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider

Enter Code <input type="text"/>	Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed
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X0200. Name of Resident on existing record to be modified/inactivated

<input type="text"/>	A. First name:
	C. Last name:

X0300. Gender on existing record to be modified/inactivated

Enter Code <input type="text"/>	1. Male 2. Female
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X0400. Birth Date on existing record to be modified/inactivated

<input type="text"/>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div>—</div> <div>—</div> </div> <div style="display: flex; justify-content: space-around; align-items: center;"> <div>Month</div> <div>Day</div> <div>Year</div> </div>
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X0500. Social Security Number on existing record to be modified/inactivated

<input type="text"/>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div>—</div> <div>—</div> </div>
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X0600. Type of Assessment on existing record to be modified/inactivated

Enter Code <input type="text"/>	A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. Not OBRA required assessment
Enter Code <input type="text"/>	B. PPS Assessment <u>PPS Scheduled Assessments for a Medicare Part A Stay</u> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment <u>PPS Unscheduled Assessments for a Medicare Part A Stay</u> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <u>Not PPS Assessment</u> 99. Not PPS assessment
Enter Code <input type="text"/>	C. PPS Other Medicare Required Assessment - OMRA 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment

X0600 continued on next page

Section X**Correction Request****X0600. Type of Assessment - Continued**

Enter Code <input type="text"/>	D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2 0. No 1. Yes
Enter Code <input type="text"/>	F. Entry/discharge reporting 01. Entry record 10. Discharge assessment- return not anticipated 11. Discharge assessment- return anticipated 12. Death in facility record 99. Not entry/discharge record

X0700. Date on existing record to be modified/inactivated - Complete one only

<input type="text"/>	A. Assessment Reference Date - Complete only if X0600F = 99 <div style="display: flex; justify-content: space-around; width: 100%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>
	B. Discharge Date - Complete only if X0600F = 10, 11, or 12 <div style="display: flex; justify-content: space-around; width: 100%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>
	C. Entry Date - Complete only if X0600F = 01 <div style="display: flex; justify-content: space-around; width: 100%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request**X0800. Correction Number**

Enter Number <input type="text"/>	Enter the number of correction requests to modify/inactivate the existing record, including the present one
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X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 2)

↓ Check all that apply	
<input type="checkbox"/>	A. Transcription error
<input type="checkbox"/>	B. Data entry error
<input type="checkbox"/>	C. Software product error
<input type="checkbox"/>	D. Item coding error
<input type="checkbox"/>	Z. Other error requiring modification If "Other" checked, please specify: _____

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (X0100 = 3)

↓ Check all that apply	
<input type="checkbox"/>	A. Event did not occur
<input type="checkbox"/>	Z. Other error requiring inactivation If "Other" checked, please specify: _____

Section X

Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

	A. Attesting individual's first name:
	B. Attesting individual's last name:
	C. Attesting individual's title:
	D. Signature
	E. Attestation date <div>Month Day Year</div>

Section Z

Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident 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 ensuring that residents receive appropriate and quality care, and 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 I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. 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.			