

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

A0050. Type of Record

Enter Code

☐

1. **Add new record** → Continue to A0100, Facility Provider Numbers
2. **Modify existing record** → Continue to A0100, Facility Provider Numbers
3. **Inactivate existing record** → Skip to X0150, Type of Provider

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

☐
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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. **None of the above**

Enter Code

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B. PPS Assessment

PPS Scheduled Assessment for a Medicare Part A Stay

01. **5-day** scheduled assessment

PPS Unscheduled Assessment for a Medicare Part A Stay

08. **IPA** - Interim Payment Assessment

Not PPS Assessment

99. **None of the above**

Enter Code

☐

E. **Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry?**

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

Enter Code

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F. Entry/discharge reporting

01. **Entry** tracking record
10. **Discharge** assessment - **return not anticipated**
11. **Discharge** assessment - **return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

A0310 continued on next page

Section A - Identification Information

A0310. Type of Assessment - Continued

Enter Code

- G. Type of discharge** - Complete only if A0310F = 10 or 11
- 1. Planned**
 - 2. Unplanned**

Enter Code

- H. Is this a SNF Part A PPS Discharge Assessment?
0. No
1. Yes

A0410. Unit Certification or Licensure Designation

Enter Code

1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State
2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
3. Unit is Medicare and/or Medicaid certified

A0500. Legal Name of Resident

- | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|
| <p>A. First name:</p> <table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td> </tr> </table> | | | | | | | | | | | | | | | | | | | | | <p>B. Middle initial:</p> <table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="width: 100%;"></td> </tr> </table> | | | |
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| <p>C. Last name:</p> <table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td> </tr> </table> | | | | | | | | | | | | | | | | | | | | | <p>D. Suffix:</p> <table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="width: 33%;"></td><td style="width: 33%;"></td><td style="width: 33%;"></td> </tr> </table> | | | |
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A0600. Social Security and Medicare Numbers

- [illegible]

A0700. Medicaid Number

Enter “+” if pending, “N” if not a Medicaid recipient

[illegible]

A0810. Sex

Enter Code

1. Male
2. Female

A0900. Birth Date

Month Day Year

Section A - Identification Information

A1005. Ethnicity

Are you of Hispanic, Latino/a, or Spanish origin?

↓

Check all that apply

- | | |
|--------------------------|---|
| <input type="checkbox"/> | A. No, not of Hispanic, Latino/a, or Spanish origin |
| <input type="checkbox"/> | B. Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> | C. Yes, Puerto Rican |
| <input type="checkbox"/> | D. Yes, Cuban |
| <input type="checkbox"/> | E. Yes, another Hispanic, Latino/a, or Spanish origin |
| <input type="checkbox"/> | X. Resident unable to respond |
| <input type="checkbox"/> | Y. Resident declines to respond |

A1010. Race

What is your race?

↓

Check all that apply

- | | |
|--------------------------|-------------------------------------|
| <input type="checkbox"/> | A. White |
| <input type="checkbox"/> | B. Black or African American |
| <input type="checkbox"/> | C. American Indian or Alaska Native |
| <input type="checkbox"/> | D. Asian Indian |
| <input type="checkbox"/> | E. Chinese |
| <input type="checkbox"/> | F. Filipino |
| <input type="checkbox"/> | G. Japanese |
| <input type="checkbox"/> | H. Korean |
| <input type="checkbox"/> | I. Vietnamese |
| <input type="checkbox"/> | J. Other Asian |
| <input type="checkbox"/> | K. Native Hawaiian |
| <input type="checkbox"/> | L. Guamanian or Chamorro |
| <input type="checkbox"/> | M. Samoan |
| <input type="checkbox"/> | N. Other Pacific Islander |
| <input type="checkbox"/> | X. Resident unable to respond |
| <input type="checkbox"/> | Y. Resident declines to respond |
| <input type="checkbox"/> | Z. None of the above |

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:

[illegible]

B. Room number:

[illegible]

C. Name by which resident prefers to be addressed:

[illegible]

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

[illegible]

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

Month Day Year

A1700. Type of Entry

Enter Code

1. Admission
2. Reentry

A1805. Entered From

Enter Code

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01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**

A1900. Admission Date (Date this episode of care in this facility began)

Month Day Year

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

- -
 Month Day Year

Section A - Identification Information

A2105. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

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01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed**

A2400. Medicare Stay

Enter Code

--

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to Section X, Correction Request
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

		-			-				
Month			Day			Year			

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

		-			-				
Month			Day			Year			

Section X - Correction Request

Complete Section X only if A0050 = 2 or 3

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 (A0200 on existing record to be modified/inactivated)

Enter Code

5

Type of provider

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

X0200. Name of Resident (A0500 on existing record to be modified/inactivated)

A. First name:

[illegible]

C. Last name:

[illegible]

X0310. Sex (A0810 on existing record to be modified/inactivated)

Enter Code

9

1. Male
2. Female

X0400. Birth Date (A0900 on existing record to be modified/inactivated)

Month Day Year

X0500. Social Security Number (A0600A on existing record to be modified/inactivated)

			-			-				
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Section X - Correction Request

X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)

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. **None of the above**

Enter Code

B. PPS Assessment

PPS Scheduled Assessment for a Medicare Part A Stay

- 01. **5-day** scheduled assessment

PPS Unscheduled Assessment for a Medicare Part A Stay

- 08. **IPA** - Interim Payment Assessment

Not PPS Assessment

- 99. **None of the above**

Enter Code

F. Entry/discharge reporting

- 01. **Entry** tracking record
- 10. **Discharge** assessment - **return not anticipated**
- 11. **Discharge** assessment - **return anticipated**
- 12. **Death in facility** tracking record
- 99. **None of the above**

Enter Code

H. Is this a SNF Part A PPS Discharge Assessment?

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

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

A. Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

B. Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

C. Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

Section X - Correction Request

Correction Attestation Section

Complete this section to explain and attest to the modification/inactivation request

X0800. Correction Number

Enter Number

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Enter the number of correction requests to modify/inactivate the existing record, including the present one

X0900. Reasons for Modification

Complete only if Type of Record is to modify a record in error (A0050 = 2)

↓

Check all that apply

☐

A. Transcription error

☐

B. Data entry error

☐

C. Software product error

☐

D. Item coding error

☐

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 (A0050 = 3)

↓

Check all that apply

☐

A. Event did not occur

☐

Z. Other error requiring inactivation

If "Other" checked, please specify: _____

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

		-			-				
Month			Day			Year			

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.			

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