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# LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 5.3 PATIENT ASSESSMENT FORM - EXPIRED

Section A	Administrative Information
<b>A0050. Type of Record</b>	
Enter Code <div style="border: 1px solid black; width: 20px; height: 20px; margin: 5px;"></div>	1. <b>Add new assessment/record</b> 2. <b>Modify existing record</b> 3. <b>Inactivate existing record</b>
<b>A0100. Facility Provider Numbers. Enter Code in boxes provided.</b>	
	<b>A. National Provider Identifier (NPI):</b> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px;"></div> <b>B. CMS Certification Number (CCN):</b> <div style="border: 1px solid black; width: 120px; height: 20px; margin: 5px;"></div> <b>C. State Medicaid Provider Number:</b> <div style="border: 1px solid black; width: 150px; height: 20px; margin: 5px;"></div>
<b>A0200. Type of Provider</b>	
Enter Code <div style="border: 1px solid black; width: 20px; height: 20px; margin: 5px;"></div>	3. <b>Long-Term Care Hospital</b>
<b>A0210. Assessment Reference Date</b>	
	<b>Observation end date:</b> <div style="display: flex; align-items: center; margin: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small; margin-top: 2px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
<b>A0220. Admission Date</b>	
	<div style="display: flex; align-items: center; margin: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small; margin-top: 2px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
<b>A0250. Reason for Assessment</b>	
Enter Code <div style="border: 1px solid black; width: 20px; height: 20px; margin: 5px;"></div>	01. <b>Admission</b> 10. <b>Planned discharge</b> 11. <b>Unplanned discharge</b> 12. <b>Expired</b>
<b>A0270. Discharge Date. This is the date of death.</b>	
	<div style="display: flex; align-items: center; margin: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small; margin-top: 2px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>

<b>Section A</b>	<b>Administrative Information</b>
<b>Patient Demographic Information</b>	
<b>A0500. Legal Name of Patient</b>	
	<p><b>A. First name:</b></p> <div style="border: 1px solid black; width: 200px; height: 20px; margin-bottom: 5px;"></div> <p><b>B. Middle initial:</b></p> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 5px;"></div> <p><b>C. Last name:</b></p> <div style="border: 1px solid black; width: 300px; height: 20px; margin-bottom: 5px;"></div> <p><b>D. Suffix:</b></p> <div style="border: 1px solid black; width: 40px; height: 20px; margin-bottom: 5px;"></div>
<b>A0600. Social Security and Medicare Numbers</b>	
	<p><b>A. Social Security Number:</b></p> <div style="display: flex; align-items: center; margin-bottom: 5px;"> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">-</span> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">-</span> <div style="border: 1px solid black; width: 60px; height: 20px;"></div> </div> <p><b>B. Medicare number</b> (or comparable railroad insurance number):</p> <div style="border: 1px solid black; width: 150px; height: 20px; margin-bottom: 5px;"></div>
<b>A0700. Medicaid Number</b> - Enter "+" if pending, "N" if not a Medicaid recipient	
	<div style="border: 1px solid black; width: 200px; height: 20px; margin-bottom: 5px;"></div>
<b>A0810. Sex</b>	
Enter Code <div style="border: 1px solid black; width: 20px; height: 20px; margin: 5px 0;"></div>	<p>1. <b>Male.</b></p> <p>2. <b>Female</b></p>
<b>A0900. Birth Date</b>	
	<div style="display: flex; align-items: center; margin-bottom: 5px;"> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">-</span> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">-</span> <div style="border: 1px solid black; width: 60px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>

Section A	Administrative Information
A1400. Payer Information	
↓ Check all that apply	
<input type="checkbox"/>	A. Medicare (traditional fee-for-service)
<input type="checkbox"/>	B. Medicare (managed care/Part C/Medicare Advantage)
<input type="checkbox"/>	C. Medicaid (traditional fee-for-service)
<input type="checkbox"/>	D. Medicaid (managed care)
<input type="checkbox"/>	E. Workers' compensation
<input type="checkbox"/>	F. Title programs (e.g., Title III, V, or XX)
<input type="checkbox"/>	G. Other government (e.g., TRICARE, VA, etc.)
<input type="checkbox"/>	H. Private insurance/Medigap
<input type="checkbox"/>	I. Private managed care
<input type="checkbox"/>	J. Self-pay
<input type="checkbox"/>	K. No payer source
<input type="checkbox"/>	X. Unknown
<input type="checkbox"/>	Y. Other

Section J		Health Conditions	
J1800. Any Falls Since Admission			
Enter Code	Has the patient <b>had any falls since admission?</b>		
<div></div>	0. <b>No</b> → <i>Skip to N2005, Medication Intervention</i>		
	1. <b>Yes</b> → <i>Continue to J1900, Number of Falls Since Admission.</i>		
J1900. Number of Falls Since Admission			
Coding: 0. <b>None</b> 1. <b>One</b> 2. <b>Two or more</b>	↓ Enter Codes in Boxes		
	<div></div>	A. <b>No injury:</b> 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	
	<div></div>	B. <b>Injury (except major)</b> – as described in the LCDS Manual	
	<div></div>	C. <b>Major injury</b> – as described in the LCDS Manual	

Section N		Medications	
N2005. Medication Intervention			
Enter Code <div></div>		<div>Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?</div> <div><div>0. No</div><div>1. Yes</div><div>9. Not applicable - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications</div></div>	

Section Z		Assessment Administration	
Z0400. Signature of Persons Completing the Assessment			
<p>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.</p>			
Signature		Title	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	