

A PROJECT TO DEVELOP AN OUTCOME-BASED CONTINUOUS  
QUALITY IMPROVEMENT SYSTEM AND CORE OUTCOME AND  
COMPREHENSIVE ASSESSMENT DATA SET FOR PACE

**DRAFT COCOA DATA SET  
INTAKE/CONTACT FORM**

Conducted by:  
Center for Health Services Research  
University of Colorado Health Sciences Center

for:

Department of Health and Human Services  
Centers for Medicare & Medicaid Services

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0791. The time required to complete this information collection is estimated to vary from four to six minutes with an average of five minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment. Responses to the collection of the information are voluntary.

**FIRST PHASE RELIABILITY TEST  
DRAFT INTAKE/CONTACT FORM**

Site ID

Participant ID

1. **Participant Name:** \_\_\_\_\_  
(Last) (First) (MI) (Suffix)
2. **Date Form Completed:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
month day year
3. **Staff Member Completing Form (Name):** \_\_\_\_\_  
(Last) (First)
4. **Program Enrollment Date (Date PACE Services Began):** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
month day year
5. **Participant Social Security Number:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
☐ UK - Unknown or Not Available
6. **Gender:** ☐ 1 - Male  
☐ 2 - Female
7. **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ☐ UK - Unknown  
month day year
8. **Birthplace:** \_\_\_\_\_  
City State/Province Country
9. **Citizenship:** ☐ 1 - United States  
☐ 2 - Other (specify): \_\_\_\_\_
10. **Race/Ethnicity** (as identified by participant): **(Mark all that apply.)**  
☐ 1 - American Indian or Alaska Native  
☐ 2 - Asian  
☐ 3 - Black or African-American  
☐ 4 - Hispanic or Latino  
☐ 5 - Native Hawaiian or Pacific Islander  
☐ 6 - White  
☐ UK - Unknown
- 11a. **Medicare Number:** \_\_\_\_  
(including suffix)  
☐ NA - No Medicare [ **Go to Item c** ]
- b. **Medicare Entitlement:**  
☐ 1 - Part A and Part B  
☐ 2 - Part A only  
☐ 3 - Part B only
- c. **Medicaid Number:** \_\_\_\_  
☐ NA - No Medicaid [ **Go to Item 12** ]
- d. **Medicaid Eligibility:**  
☐ 1 - Medicaid and SSI  
☐ 2 - Medicaid, no SSI

12. **Participant Address:**

\_\_\_\_\_  
Street Address (include house/apt. number)

\_\_\_\_\_  
City State ZIP Code

County: \_\_\_\_\_

13. **Participant Phone Number:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_ ☐ NA - Participant does not have telephone

14. **Source of Referral:**

- ☐ 1 - Hospital
- ☐ 2 - SNF/ICF
- ☐ 3 - Home health agency/clinic
- ☐ 4 - Social service agency
- ☐ 5 - Individual health professional/clinic
- ☐ 6 - Family or friend
- ☐ 7 - Self-referral
- ☐ 8 - State agency
- ☐ 9 - Sponsoring or affiliated agency
- ☐ 10 - Other (specify): \_\_\_\_\_
- ☐ 11 - Undetermined

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

- ☐ 1 - Hospital
- ☐ 2 - Rehabilitation facility
- ☐ 3 - Skilled nursing home
- ☐ 4 - Other nursing home
- ☐ 5 - Other (specify): \_\_\_\_\_
- ☐ NA - Participant was not discharged from an inpatient facility

16. **Formal Services Being Received Prior to Enrollment:** **(Mark all that apply.)**

- ☐ 1 - Adult day care center
- ☐ 2 - Senior Center
- ☐ 3 - Nursing home
- ☐ 4 - Acute hospital
- ☐ 5 - Home health care
- ☐ 6 - Personal care in home
- ☐ 7 - Home chore services
- ☐ 8 - Congregate or portable meals

Notes (optional): \_\_\_\_\_

**17. Primary Contact Person:**

a. Name: \_\_\_\_\_  
(Last) (First) (MI) (Suffix)

Address: \_\_\_\_\_  
Street Address (include house/apt. number)

City State ZIP Code

Phone Number: Day: ( ) -  
Eve: ( ) -  
Pager: ( ) - (optional)

E-mail address: \_\_\_\_\_ (optional)

**b. Relationship to Participant:**

- ☐ 1 - Spouse  
☐ 2 - Daughter or son (including step)  
☐ 3 - Daughter-in-law or son-in-law  
☐ 4 - Sibling  
☐ 5 - Other relative (specify): \_\_\_\_\_  
☐ 6 - Friend  
☐ 7 - Other (specify): \_\_\_\_\_

c. Gender: ☐ 1 - Male  
☐ 2 - Female

d. Primary Languages Spoken: \_\_\_\_\_

e. Interpreter Needed? ☐ 0 - No  
☐ 1 - Yes

**18. Secondary Contact Person:**

☐ NA - No secondary contact person [ Go to Item 19 ]

a. Name: \_\_\_\_\_  
(Last) (First) (MI) (Suffix)

Address: \_\_\_\_\_  
Street Address (include house/apt. number)

City State ZIP Code

Phone Number: Day: ( ) -  
Eve: ( ) -  
Pager: ( ) - (optional)

E-mail address: \_\_\_\_\_ (optional)

**b. Relationship to Participant:**

- ☐ 1 - Spouse  
☐ 2 - Daughter or son (including step)  
☐ 3 - Daughter-in-law or son-in-law  
☐ 4 - Sibling  
☐ 5 - Other relative (specify): \_\_\_\_\_  
☐ 6 - Friend  
☐ 7 - Other (specify): \_\_\_\_\_

c. Gender: ☐ 1 - Male  
☐ 2 - Female

d. Primary Languages Spoken: \_\_\_\_\_

e. Interpreter Needed? ☐ 0 - No  
☐ 1 - Yes

19. **Next of Kin/Closest Relative:**

☐ Same as primary or secondary contact person [ Skip remaining data items and complete information box at end of form ]

a. Name: \_\_\_\_\_  
(Last) (First) (MI) (Suffix)

Address: \_\_\_\_\_  
Street Address (include house/apt. number)

\_\_\_\_\_  
City State ZIP Code

Phone Number: Day: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Eve: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Pager: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (optional)

E-mail address: \_\_\_\_\_ (optional)

b. Relationship to Participant:

- ☐ 1 - Spouse  
☐ 2 - Daughter or son (including step)  
☐ 3 - Daughter-in-law or son-in-law  
☐ 4 - Sibling  
☐ 5 - Other relative (specify): \_\_\_\_\_

c. Gender: ☐ 1 - Male  
☐ 2 - Female

d. Primary Languages Spoken: \_\_\_\_\_

e. Interpreter Needed? ☐ 0 - No  
☐ 1 - Yes

**The following question should be completed by the PACE care provider or staff member after completing the COCOA form.**

1. Estimated form completion time (in minutes): \_\_\_\_\_

**Please return the completed form to your site's Data Collection Coordinator.**

**Thank you for your participation.**