

# LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 3.00

## PATIENT ASSESSMENT FORM - EXPIRED

<b>Section A</b>	<b>Administrative Information</b>
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**A0050. Type of Record**

Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px;"></div>	1. <b>Add new assessment/record</b> 2. <b>Modify existing record</b> 3. <b>Inactivate existing record</b>
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**A0100. Facility Provider Numbers.** Enter Code in boxes provided.

	<b>A. National Provider Identifier (NPI):</b>  <b>B. CMS Certification Number (CCN):</b>  <b>C. State Medicaid Provider Number:</b>
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**A0200. Type of Provider**

Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px;"></div>	3. <b>Long-Term Care Hospital</b>
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**A0210. Assessment Reference Date**

	Observation end date: <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <span>—</span> <span>—</span> <span>—</span> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
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**A0220. Admission Date**

	<div style="display: flex; justify-content: space-around; margin-top: 10px;"> <span>—</span> <span>—</span> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
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**A0250. Reason for Assessment**

Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px;"></div>	01. <b>Admission</b> 10. <b>Planned discharge</b> 11. <b>Unplanned discharge</b> 12. <b>Expired</b>
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**A0270. Discharge Date.** This is the date of death.

	<div style="display: flex; justify-content: space-around; margin-top: 10px;"> <span>—</span> <span>—</span> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
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## Section A Administrative Information

### Patient Demographic Information

#### A0500. Legal Name of Patient

**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

☐

**A. American Indian or Alaska Native**

☐

**B. Asian**

☐

**C. Black or African American**

☐

**D. Hispanic or Latino**

☐

**E. Native Hawaiian or Other Pacific Islander**

☐

**F. White**

## Section A

## Administrative Information

### A1400. Payer Information

↓ Check all that apply

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

Section J

Health Conditions

J1800. Any Falls Since Admission

Enter Code	Has the patient <b>had any falls since admission?</b>
<div></div>	<div>0. <b>No</b> → <i>Skip to O0250. Influenza Vaccine</i></div> <div>1. <b>Yes</b> → <i>Continue to J1900. Number of Falls Since Admission</i></div>

J1900. Number of Falls Since Admission

<div>CODING:</div> <div>0. None</div> <div>1. One</div> <div>2. Two or more</div>	↓	Enter Codes in Boxes
	<div></div>	<b>A. 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> Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	<div></div>	<b>C. Major injury:</b> Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section O		Special Treatments, Procedures, and Programs	
<b>O0250. Influenza Vaccine - Refer to current version of LTCH Quality Reporting Program Manual for current influenza season and reporting period.</b>			
<div>Enter Code</div> <div></div>	<b>A.</b> Did the <b>patient receive the influenza vaccine in this facility</b> for this year's influenza <u>vaccination</u> season? 0. <b>No</b> → Skip to O0250C. If influenza vaccine not received, state reason 1. <b>Yes</b> → Continue to O0250B. Date influenza vaccine received		
	<b>B.</b> Date influenza vaccine received → Complete date and skip to Z0400. Signature of Persons Completing the Assessment  <div> <div>Month</div> <div>—</div> <div>Day</div> <div>—</div> <div>Year</div> </div>		
<div>Enter Code</div> <div></div>	<b>C. If influenza vaccine not received, state reason:</b> 1. <b>Patient not in this facility during this year's influenza vaccination season</b> 2. <b>Received outside of this facility</b> 3. <b>Not eligible</b> - medical contraindication 4. <b>Offered and declined</b> 5. <b>Not offered</b> 6. <b>Inability to obtain influenza vaccine</b> due to a declared shortage 9. <b>None of the above</b>		

## Section Z Assessment Administration

### Z0400. Signature of Persons Completing the Assessment

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.

Signature	Title	Sections	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

### **PRA Disclosure Statement**

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 **0938-1163**. The time required to complete this information collection is estimated to average **20 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, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.