

LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 2.00 PATIENT ASSESSMENT FORM - EXPIRED

Section A	Administrative Information
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A0050. Type of Record

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 1. Add new assessment/record 2. Modify existing record 3. Inactivate existing record
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A0100. Facility Provider Numbers. Enter Code in boxes provided.
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	<p>A. National Provider Identifier (NPI):</p> <p>B. CMS Certification Number (CCN):</p> <p>C. State Provider Number:</p>
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A0200. Type of Provider

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 3. Long-Term Care Hospital
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A0210. Assessment Reference Date

	<p>Observation end date:</p> <p style="text-align: center;"> _____ Month Day Year </p>
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A0220. Admission Date

	<p style="text-align: center;"> _____ Month Day Year </p>
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A0250. Reason for Assessment

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 01. Admission 10. Planned discharge 11. Unplanned discharge 12. Expired
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A0270. Discharge Date. This is the date of death.
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	<p style="text-align: center;"> _____ Month Day Year </p>
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Section A **Administrative Information**

Patient Demographic Information

A0500. Legal Name of Patient

	<p>A. First name:</p> <p>B. Middle initial:</p> <p>C. Last name:</p> <p>D. Suffix:</p>
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A0600. Social Security and Medicare Numbers

	<p>A. Social Security Number:</p> <p style="text-align: center;">- - -</p> <p>B. Medicare number (or comparable railroad insurance number):</p>
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A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

	<p>_____</p>
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A0800. Gender

Enter Code	<p>1. Male</p> <p>2. Female</p>
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A0900. Birth Date

	<p style="text-align: center;">- -</p> <p style="text-align: center;">Month Day Year</p>
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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

Section A	Administrative Information
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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 payor source
<input type="checkbox"/>	X. Unknown
<input type="checkbox"/>	Y. Other

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

<p>A. Signature:</p> 	<p>B. LTCH CARE Data Set Completion Date:</p> <p style="text-align: center;"> _____ Month Day Year </p>
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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 **5 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.