

## MINIMUM DATA SET (MDS) - Version 3.0

### RESIDENT ASSESSMENT AND CARE SCREENING

#### *Nursing Home and Swing Bed OMRA-Start of Therapy (NS/SS) Item Set*

<b>Section A</b>	<b>Identification Information</b>
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<b>A0050. Type of Record</b>	
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Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<ol style="list-style-type: none"> <li>1. <b>Add new record</b> → Continue to A0100, Facility Provider Numbers</li> <li>2. <b>Modify existing record</b> → Continue to A0100, Facility Provider Numbers</li> <li>3. <b>Inactivate existing record</b> → Skip to X0150, Type of Provider</li> </ol>
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<b>A0100. Facility Provider Numbers</b>	
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	<p><b>A. National Provider Identifier (NPI):</b></p> <p><b>B. CMS Certification Number (CCN):</b></p> <p><b>C. State Provider Number:</b></p>
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<b>A0200. Type of Provider</b>	
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Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<p><b>Type of provider</b></p> <ol style="list-style-type: none"> <li>1. <b>Nursing home (SNF/NF)</b></li> <li>2. <b>Swing Bed</b></li> </ol>
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<b>A0310. Type of Assessment</b>	
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Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<p><b>A. Federal OBRA Reason for Assessment</b></p> <ol style="list-style-type: none"> <li>01. <b>Admission</b> assessment (required by day 14)</li> <li>02. <b>Quarterly</b> review assessment</li> <li>03. <b>Annual</b> assessment</li> <li>04. <b>Significant change in status</b> assessment</li> <li>05. <b>Significant correction to prior comprehensive</b> assessment</li> <li>06. <b>Significant correction to prior quarterly</b> assessment</li> <li>99. <b>None of the above</b></li> </ol>
Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<p><b>B. PPS Assessment</b></p> <p><b><u>PPS Scheduled Assessments for a Medicare Part A Stay</u></b></p> <ol style="list-style-type: none"> <li>01. <b>5-day</b> scheduled assessment</li> <li>02. <b>14-day</b> scheduled assessment</li> <li>03. <b>30-day</b> scheduled assessment</li> <li>04. <b>60-day</b> scheduled assessment</li> <li>05. <b>90-day</b> scheduled assessment</li> <li>06. <b>Readmission/return</b> assessment</li> </ol> <p><b><u>PPS Unscheduled Assessments for a Medicare Part A Stay</u></b></p> <ol style="list-style-type: none"> <li>07. <b>Unscheduled assessment used for PPS</b> (OMRA, significant or clinical change, or significant correction assessment)</li> </ol> <p><b><u>Not PPS Assessment</u></b></p> <ol style="list-style-type: none"> <li>99. <b>None of the above</b></li> </ol>
Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<p><b>C. PPS Other Medicare Required Assessment - OMRA</b></p> <ol style="list-style-type: none"> <li>0. <b>No</b></li> <li>1. <b>Start of therapy</b> assessment</li> <li>2. <b>End of therapy</b> assessment</li> <li>3. <b>Both Start and End of therapy</b> assessment</li> <li>4. <b>Change of therapy</b> assessment</li> </ol>
Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<p><b>D. Is this a Swing Bed clinical change assessment?</b> Complete only if A0200 = 2</p> <ol style="list-style-type: none"> <li>0. <b>No</b></li> <li>1. <b>Yes</b></li> </ol>

<b>A0310 continued on next page</b>	
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<b>Section A</b>	<b>Identification Information</b>
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**A0310. Type of Assessment - Continued**

Enter Code <input type="checkbox"/>	<b>E. Is this assessment the first assessment</b> (OBRA, Scheduled PPS, or Discharge) <b>since the most recent admission/entry or reentry?</b> 0. <b>No</b> 1. <b>Yes</b>
Enter Code <input type="checkbox"/>	<b>F. Entry/discharge reporting</b> 01. <b>Entry</b> tracking record 10. <b>Discharge</b> assessment- <b>return not anticipated</b> 11. <b>Discharge</b> assessment- <b>return anticipated</b> 12. <b>Death in facility</b> tracking record 99. <b>None of the above</b>
Enter Code <input type="checkbox"/>	<b>G. Type of discharge</b> - Complete only if A0310F = 10 or 11 1. <b>Planned</b> 2. <b>Unplanned</b>

**A0410. Submission Requirement**

Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> <li>1. <b>Neither federal nor state required submission</b></li> <li>2. <b>State but not federal required submission</b> (FOR NURSING HOMES ONLY)</li> <li>3. <b>Federal required submission</b></li> </ol>
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**A0500. Legal Name of Resident**

	<b>A. First name:</b>	<b>B. Middle initial:</b>
	<b>C. Last name:</b>	<b>D. Suffix:</b>

**A0600. Social Security and Medicare Numbers**

	<b>A. Social Security Number:</b>  -      -
	<b>B. Medicare number</b> (or comparable railroad insurance number):

**A0700. Medicaid Number** - Enter "+" if pending, "N" if not a Medicaid recipient

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**A0800. Gender**

Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> <li>1. <b>Male</b></li> <li>2. <b>Female</b></li> </ol>
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**A0900. Birth Date**

	_____ - _____ - _____ Month            Day            Year
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**A1000. Race/Ethnicity**

↓ Check all that apply

<input type="checkbox"/>	<b>A. American Indian or Alaska Native</b>
<input type="checkbox"/>	<b>B. Asian</b>
<input type="checkbox"/>	<b>C. Black or African American</b>
<input type="checkbox"/>	<b>D. Hispanic or Latino</b>
<input type="checkbox"/>	<b>E. Native Hawaiian or Other Pacific Islander</b>
<input type="checkbox"/>	<b>F. White</b>

**Section A****Identification Information****A1200. Marital Status**

Enter Code

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

**A1300. Optional Resident Items****A. Medical record number:****B. Room number:****C. Name by which resident prefers to be addressed:****D. Lifetime occupation(s) - put "/" between two occupations:****A1600. Entry Date (date of this admission/entry or reentry into the facility)**

—                      —

Month                      Day                      Year

**A1700. Type of Entry**

Enter Code

1. **Admission**
2. **Reentry**

**A1800. Entered From**

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **ID/DD facility**
07. **Hospice**
09. **Long Term Care Hospital (LTCH)**
99. **Other**

**A2000. Discharge Date**

Complete only if A0310F = 10, 11, or 12

—                      —

Month                      Day                      Year

**A2100. Discharge Status**

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **ID/DD facility**
07. **Hospice**
08. **Deceased**
09. **Long Term Care Hospital (LTCH)**
99. **Other**

<b>Section A</b>	<b>Identification Information</b>
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**A2300. Assessment Reference Date**

	<p><b>Observation end date:</b></p> <p style="text-align: center;">             _                      _              Month                  Day                      Year         </p>
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**A2400. Medicare Stay**

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p><b>A. Has the resident had a Medicare-covered stay since the most recent entry?</b></p> <p>0. <b>No</b> → Skip to G0110, Activities of Daily Living (ADL) Assistance</p> <p>1. <b>Yes</b> → Continue to A2400B, Start date of most recent Medicare stay</p> <p><b>B. Start date of most recent Medicare stay:</b></p> <p style="text-align: center;">             _                      _              Month                  Day                      Year         </p> <p><b>C. End date of most recent Medicare stay</b> - Enter dashes if stay is ongoing:</p> <p style="text-align: center;">             _                      _              Month                  Day                      Year         </p>
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**Section G****Functional Status****G0110. Activities of Daily Living (ADL) Assistance**

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

**Instructions for Rule of 3**

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

**If none of the above are met, code supervision.**

**1. ADL Self-Performance**

Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

**Coding:****Activity Occurred 3 or More Times**

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

**Activity Occurred 2 or Fewer Times**

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

**2. ADL Support Provided**

Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

**Coding:**

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

1. Self-Performance	2. Support
↓ Enter Codes in Boxes ↓	
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

**A. Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture

**B. Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)

**H. Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)

**I. Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag

**Section H****Bladder and Bowel****H0200. Urinary Toileting Program**

Enter Code <input type="text"/>	<p><b>A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?</b></p> <ol style="list-style-type: none"> <li>0. <b>No</b> → Skip to H0500, Bowel Toileting Program</li> <li>1. <b>Yes</b> → Continue to H0200C, Current toileting program or trial</li> <li>9. <b>Unable to determine</b> → Continue to H0200C, Current toileting program or trial</li> </ol>
Enter Code <input type="text"/>	<p><b>C. Current toileting program or trial</b> - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?</p> <ol style="list-style-type: none"> <li>0. <b>No</b></li> <li>1. <b>Yes</b></li> </ol>

**H0500. Bowel Toileting Program**

Enter Code <input type="text"/>	<p><b>Is a toileting program currently being used to manage the resident's bowel continence?</b></p> <ol style="list-style-type: none"> <li>0. <b>No</b></li> <li>1. <b>Yes</b></li> </ol>
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<b>Section O</b>	<b>Special Treatments, Procedures, and Programs</b>
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**O0100. Special Treatments, Procedures, and Programs**

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

<p><b>1. While NOT a Resident</b>                  Performed <b>while NOT a resident</b> of this facility and within the <b>last 14 days</b>. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank</p> <p><b>2. While a Resident</b>                  Performed <b>while a resident</b> of this facility and within the <b>last 14 days</b></p>	<b>1. While NOT a Resident</b>	<b>2. While a Resident</b>
↓ <b>Check all that apply</b> ↓		
<b>Respiratory Treatments</b>		
<b>E. Tracheostomy care</b>		<input type="checkbox"/>
<b>F. Ventilator or respirator</b>		<input type="checkbox"/>
<b>Other</b>		
<b>M. Isolation or quarantine for active infectious disease</b> (does not include standard body/fluid precautions)		<input type="checkbox"/>

**O0400. Therapies**

<b>Enter Number of Minutes</b> <input style="width:100%;" type="text"/>	<b>A. Speech-Language Pathology and Audiology Services</b>	
<b>Enter Number of Minutes</b> <input style="width:100%;" type="text"/>	<p><b>1. Individual minutes</b> - record the total number of minutes this therapy was administered to the resident <b>individually</b> in the last 7 days</p> <p><b>2. Concurrent minutes</b> - record the total number of minutes this therapy was administered to the resident <b>concurrently with one other resident</b> in the last 7 days</p> <p><b>3. Group minutes</b> - record the total number of minutes this therapy was administered to the resident as <b>part of a group of residents</b> in the last 7 days</p> <p><b>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date</b></p> <p><b>3A. Co-treatment minutes</b> - record the total number of minutes this therapy was administered to the resident in <b>co-treatment sessions</b> in the last 7 days</p> <p><b>4. Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</p> <p><b>5. Therapy start date</b> - record the date the most recent therapy regimen (since the most recent entry) started</p> <p style="text-align: center;">                 _                      _                      _                  Month                      Day                      Year             </p> <p><b>6. Therapy end date</b> - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing</p> <p style="text-align: center;">                 _                      _                      _                  Month                      Day                      Year             </p>	
<b>Enter Number of Minutes</b> <input style="width:100%;" type="text"/>	<b>B. Occupational Therapy</b>	
<b>Enter Number of Minutes</b> <input style="width:100%;" type="text"/>	<p><b>1. Individual minutes</b> - record the total number of minutes this therapy was administered to the resident <b>individually</b> in the last 7 days</p> <p><b>2. Concurrent minutes</b> - record the total number of minutes this therapy was administered to the resident <b>concurrently with one other resident</b> in the last 7 days</p> <p><b>3. Group minutes</b> - record the total number of minutes this therapy was administered to the resident as <b>part of a group of residents</b> in the last 7 days</p> <p><b>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date</b></p> <p><b>3A. Co-treatment minutes</b> - record the total number of minutes this therapy was administered to the resident in <b>co-treatment sessions</b> in the last 7 days</p> <p><b>4. Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</p> <p><b>5. Therapy start date</b> - record the date the most recent therapy regimen (since the most recent entry) started</p> <p style="text-align: center;">                 _                      _                      _                  Month                      Day                      Year             </p> <p><b>6. Therapy end date</b> - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing</p> <p style="text-align: center;">                 _                      _                      _                  Month                      Day                      Year             </p>	
<b>Enter Number of Minutes</b> <input style="width:100%;" type="text"/>	<b>Enter Number of Days</b> <input style="width:100%;" type="text"/>	

**O0400 continued on next page**

**Section O****Special Treatments, Procedures, and Programs****O0400. Therapies - Continued**

<b>C. Physical Therapy</b>	
Enter Number of Minutes <input type="text"/>	<b>1. Individual minutes</b> - record the total number of minutes this therapy was administered to the resident <b>individually</b> in the last 7 days
Enter Number of Minutes <input type="text"/>	<b>2. Concurrent minutes</b> - record the total number of minutes this therapy was administered to the resident <b>concurrently with one other resident</b> in the last 7 days
Enter Number of Minutes <input type="text"/>	<b>3. Group minutes</b> - record the total number of minutes this therapy was administered to the resident as <b>part of a group of residents</b> in the last 7 days
Enter Number of Minutes <input type="text"/>	<b>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date</b>
Enter Number of Days <input type="text"/>	<b>3A. Co-treatment minutes</b> - record the total number of minutes this therapy was administered to the resident in <b>co-treatment sessions</b> in the last 7 days
Enter Number of Days <input type="text"/>	<b>4. Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days
	<b>5. Therapy start date</b> - record the date the most recent therapy regimen (since the most recent entry) started
	<b>6. Therapy end date</b> - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing
	_____ Month                  Day                  Year                                  Month                  Day                  Year

**O0420. Distinct Calendar Days of Therapy**

Enter Number of Days <input type="text"/>	<b>Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.</b>
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**O0450. Resumption of Therapy - Complete only if A0310C = 2 or 3 and A0310F = 99**

Enter Code <input type="text"/>	<b>A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?</b> 0. <b>No</b> → Skip to O0500, Restorative Nursing Programs 1. <b>Yes</b> <b>B. Date on which therapy regimen resumed:</b>  <div style="text-align: center;">           _____            Month                  Day                  Year         </div>
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<b>Section O</b>	<b>Special Treatments, Procedures, and Programs</b>
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**00500. Restorative Nursing Programs**

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique
<input type="text"/>	<b>A. Range of motion (passive)</b>
<input type="text"/>	<b>B. Range of motion (active)</b>
<input type="text"/>	<b>C. Splint or brace assistance</b>
Number of Days	Training and Skill Practice In:
<input type="text"/>	<b>D. Bed mobility</b>
<input type="text"/>	<b>E. Transfer</b>
<input type="text"/>	<b>F. Walking</b>
<input type="text"/>	<b>G. Dressing and/or grooming</b>
<input type="text"/>	<b>H. Eating and/or swallowing</b>
<input type="text"/>	<b>I. Amputation/prostheses care</b>
<input type="text"/>	<b>J. Communication</b>

<b>Section Q</b>	<b>Participation in Assessment and Goal Setting</b>
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**Q0100. Participation in Assessment**

Enter Code <input type="text"/>	<b>A. Resident participated in assessment</b> 0. No 1. Yes
Enter Code <input type="text"/>	<b>B. Family or significant other participated in assessment</b> 0. No 1. Yes 9. Resident has no family or significant other
Enter Code <input type="text"/>	<b>C. Guardian or legally authorized representative participated in assessment</b> 0. No 1. Yes 9. Resident has no guardian or legally authorized representative



**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**

Enter Code	<b>Type of provider</b>
<input type="text"/>	1. <b>Nursing home (SNF/NF)</b>
	2. <b>Swing Bed</b>

**X0200. Name of Resident** on existing record to be modified/inactivatedA. **First name:**C. **Last name:****X0300. Gender** on existing record to be modified/inactivated

Enter Code	1. <b>Male</b>
<input type="text"/>	2. <b>Female</b>

**X0400. Birth Date** on existing record to be modified/inactivated

	—	—	
Month	Day	Year	

**X0500. Social Security Number** on existing record to be modified/inactivated

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**X0600. Type of Assessment** on existing record to be modified/inactivated

Enter Code	<b>A. Federal OBRA Reason for Assessment</b>
<input type="text"/>	01. <b>Admission</b> assessment (required by day 14)
	02. <b>Quarterly</b> review assessment
	03. <b>Annual</b> assessment
	04. <b>Significant change in status</b> assessment
	05. <b>Significant correction to prior comprehensive</b> assessment
	06. <b>Significant correction to prior quarterly</b> assessment
	99. <b>None of the above</b>

Enter Code	<b>B. PPS Assessment</b>
<input type="text"/>	<b>PPS Scheduled Assessments for a Medicare Part A Stay</b>
	01. <b>5-day</b> scheduled assessment
	02. <b>14-day</b> scheduled assessment
	03. <b>30-day</b> scheduled assessment
	04. <b>60-day</b> scheduled assessment
	05. <b>90-day</b> scheduled assessment
	06. <b>Readmission/return</b> assessment
	<b>PPS Unscheduled Assessments for a Medicare Part A Stay</b>
	07. <b>Unscheduled assessment used for PPS</b> (OMRA, significant or clinical change, or significant correction assessment)
	<b>Not PPS Assessment</b>
	99. <b>None of the above</b>

Enter Code	<b>C. PPS Other Medicare Required Assessment - OMRA</b>
<input type="text"/>	0. <b>No</b>
	1. <b>Start of therapy</b> assessment
	2. <b>End of therapy</b> assessment
	3. <b>Both Start and End of therapy</b> assessment
	4. <b>Change of therapy</b> assessment

**X0600 continued on next page**

<b>Section X</b>	<b>Correction Request</b>
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**X0600. Type of Assessment - Continued**

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<b>D. Is this a Swing Bed clinical change assessment?</b> Complete only if X0150 = 2 0. <b>No</b> 1. <b>Yes</b>
Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<b>F. Entry/discharge reporting</b> 01. <b>Entry</b> tracking record 10. <b>Discharge</b> assessment- <b>return not anticipated</b> 11. <b>Discharge</b> assessment- <b>return anticipated</b> 12. <b>Death in facility</b> tracking record 99. <b>None of the above</b>

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

	<b>A. Assessment Reference Date</b> - Complete only if X0600F = 99  <div style="display: flex; justify-content: space-around; width: 80%;"> <span>—</span> <span>—</span> <span>—</span> </div> <div style="display: flex; justify-content: space-around; width: 80%;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
	<b>B. Discharge Date</b> - Complete only if X0600F = 10, 11, or 12  <div style="display: flex; justify-content: space-around; width: 80%;"> <span>—</span> <span>—</span> <span>—</span> </div> <div style="display: flex; justify-content: space-around; width: 80%;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
	<b>C. Entry Date</b> - Complete only if X0600F = 01  <div style="display: flex; justify-content: space-around; width: 80%;"> <span>—</span> <span>—</span> <span>—</span> </div> <div style="display: flex; justify-content: space-around; width: 80%;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>

**Correction Attestation Section** - Complete this section to explain and attest to the modification/inactivation request

**X0800. Correction Number**

Enter Number <input style="width: 20px; height: 20px;" type="text"/>	<b>Enter the number of correction requests to modify/inactivate the existing record, including the present one</b>
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**X0900. Reasons for Modification** - Complete only if Type of Record is to modify a record in error (A0050 = 2)

↓ **Check all that apply**

<input type="checkbox"/>	<b>A. Transcription error</b>
<input type="checkbox"/>	<b>B. Data entry error</b>
<input type="checkbox"/>	<b>C. Software product error</b>
<input type="checkbox"/>	<b>D. Item coding error</b>
<input type="checkbox"/>	<b>E. End of Therapy - Resumption (EOT-R) date</b>
<input type="checkbox"/>	<b>Z. Other error requiring modification</b> 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**

<input type="checkbox"/>	<b>A. Event did not occur</b>
<input type="checkbox"/>	<b>Z. Other error requiring inactivation</b> If "Other" checked, please specify: _____

**Section X**

**Correction Request**

**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****Z0100. Medicare Part A Billing**

Enter Code <input type="checkbox"/>	<b>A. Medicare Part A HIPPS code</b> (RUG group followed by assessment type indicator):
	<b>B. RUG version code:</b>
	<b>C. Is this a Medicare Short Stay assessment?</b> 0. No 1. Yes

**Z0150. Medicare Part A Non-Therapy Billing**

	<b>A. Medicare Part A non-therapy HIPPS code</b> (RUG group followed by assessment type indicator):
	<b>B. RUG version code:</b>

**Z0300. Insurance Billing**

	<b>A. RUG billing code:</b>
	<b>B. RUG billing version:</b>

<b>Section Z</b>	<b>Assessment Administration</b>
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**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.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

**Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion**

<p><b>A. Signature:</b></p>    	<p><b>B. Date RN Assessment Coordinator signed assessment as complete:</b></p> <p style="text-align: center;">             _____              Month                  Day                  Year           </p>
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