Patient _____ Identifier _____ Date _____

# LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 4.00

## PATIENT ASSESSMENT FORM - EXPIRED

## Section A Administrative Information

**A0050. Type of Record**

Enter Code ☐

1. **Add new assessment/record**
2. **Modify existing record**
3. **Inactivate existing record**

**A0100. Facility Provider Numbers.** Enter Code in boxes provided.

**A. National Provider Identifier (NPI):** ☐☐☐☐☐☐☐☐☐☐

**B. CMS Certification Number (CCN):** ☐☐☐☐☐☐☐☐☐☐☐☐

**C. State Medicaid Provider Number:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

**A0200. Type of Provider**

Enter Code ☐

3. **Long-Term Care Hospital**

**A0210. Assessment Reference Date**

Observation end date: ☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

**A0220. Admission Date**

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

**A0250. Reason for Assessment**

Enter Code ☐☐

01. **Admission**
10. **Planned discharge**
11. **Unplanned discharge**
12. **Expired**

**A0270. Discharge Date.** This is the date of death.

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

# Section J Health Conditions

## J1800. Any Falls Since Admission

Enter Code ☐

Has the patient **had any falls since admission?**

0. **No** → *Skip to N2005, Medication Intervention*
1. **Yes** → *Continue to J1900, Number of Falls Since Admission*

## J1900. Number of Falls Since Admission

**Coding:**
0. None
1. One
2. Two or more

**Enter Codes in Boxes**

| | |
|---|---|
| ☐ | **A. No injury:** 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 |
| ☐ | **B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain |
| ☐ | **C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma |

## Section N Medications

### N2005. Medication Intervention

Enter Code ☐

**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?**

0. **No**
1. **Yes**
9. **NA - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications**

## Section O — Special Treatments, Procedures, and Programs

**O0250. Influenza Vaccine - Refer to current version of LTCH Quality Reporting Program Manual for current influenza season and reporting period.**

Enter Code ☐

**A.** Did the **patient receive the influenza vaccine <u>in this facility</u>** for this year's influenza vaccination season?
0. **No** → *Skip to O0250C, If influenza vaccine not received, state reason*
1. **Yes** → *Continue to O0250B, Date influenza vaccine received*

**B.** Date influenza vaccine received → *Complete date and skip to Z0400, Signature of Persons Completing the Assessment*

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

**C. If influenza vaccine not received, state reason:**
1. **Patient not in this facility during this year's influenza vaccination season**
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

# 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

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