

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home and Swing Bed Tracking (NT/ST) Item Set

Section A	Identification Information
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A0050. Type of Record

Enter Code <input style="width: 100%;" type="text"/>	<ol style="list-style-type: none"> 1. Add new record → Continue to A0100, Facility Provider Numbers 2. Modify existing record → Continue to A0100, Facility Provider Numbers 3. Inactivate existing record → Skip to X0150, Type of Provider
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A0100. Facility Provider Numbers

	<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: 100%;" type="text"/>	<p>Type of provider</p> <ol style="list-style-type: none"> 1. Nursing home (SNF/NF) 2. Swing Bed
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A0300. Optional State Assessment
Complete only if A0200 = 1

Enter Code <input style="width: 100%;" type="text"/>	<p>A. Is this assessment for state payment purposes only?</p> <ol style="list-style-type: none"> 0. No
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A0310. Type of Assessment

Enter Code <input style="width: 100%;" type="text"/>	<p>A. Federal OBRA Reason for Assessment</p> <ol style="list-style-type: none"> 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above
Enter Code <input style="width: 100%;" type="text"/>	<p>B. PPS Assessment</p> <p><u>PPS Scheduled Assessment for a Medicare Part A Stay</u></p> <ol style="list-style-type: none"> 01. 5-day scheduled assessment <p><u>PPS Unscheduled Assessment for a Medicare Part A Stay</u></p> <ol style="list-style-type: none"> 08. IPA - Interim Payment Assessment <p><u>Not PPS Assessment</u></p> <ol style="list-style-type: none"> 99. None of the above
Enter Code <input style="width: 100%;" type="text"/>	<p>E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry?</p> <ol style="list-style-type: none"> 0. No 1. Yes
Enter Code <input style="width: 100%;" type="text"/>	<p>F. Entry/discharge reporting</p> <ol style="list-style-type: none"> 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above

A0310 continued on next page

Section A	Identification Information
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A0310. Type of Assessment - Continued

Enter Code <input style="width:20px; height:20px;" type="text"/>	G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned
Enter Code <input style="width:20px; height:20px;" type="text"/>	H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes

A0410. Unit Certification or Licensure Designation

Enter Code <input style="width:20px; height:20px;" type="text"/>	1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State 3. Unit is Medicare and/or Medicaid certified
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A0500. Legal Name of Resident

	A. First name:		B. Middle initial:
	C. Last name:		D. Suffix:

A0600. Social Security and Medicare Numbers

	A. Social Security Number: - - -
	B. Medicare number:

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

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A0800. Gender

Enter Code <input style="width:20px; height:20px;" type="text"/>	1. Male 2. Female
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A0900. Birth Date

	_____ - _____ - _____ Month Day Year
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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 Identification Information

A1200. Marital Status

Enter Code	<ol style="list-style-type: none"> 1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced
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A1300. Optional Resident Items

	<p>A. Medical record number:</p> <p>B. Room number:</p> <p>C. Name by which resident prefers to be addressed:</p> <p>D. Lifetime occupation(s) - put "/" between two occupations:</p>
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Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

	_ _ _ Month Day Year
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A1700. Type of Entry

Enter Code	<ol style="list-style-type: none"> 1. Admission 2. Reentry
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A1800. Entered From

Enter Code	<ol style="list-style-type: none"> 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
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A1900. Admission Date (Date this episode of care in this facility began)

	_ _ _ Month Day Year
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Section A	Identification Information
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A2000. Discharge Date Complete only if A0310F = 10, 11, or 12

	— — Month Day Year
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A2100. Discharge Status Complete only if A0310F = 10, 11, or 12

Enter Code <input style="width: 100%; height: 20px;" type="text"/>	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
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A2400. Medicare Stay

Enter Code <input style="width: 100%; height: 20px;" type="text"/>	A. Has the resident had a Medicare-covered stay since the most recent entry? 0. No → Skip to Section X, Correction Request 1. Yes → Continue to A2400B, Start date of most recent Medicare stay
	B. Start date of most recent Medicare stay: — — Month Day Year
	C. End date of most recent Medicare stay - Enter dashes if stay is ongoing: — — Month Day Year

Section X	Correction Request
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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 (A0200 on existing record to be modified/inactivated)

Enter Code <input style="width:100%; height:20px;" type="text"/>	Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed
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X0200. Name of Resident (A0500 on existing record to be modified/inactivated)

	A. First name: C. Last name:
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X0300. Gender (A0800 on existing record to be modified/inactivated)

Enter Code <input style="width:100%; height:20px;" type="text"/>	1. Male 2. Female
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X0400. Birth Date (A0900 on existing record to be modified/inactivated)

	- - Month Day Year
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X0500. Social Security Number (A0600A on existing record to be modified/inactivated)

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X0570. Optional State Assessment (A0300A on existing record to be modified/inactivated)

Enter Code <input style="width:100%; height:20px;" type="text"/>	A. Is this assessment for state payment purposes only? 0. No 1. Yes
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X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)

Enter Code <input style="width:100%; height:20px;" type="text"/>	A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above
Enter Code <input style="width:100%; height:20px;" type="text"/>	B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above
Enter Code <input style="width:100%; height:20px;" type="text"/>	F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment- return not anticipated 11. Discharge assessment- return anticipated 12. Death in facility tracking record 99. None of the above
Enter Code <input style="width:100%; height:20px;" type="text"/>	H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes

Section X	Correction Request
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X0700. Date on existing record to be modified/inactivated - Complete one only

	A. Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99 <div style="text-align: center; margin-top: 5px;"> - - Month Day Year </div>
	B. Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12 <div style="text-align: center; margin-top: 5px;"> - - Month Day Year </div>
	C. Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01 <div style="text-align: center; margin-top: 5px;"> - - Month Day Year </div>

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

X0800. Correction Number

Enter Number	<input style="width: 80px; height: 20px;" type="text"/>
Enter the number of correction requests to modify/inactivate the existing record, including the present one	

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"/>	A. Transcription error
<input type="checkbox"/>	B. Data entry error
<input type="checkbox"/>	C. Software product error
<input type="checkbox"/>	D. Item coding error
<input type="checkbox"/>	Z. Other error requiring modification 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"/>	A. Event did not occur
<input type="checkbox"/>	Z. Other error requiring inactivation If "Other" checked, please specify: _____

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 <div style="text-align: center; margin-top: 5px;"> - - Month Day Year </div>

Section Z**Assessment Administration****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.			

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