Resident ______ Identifier ______ Date _____

MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING

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

Sectio	n A	Identification Information
A0050. T	Type of Record	
Enter Code	2. Modify exist	cord → Continue to A0100, Facility Provider Numbers ting record → Continue to A0100, Facility Provider Numbers xisting record → Skip to X0150, Type of Provider
A0100. F	acility Provider Nu	mbers
	A. National Provide	er Identifier (NPI):
	B. CMS Certification	n Number (CCN):
	C. State Provider N	umber:
A0200. T	ype of Provider	
Enter Code	Type of provider	- (CNIF/NIF)
	 Nursing hom Swing Bed 	e (SNF/NF)
A0300. O	ptional State Asses	
	e only if A0200 = 1	
Enter Code	A. Is this assessme	nt for state payment purposes only?
	0. No	
A0310. T	Type of Assessment	
Enter Code		eason for Assessment
	1	ssessment (required by day 14)
	02. Quarterly re 03. Annual asses	
		change in status assessment
		correction to prior comprehensive assessment
		correction to prior quarterly assessment
	99. None of the	above
	B. PPS Assessment	
Enter Code		Assessment <u>for a Medicare Part A Stay</u>
	01. 5-day sched	
	1	d Assessment for a Medicare Part A Stay
		Payment Assessment
	Not PPS Assessn 99. None of the	
Enter Code	0. No	t the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry?
	1. Yes	
5 . 6 .	F. Entry/discharge	
Enter Code	01. Entry trackin	
		ssessment- return not anticipated
		ssessment- return anticipated
	12. Death in fac	ility tracking record
	99. None of the	above
A0310 co	ontinued on next pa	age

Resident		Identifier	Date
Section	n A	Identification Information	
A0310. Type of Assessment - Continued Enter Code G. Type of discharge - Complete only if A0310F = 10 or 11 1 Planned			
Enter Code	G. Type of discharge 1. Planned 2. Unplanned	e - Complete only if A0310F = 10 or 11	
Enter Code	H. Is this a SNF Part 0. No 1. Yes	A PPS Discharge Assessment?	
A0410. U	Init Certification or	Licensure Designation	
Enter Code	2. Unit is neithe	r Medicare nor Medicaid certified and MDS data is not required by the State r Medicare nor Medicaid certified but MDS data is required by the State are and/or Medicaid certified	
A0500. L	egal Name of Resid	lent	
	A. First name:		B. Middle initial:
	C. Last name:		D. Suffix:
A0600. S	ocial Security and	Medicare Numbers	
	A. Social Security N	umber: _	
	B. Medicare numbe	r:	
A0700. N	ledicaid Number -	Enter "+" if pending, "N" if not a Medicaid recipient	
A0800. G	iender		
Enter Code	1. Male 2. Female		
A0900. B	irth Date		
	_ Month	– Day Year	
A1000. R	ace/Ethnicity		
↓ Che	ck all that apply		
	A. American Indian	or Alaska Native	
	B. Asian		
	C. Black or African	American	
	D. Hispanic or Latin	10	
	E. Native Hawaiian	or Other Pacific Islander	
	F. White		

Resident			Identifier	Date
Section	ı A	Identification Informatio	n	
A1200. M	arital Status			
Enter Code	 Never married Married Widowed Separated Divorced 	d		
A1300. O _l	ptional Resident It	ems		
	A. Medical record n B. Room number:	umber:		
	C. Name by which r	esident prefers to be addressed:		
ı	D. Lifetime occupati	ion(s) - put "/" between two occupations:		
Mast Dass				
		ry or Reentry into this Facility		
A1600. En	ntry Date			
	– Month [– Day Year		
A1700. Ty	pe of Entry			
Enter Code	 Admission Reentry 			
A1800. En	ntered From			
Enter Code	 02. Another nur 03. Acute hospit 04. Psychiatric h 05. Inpatient rel 06. ID/DD facilit 07. Hospice 	nospital habilitation facility	ving, group home)	
A1900. Ac	dmission Date (Da	te this episode of care in this facility	y began)	
	– Month [– Day Year		

Resident			Identifier	Date
Sectio	n A	Identification In	formation	
A2000. D	ischarge Date			
Complete	only if A0310F = 10,	, 11, or 12		
	– Month	– Day Year		
A2100. D	ischarge Status			
Complete	only if A0310F = 10,	, 11, or 12		
Enter Code	02. Another nur 03. Acute hospit 04. Psychiatric h 05. Inpatient rel 06. ID/DD facilit 07. Hospice 08. Deceased 09. Long Term C 99. Other	sing home or swing bed cal cospital nabilitation facility	care, assisted living, group home)	
A2400. N	ledicare Stay			
Enter Code	 No → Skip to Yes → Conti 	Section X, Correction Requ	stay since the most recent entry? uest of most recent Medicare stay	

Month

Month

Day

Day

Year

Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

Complete Section X only if AOOS0 = 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 error cond, even if the information is incorrect. Within information is necessary to locate the existing record to be modified/inactivated) Type of Provider (A0200 on existing record to be modified/inactivated) Type of provider Type of Provider (A0200 on existing record to be modified/inactivated) A. First name: C. Last name: C. Last name: C. Last name: X0300. Gender (A0800 on existing record to be modified/inactivated) A. First name: X0400. Birth Date (A0800 on existing record to be modified/inactivated) I. Male Ley Wear X0500. Social Security Number (A0600 An existing record to be modified/inactivated) A. Is this assessment (A0300 An existing record to be modified/inactivated) CX0500. Type of Provider (A0800 An existing record to be modified/inactivated) A. Is this assessment (A0300 An existing record to be modified/inactivated) CX0500. Type of A0800 An existing record to be modified/inactivated) A. Is this assessment (A0300 An existing record to be modified/inactivated) CX0500. Type of A0800 An existing record to be modified/inactivated) A. Is this assessment (A0300 An existing record to be modified/inactivated) CX0500. Type of A0800 Annual assessment (A0300 An existing record to be modified/inactivated) CX0500. Type of A0800 Annual A08000 Annual A08000 Annual A080000 Annual A080000 Annual A080000 Annual A0800000 Annual A080000000 Annual A080000000 Annual A0800000000000000000000000000000000000	esident _			ldentifier	Date
Interctact	Sectio	n X	Correction Requ	est	
Type of provider 1. Nursing home (SNF/NF) 2. Swing Ised X0200. Name of Resident (A0500 on existing record to be modified/inactivated) A. First name: C. Last name: C. Last name: C. Last name: X0300. Gender (A0800 on existing record to be modified/inactivated) Intercord 1. Male 2. Female X0400. Birth Date (A0900 on existing record to be modified/inactivated) Month Day Year X0500. Social Security Number (A0600A on existing record to be modified/inactivated) X0500. Social Security Number (A0600A on existing record to be modified/inactivated) X0500. Optional State Assessment (A0300A on existing record to be modified/inactivated) X0500. Type of Assessment (A0310 on existing record to be modified/inactivated) X0500. Type of Assessment (A0310 on existing record to be modified/inactivated) A. Is this assessment (A0310 on existing record to be modified/inactivated) A. Is annual assessment (A0310 on existing record to be modified/inactivated) A. Federal OBRA Reason for Assessment 9. Nonual Admission assessment (required by day 14) 10. Quarterly review assessment 10. Significant correction to prior comprehensive assessment 10. Significant correction to prior comprehensive assessment 10. Significant correction to prior comprehensive assessment 9. None of the above B. PPS Assessment PPS Unscheduled Assessment for a Medicare Part A Stay 10. Enter Code Enter Code F. Entry/discharge reporting 10. Enter y tacking record 10. Discharge assessment-return anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 13. None of the above Titles Code H. Is this a SNP Part A PPS Discharge Assessment? No PPS Assessment No PPS Assessment Assessment? No None of the above	Identific section, re	ation of Record to be produce the information	be Modified/Inactivated on EXACTLY as it appeared o	n the existing erroneous record, even if	
1. Nursing home (SNF/NF) 2. Swing Bed X0200. Name of Resident (A0500 on existing record to be modified/inactivated) A. First name: C. Last name: C. Last name: 1. Male 2. Female X0400. Birth Date (A0800 on existing record to be modified/inactivated) Month Day Year X0500. Social Security Number (A0600A on existing record to be modified/inactivated)	X0150. T	Гуре of Provider (A	0200 on existing record to	be modified/inactivated)	
A. First name: C. Last name: C. Last name: C. Last name: I. Male 2. Female X0400. Birth Date (A0900 on existing record to be modified/inactivated) Month Day Year X0500. Social Security Number (A0600A on existing record to be modified/inactivated) A last this assessment (A0300A on existing record to be modified/inactivated) X0570. Optional State Assessment (A0300A on existing record to be modified/inactivated) A last this assessment for state payment purposes only? No No 1. Yes X0600. Type of Assessment (A0310 on existing record to be modified/inactivated) A. Federal OBRA Reason for Assessment OI. Admission assessment (required by day 14) Quarterly review assessment OI. Admission assessment (required by day 14) Quarterly review assessment OI. Significant correction to prior comprehensive assessment OI. Significant correction to prior quarterly assessment OI. Significant days in status assessment OI. Significant correction to prior quarterly assessment OI. Significant Assessment for a Medicare Part A Stay OII. Significant Assessment for a Medicare Part A Stay OII. Significant Assessment for a Medicare Part A Stay OII. Significant Assessment for a Medicare Part A Stay OII. Significant Assessment for a Medicare Part A Stay OII. Entry tracking record OII. Discharge assessment return not anticipated OII. Discharge assessment return anticipated OII. Disch	Enter Code	1. Nursing hom	e (SNF/NF)		
C. Last name: X0300. Gender (A0800 on existing record to be modified/inactivated) I. Male 2. Female X0400. Birth Date (A0900 on existing record to be modified/inactivated) Month Day Year X0500. Social Security Number (A0600A on existing record to be modified/inactivated) Total Code A. Is this assessment (A0300A on existing record to be modified/inactivated) Total Code A. Is this assessment for state payment purposes only? O. No 1. Yes X0600. Type of Assessment (A0310 on existing record to be modified/inactivated) Enter Code A. Federal OBRA Reason for Assessment O1. Admission assessment (required by day 14) O2. Quarterly review assessment O3. Annual assessment O5. Significant correction to prior comprehensive assessment O5. Significant correction to prior comprehensive assessment O9. None of the above B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay O1. S-day scheduled assessment for a Medicare Part A Stay O8. IPA - Interim Payment Assessment O9. None of the above InterCode II. Is this a SNF Part A PPS Discharge Assessment? O9. None of the above II. Is this a SNF Part A PPS Discharge Assessment? O9. None of the above III. Is this a SNF Part A PPS Discharge Assessment? O9. None of the above III. Is this a SNF Part A PPS Discharge Assessment? O9. None of the above	X0200. I	Name of Resident (A	A0500 on existing record t	o be modified/inactivated)	
EnterCode 1. Male 2. Female X0400. Birth Date (A0900 on existing record to be modified/inactivated)					
2. Female X0400. Birth Date (A0900 on existing record to be modified/inactivated) Month Day Year X0500. Social Security Number (A0600A on existing record to be modified/inactivated) A Is this assessment (A0300A on existing record to be modified/inactivated) EnterCode A. Is this assessment for state payment purposes only? O. No 1. Yes X0600. Type of Assessment (A0310 on existing record to be modified/inactivated) EnterCode A. Federal OBRA Reason for Assessment O1. Admission assessment (required by day 14) O2. Quarterly review assessment O3. Annual assessment O5. Significant correction to prior comprehensive assessment O5. Significant correction to prior quarterly assessment O6. Significant correction to prior quarterly assessment O8. Significant correction to prior quarterly assessment O9. None of the above B. PPS Scheduled Assessment for a Medicare Part A Stay O1. 5-day scheduled Assessment for a Medicare Part A Stay O8. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above F. Entry/discharge reporting O1. Entry tracking record O1. Discharge assessment-return not anticipated O1. Discharge assessment-return anticipated O1. Discharge assessment return anticipated O1. Discharge assessment-return anticipated O1. No	X0300. (Gender (A0800 on ex	xisting record to be modif	ied/inactivated)	
XOSOO. Social Security Number (A0600A on existing record to be modified/inactivated) XOSOO. Social State Assessment (A0300A on existing record to be modified/inactivated) Enter Code A. Is this assessment for state payment purposes only? O. No 1. Yes XOGOO. Type of Assessment (A0310 on existing record to be modified/inactivated) A. Federal OBRA Reason for Assessment OI. Admission assessment (required by day 14) O2. Quarterly review assessment O3. Significant change in status assessment O5. Significant correction to prior comprehensive assessment O5. Significant correction to prior quarterly assessment O9. None of the above B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay O1. 5-day scheduled assessment O3. IPPS Unscheduled Assessment O4. IPPS Unscheduled Assessment O5. IPPS Unscheduled Assessment O6. IPPS Unscheduled Assessment O7. IPPS Un	Enter Code				
X0570. Optional State Assessment (A0300A on existing record to be modified/inactivated) EnterCode A. Is this assessment for state payment purposes only? O. No 1. Yes X0600. Type of Assessment (A0310 on existing record to be modified/inactivated) EnterCode A. Federal OBRA Reason for Assessment O1. Admission assessment (required by day 14) O2. Quarterly review assessment O3. Annual assessment O4. Significant change in status assessment O5. Significant correction to prior comprehensive assessment O6. Significant correction to prior quarterly assessment O9. None of the above EnterCode EnterCode EnterCode F. Entry/discharge assessment return not anticipated 11. Discharge assessment-return not anticipated 12. Death in facility tracking record 99. None of the above H. Is this a SNF Part A PPS Discharge Assessment? O. No	X0400. E	Birth Date (A0900 or	n existing record to be mo	odified/inactivated)	
X0570. Optional State Assessment (A0300A on existing record to be modified/inactivated) EnterCode A. Is this assessment for state payment purposes only? O. No 1. Yes X0600. Type of Assessment (A0310 on existing record to be modified/inactivated) EnterCode A. Federal OBRA Reason for Assessment O1. Admission assessment (required by day 14) O2. Quarterly review assessment O3. Annual assessment O3. Significant correction to prior comprehensive assessment O5. Significant correction to prior quarterly assessment O6. Significant correction to prior quarterly assessment O9. None of the above EnterCode B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay O8. IPA - Interim Payment Assessment PPS Unscheduled Assessment O9. None of the above EnterCode F. Entry/discharge reporting O1. Entry tracking record O1. Discharge assessment-return not anticipated O1. Discharge assessment-return naticipated O1. Discharge assessment-return anticipated O1. Discharge assessment-return anticipated O1. None of the above H. Is this a SNF Part A PPS Discharge Assessment? O. No		– Month	– Day Year		
Enter Code A. Is this assessment for state payment purposes only? 0. No 1. Yes XO600. Type of Assessment (A0310 on existing record to be modified/inactivated) Enter Code Enter Code A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant correction to prior comprehensive assessment 05. Significant correction to prior quarterly assessment 06. Significant correction to prior quarterly assessment 09. None of the above Enter Code Enter Code Enter Co	X0500.	Social Security Nun	nber (A0600A on existing	record to be modified/inactivated)	
Enter Code A. Is this assessment for state payment purposes only? 0. No 1. Yes XO600. Type of Assessment (A0310 on existing record to be modified/inactivated) Enter Code Enter Code A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant correction to prior comprehensive assessment 05. Significant correction to prior quarterly assessment 06. Significant correction to prior quarterly assessment 09. None of the above Enter Code Enter Code Enter Co		_			
Comparison of the above Comparison of th	X0570. (│ Optional State Asse	essment (A0300A on existi	ing record to be modified/inactivate	ed)
Enter Code 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 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 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 H. Is this a SNF Part A PPS Discharge Assessment? 0. No	Enter Code	0. No	nt for state payment purpos	ses only?	
O1. Admission assessment (required by day 14) O2. Quarterly review assessment O3. Annual assessment O4. Significant correction to prior comprehensive assessment O5. Significant correction to prior quarterly assessment O6. Significant correction to prior quarterly assessment O7. Significant correction to prior quarterly assessment O8. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay O7. 5-day scheduled Assessment for a Medicare Part A Stay O8. IPA - Interim Payment Assessment Not PPS Assessment O7. None of the above Enter Code F. Entry/discharge reporting O7. Entry/discharge reporting O7. Discharge assessment-return not anticipated O7. Discharge assessment-return anticipated O7. None of the above H. Is this a SNF Part A PPS Discharge Assessment? O. No	X0600. 1	Type of Assessment	t (A0310 on existing record	d to be modified/inactivated)	
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 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 H. Is this a SNF Part A PPS Discharge Assessment? 0. No	Enter Code	01. Admission a 02. Quarterly re 03. Annual asse 04. Significant o 05. Significant o	assessment (required by day beview assessment essment change in status assessment correction to prior compreh correction to prior quarterly	t n ensive assessment	
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 H. Is this a SNF Part A PPS Discharge Assessment? 0. No	Enter Code	PPS Scheduled A 01. 5-day sched PPS Unschedule 08. IPA - Interim Not PPS Assessn	Assessment for a Medicare I luled assessment ed Assessment for a Medica n Payment Assessment ment	·	
0. No	Enter Code	01. Entry trackir 10. Discharge a 11. Discharge a 12. Death in fac 99. None of the	ng record ssessment- return not antici ssessment- return anticipate c ility tracking record a above	ed	
	Enter Code	0. No	A PPS Discharge Assessme	ent?	

Resident			Identifier	Date
Sectio	n X	Correction Request	t	
X0700. E	Date on existing reco	ord to be modified/inactivated	d - Complete one only	
	A. Assessment Refe	erence Date (A2300 on existing r	record to be modified/inactivated	- Complete only if X0600F = 99
	— Month	— Year		
			nodified/inactivated) - Complete c	only if X0600F = 10, 11, or 12
	_	_		
	Month	Day Year		
	C. Entry Date (A160	0 on existing record to be modif	ied/inactivated) - Complete only i	f X0600F = 01
	— Month	— Year		
Correction		<u> </u>	explain and attest to the mod	lification/inactivation request
	Correction Number			
Enter Number				
Enter Namber	Enter the number of	f correction requests to modify	/inactivate the existing record,	including the present one
X0900. R	 Reasons for Modific	ation - Complete only if Type	e of Record is to modify a recor	d in error (A0050 = 2)
	eck all that apply			
	A. Transcription er	ror		
	B. Data entry error			
	C. Software produc	t error		
	D. Item coding erro	or		
	Z. Other error requ			
	If "Other" checked	<u> </u>		
		ation - Complete only if Type	of Record is to inactivate a rec	ord in error (A0050 = 3)
↓ Che	eck all that apply			
	A. Event did not oc			
	Z. Other error requ If "Other" checked			
X1100. F	N Assessment Coo	rdinator Attestation of Com	pletion	
	A. Attesting individ	lual's first name:		
	B. Attesting individ	lual's last name:		
	C. Attesting individ	lual's title:		
	D. Signature			
	E. Attestation date			
	_	_		

Day

Year

Month

Z 0	0400. 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	l	
	collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable	l	
	Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality	l	
	care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the	l	
	government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to	l	
	or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am	l	
	authorized to submit this information by this facility on its behalf.	L	

Assessment Administration

Identifier

Date

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			

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Resident

Section Z