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**LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 5.1 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. |
|  | 1. **National Provider Identifier (NPI):**
2. **CMS Certification Number (CCN):**
3. **State Medicaid Provider Number:**
 |
| **A0200. Type of Provider** |
| Enter Code | 3. **Long-Term Care Hospital** |
| **A0210. Assessment Reference Date** |
|  |  **Observation end date:**

|  |  |  |  |  |  |  |  |  |  |
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 **Month Day Year** |
| **A0220. Admission Date** |
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 **Month Day Year** |
| **A0250. Reason for Assessment** |
| Enter Code | 01. **Admission**1. **Planned discharge**
2. **Unplanned discharge**
3. **Expired**
 |
| **A0270. Discharge Date.** This is the date of death. |
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 **Month Day Year**  |

**Section A**

**Administrative Information**

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| **Patient Demographic Information** |
| **A0500. Legal Name of Patient** |
|  | 1. **First name:**

|  |  |  |  |  |  |  |  |  |  |  |  |
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1. **Middle initial:**

|  |
| --- |
|  |

1. **Last name:**

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1. **Suffix:**

|  |  |  |
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 |
| **A0600. Social Security and Medicare Numbers** |
|  | 1. **Social Security Number:**

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1. **Medicare number** (or comparable railroad insurance number)**:**

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

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 |
| **A0800. Gender** |
| Enter Code | 1. **Male.**
2. **Female**
 |
| **A0900. Birth Date** |
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 **Month Day Year** |

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| **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 payer source** |
|  | **X. Unknown** |
|  | **Y. Other** |



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| **Section J** | **Health Conditions** |
| **J1800. Any Falls Since Admission** |
| Enter Code | Has the patient **had any falls since admission?**1. **No** *Skip to N2005, Medication Intervention*
2. **Yes** *Continue to J1900, Number of Falls Since Admission.*
 |
| **J1900. Number of Falls Since Admission** |
| **Coding:**1. **None**
2. **One**
3. **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**

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| **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?**1. **No**
2. **Yes**

9. **Not applicable - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications** |

|  |  |
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| **Section O** | **Special Treatments, Procedures, and Programs** |
| **O0350. Patient’s COVID-19 vaccination is up to date.** |
| Enter Code | **0**. No, patient is not up to date**1.** Yes, patient is up to date |

**Section Z**

**Assessment Administration**

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| **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 |