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LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 5.2 PATIENT ASSESSMENT FORM - EXPIRED

Section A	Administrative Information
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A0050. Type of Record

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 1. Add new assessment/record 2. Modify existing record 3. Inactivate existing record
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A0100. Facility Provider Numbers. Enter Code in boxes provided.

	<p>A. National Provider Identifier (NPI): <input style="width: 100px; height: 20px;" type="text"/></p> <p>B. CMS Certification Number (CCN): <input style="width: 100px; height: 20px;" type="text"/></p> <p>C. State Medicaid Provider Number: <input style="width: 150px; height: 20px;" type="text"/></p>
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A0200. Type of Provider

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 3. Long-Term Care Hospital
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A0210. Assessment Reference Date

	<p>Observation end date:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="text-align: center;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="text-align: center;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td></td> <td style="text-align: center;">Year</td> <td></td> <td></td> <td style="text-align: center;">Year</td> <td></td> <td></td> <td></td> </tr> </table>			-			-					Month	Day		Year			Year			
		-			-																
Month	Day		Year			Year															

A0220. Admission Date

	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="text-align: center;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="text-align: center;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td></td> <td style="text-align: center;">Year</td> <td></td> <td></td> <td style="text-align: center;">Year</td> <td></td> <td></td> <td></td> </tr> </table>			-			-					Month	Day		Year			Year			
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Month	Day		Year			Year															

A0250. Reason for Assessment

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 01. Admission 10. Planned discharge 11. Unplanned discharge 12. Expired
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A0270. Discharge Date. This is the date of death.

	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="text-align: center;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="text-align: center;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td></td> <td style="text-align: center;">Year</td> <td></td> <td></td> <td style="text-align: center;">Year</td> <td></td> <td></td> <td></td> </tr> </table>			-			-					Month	Day		Year			Year			
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Month	Day		Year			Year															

Section A **Administrative Information**

Patient Demographic Information

A0500. Legal Name of Patient

	<p>A. First name:</p> <input style="width: 100%; height: 20px;" type="text"/>
	<p>B. Middle initial:</p> <input style="width: 20px; height: 20px;" type="text"/>
	<p>C. Last name:</p> <input style="width: 100%; height: 20px;" type="text"/>
	<p>D. Suffix:</p> <input style="width: 30px; height: 20px;" type="text"/>

A0600. Social Security and Medicare Numbers

	<p>A. Social Security Number:</p> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
	<p>B. Medicare number (or comparable railroad insurance number):</p> <input style="width: 100%; height: 20px;" type="text"/>

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

	<input style="width: 100%; height: 20px;" type="text"/>
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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

	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
	<p style="text-align: center;"> Month Day Year </p>

Section A	Administrative Information
A1400. Payer Information	
↓ Check all that apply	
<input type="checkbox"/>	A. Medicare (traditional fee-for-service)
<input type="checkbox"/>	B. Medicare (managed care/Part C/Medicare Advantage)
<input type="checkbox"/>	C. Medicaid (traditional fee-for-service)
<input type="checkbox"/>	D. Medicaid (managed care)
<input type="checkbox"/>	E. Workers' compensation
<input type="checkbox"/>	F. Title programs (e.g., Title III, V, or XX)
<input type="checkbox"/>	G. Other government (e.g., TRICARE, VA, etc.)
<input type="checkbox"/>	H. Private insurance/Medigap
<input type="checkbox"/>	I. Private managed care
<input type="checkbox"/>	J. Self-pay
<input type="checkbox"/>	K. No payer source
<input type="checkbox"/>	X. Unknown
<input type="checkbox"/>	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
	<input type="checkbox"/>	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
	<input type="checkbox"/>	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
	<input type="checkbox"/>	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 <input style="width: 30px; height: 20px;" type="text"/>	<p>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?</p> <p>0. No 1. Yes 9. Not applicable - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications</p>
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Section O	Special Treatments, Procedures, and Programs
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O0350. Patient's COVID-19 vaccination is up to date.

Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<p>0. No, patient is not up to date 1. Yes, patient is up to date</p>
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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