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## LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 5.00 PATIENT ASSESSMENT FORM - EXPIRED

<b>Section A</b>	<b>Administrative Information</b>
<b>A0050. Type of Record</b>	
Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> <li>1. <b>Add new assessment/record</b></li> <li>2. <b>Modify existing record</b></li> <li>3. <b>Inactivate existing record</b></li> </ol>
<b>A0100. Facility Provider Numbers.</b> Enter Code in boxes provided.	
	<p><b>A. National Provider Identifier (NPI):</b></p> <p><b>B. CMS Certification Number (CCN):</b></p> <p><b>C. State Medicaid Provider Number:</b></p>
<b>A0200. Type of Provider</b>	
Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> <li>3. <b>Long-Term Care Hospital</b></li> </ol>
<b>A0210. Assessment Reference Date</b>	
	<p>Observation end date:</p> <p style="text-align: center;">             _                      _              Month                  Day                      Year           </p>
<b>A0220. Admission Date</b>	
	<p style="text-align: center;">             _                      _              Month                  Day                      Year           </p>
<b>A0250. Reason for Assessment</b>	
Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> <li>01. <b>Admission</b></li> <li>10. <b>Planned discharge</b></li> <li>11. <b>Unplanned discharge</b></li> <li>12. <b>Expired</b></li> </ol>
<b>A0270. Discharge Date.</b> This is the date of death.	
	<p style="text-align: center;">             _                      _              Month                  Day                      Year           </p>

<b>Section A</b>	<b>Administrative Information</b>
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<b>Patient Demographic Information</b>
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<b>A0500. Legal Name of Patient</b>
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	<p><b>A. First name:</b></p> <p><b>B. Middle initial:</b></p> <p><b>C. Last name:</b></p> <p><b>D. Suffix:</b></p>
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<b>A0600. Social Security and Medicare Numbers</b>
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	<p><b>A. Social Security Number:</b></p> <p style="text-align: center;">-            -</p> <p><b>B. Medicare number</b> (or comparable railroad insurance number):</p>
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<b>A0700. Medicaid Number</b> - Enter "+" if pending, "N" if not a Medicaid recipient
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<b>A0800. Gender</b>
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Enter Code	<p>1. <b>Male</b></p> <p>2. <b>Female</b></p>
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<b>A0900. Birth Date</b>
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	<p style="text-align: center;">-            -</p> <p style="text-align: center;">Month            Day            Year</p>
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<b>Section A</b>	<b>Administrative Information</b>
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<b>A1400. Payer Information</b>
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↓	<b>Check all that apply</b>
<input type="checkbox"/>	<b>A. Medicare</b> (traditional fee-for-service)
<input type="checkbox"/>	<b>B. Medicare</b> (managed care/Part C/Medicare Advantage)
<input type="checkbox"/>	<b>C. Medicaid</b> (traditional fee-for-service)
<input type="checkbox"/>	<b>D. Medicaid</b> (managed care)
<input type="checkbox"/>	<b>E. Workers' compensation</b>
<input type="checkbox"/>	<b>F. Title programs</b> (e.g., Title III, V, or XX)
<input type="checkbox"/>	<b>G. Other government</b> (e.g., TRICARE, VA, etc.)
<input type="checkbox"/>	<b>H. Private insurance/Medigap</b>
<input type="checkbox"/>	<b>I. Private managed care</b>
<input type="checkbox"/>	<b>J. Self-pay</b>
<input type="checkbox"/>	<b>K. No payer source</b>
<input type="checkbox"/>	<b>X. Unknown</b>
<input type="checkbox"/>	<b>Y. Other</b>

<b>Section J</b>	<b>Health Conditions</b>
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**J1800. Any Falls Since Admission**

Enter Code	<p>Has the patient <b>had any falls since admission?</b></p> <p>0. <b>No</b> → <i>Skip to N2005, Medication Intervention</i></p> <p>1. <b>Yes</b> → <i>Continue to J1900, Number of Falls Since Admission</i></p>
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**J1900. Number of Falls Since Admission**

	↓ <b>Enter Codes in Boxes</b>						
<p><b>Coding:</b></p> <p>0. <b>None</b></p> <p>1. <b>One</b></p> <p>2. <b>Two or more</b></p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center; vertical-align: middle;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 5px;"><b>A. No injury:</b> 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</td> </tr> <tr> <td style="text-align: center; vertical-align: middle;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 5px;"><b>B. Injury (except major):</b> Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain</td> </tr> <tr> <td style="text-align: center; vertical-align: middle;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 5px;"><b>C. Major injury:</b> Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</td> </tr> </table>	<input style="width: 20px; height: 20px;" type="text"/>	<b>A. No injury:</b> 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 style="width: 20px; height: 20px;" type="text"/>	<b>B. Injury (except major):</b> Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain	<input style="width: 20px; height: 20px;" type="text"/>	<b>C. Major injury:</b> Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma
<input style="width: 20px; height: 20px;" type="text"/>	<b>A. No injury:</b> 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 style="width: 20px; height: 20px;" type="text"/>	<b>B. Injury (except major):</b> Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain						
<input style="width: 20px; height: 20px;" type="text"/>	<b>C. Major injury:</b> Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma						

<b>Section N</b>	<b>Medications</b>
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<b>N2005. Medication Intervention</b>
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<p>Enter Code</p> <input type="text"/>	<p><b>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?</b></p> <ul style="list-style-type: none"><li>0. <b>No</b></li><li>1. <b>Yes</b></li><li>9. <b>Not applicable - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications</b></li></ul>
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<b>Section Z</b>	<b>Assessment Administration</b>
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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**

<b>A. Signature:</b>	<b>B. LTCH CARE Data Set Completion Date:</b>
	_____ Month          Day          Year