

# LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 4.00 PATIENT ASSESSMENT FORM - EXPIRED

Section A	Administrative Information
<b>A0050. Type of Record</b>	
Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	1. <b>Add new assessment/record</b> 2. <b>Modify existing record</b> 3. <b>Inactivate existing record</b>
<b>A0100. Facility Provider Numbers.</b> Enter Code in boxes provided.	
	<b>A. National Provider Identifier (NPI):</b>  <b>B. CMS Certification Number (CCN):</b>  <b>C. State Medicaid Provider Number:</b>
<b>A0200. Type of Provider</b>	
Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	3. <b>Long-Term Care Hospital</b>
<b>A0210. Assessment Reference Date</b>	
	Observation end date:  <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">— Month</div> <div style="text-align: center;">— Day</div> <div style="text-align: center;">— Year</div> </div>
<b>A0220. Admission Date</b>	
	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">— Month</div> <div style="text-align: center;">— Day</div> <div style="text-align: center;">— Year</div> </div>
<b>A0250. Reason for Assessment</b>	
Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	01. <b>Admission</b> 10. <b>Planned discharge</b> 11. <b>Unplanned discharge</b> 12. <b>Expired</b>
<b>A0270. Discharge Date.</b> This is the date of death.	
	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">— Month</div> <div style="text-align: center;">— Day</div> <div style="text-align: center;">— Year</div> </div>

## Section A Administrative Information

### Patient Demographic Information

#### A0500. Legal Name of Patient

A. First name:

B. Middle initial:

C. Last name:

D. Suffix:

#### A0600. Social Security and Medicare Numbers

A. Social Security Number:

— —

B. Medicare number (or comparable railroad insurance number):

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

#### A0800. Gender

Enter Code

1. Male
2. Female

#### A0900. Birth Date

— —  
Month Day Year

#### A1000. Race/Ethnicity

↓ Check all that apply

☐

A. American Indian or Alaska Native

☐

B. Asian

☐

C. Black or African American

☐

D. Hispanic or Latino

☐

E. Native Hawaiian or Other Pacific Islander

☐

F. White

<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 payor source</b>
<input type="checkbox"/>	<b>X. Unknown</b>
<input type="checkbox"/>	<b>Y. Other</b>

<b>Section J</b>		<b>Health Conditions</b>	
<b>J1800. Any Falls Since Admission</b>			
Enter Code <div></div>	Has the patient <b>had any falls since admission?</b> 0. <b>No</b> → <i>Skip to N2005, Medication Intervention</i> 1. <b>Yes</b> → <i>Continue to J1900, Number of Falls Since Admission</i>		
<b>J1900. Number of Falls Since Admission</b>			
<b>Coding:</b> 0. None 1. One 2. Two or more	<div>↓</div> <b>Enter Codes in Boxes</b>		
	<div></div>	<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	
	<div></div>	<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	
	<div></div>	<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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Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	<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>NA - 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 O</b>		<b>Special Treatments, Procedures, and Programs</b>	
<b>O0250. Influenza Vaccine - Refer to current version of LTCH Quality Reporting Program Manual for current influenza season and reporting period.</b>			
<div>Enter Code</div> <div></div>	<b>A.</b> Did the <b>patient receive the influenza vaccine in this facility</b> for this year's influenza vaccination season? 0. <b>No</b> → <i>Skip to O0250C, If influenza vaccine not received, state reason</i> 1. <b>Yes</b> → <i>Continue to O0250B, Date influenza vaccine received</i>		
	<b>B.</b> Date influenza vaccine received → <i>Complete date and skip to Z0400, Signature of Persons Completing the Assessment</i>  <div> <div>Month</div> <div>—</div> <div>Day</div> <div>—</div> <div>Year</div> </div>		
<div>Enter Code</div> <div></div>	<b>C. If influenza vaccine not received, state reason:</b> 1. <b>Patient not in this facility during this year's influenza vaccination season</b> 2. <b>Received outside of this facility</b> 3. <b>Not eligible</b> - medical contraindication 4. <b>Offered and declined</b> 5. <b>Not offered</b> 6. <b>Inability to obtain influenza vaccine</b> due to a declared shortage 9. <b>None of the above</b>		

**Section Z**
**Assessment Administration**
**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