

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 0 - 0 1 4

2. STATE:

Ohio

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

Section 1902 (a)(13)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ -0-
b. FFY 2002 \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19D: Rule 5101:3-3-40 Pgs. 1 - 10
Appendix A Pgs. 1 - 13
Appendix B Pgs. 1 of 1
Appendix C Pgs. 1 of 1
Appendix D Pgs. 1 of 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

Attachment 4.19D: Rule 5101:3-3-40

10. SUBJECT OF AMENDMENT:

This amendment provides for the implementation of automated corrections using the new MDS Correction Request Form as published by the Health Care Financing Administration (HCFA).

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

"The Governor's Office has delegated review to the Director of ODJFS"

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Jacqueline Romer-Sensky

14. TITLE:

Director

15. DATE SUBMITTED:

October 4, 2000

16. RETURN TO:

Becky Jackson
Bureau of Health Plan Policy
Office of Ohio Health Plans
Ohio Department of Job and Family Services
30 E. Broad St., 27th floor
Columbus, Ohio 43266-0423

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 10/11/00

18. DATE APPROVED: 12/6/00

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

October 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Insurance Oversight

23. REMARKS:

**Calculation of the FFY 2001 and FFY 2002 Fiscal Impacts
According to the Fiscal Impact Set Forth in the Public Notice
Issued pursuant to Section 1902 (a)(13)(A) of the Social Security Act**

The fiscal impacts set forth below are based upon the amount specified in the initial public notice and the secondary public notice issued to reflect the implementation of the new MDS Correction Request Form as published by the Health Care Financing Administration (HCFA). The fiscal impacts referenced in these public notices were based upon an annual aggregate SFY amount that was prorated for the FFY. The FFY impacts were calculated as follows:

FFY	Annual SFY Impact	FFP% for FFYs 2001-2002	
2001	\$.00	FFY 2001: \$.00 x .5867% = \$.00	Total FFY 2001
			\$.00
2002	\$.00	FFY 2001: \$.00 x .5867% = \$.00	Total FFY 2002
			\$.00

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SECRETARY OF STATE
ELECTIONS

5101:3-3-40 Nursing facility (NF) case mix assessment instrument: Minimum data set version 2.0 (MDS2.0).

2000 SEP 18 PM 4:15

(A) As used in this rule:

- (1) "Annual facility average case mix score" is the score used to calculate the facility's cost per case mix unit, and is calculated using the methodology described in paragraph (E) of rule 5101:3-3-42 of the Administrative Code.
- (2) "Case mix report" is a report generated by the Ohio department of ~~human services~~ (~~ODHS~~) JOB AND FAMILY SERVICES (ODJFS) and distributed to the NF on the status of all MDS2.0 assessment data that pertains to the calculation of a quarterly or an annual average facility case mix score.
- (3) "Comprehensive assessment" means an assessment that includes completion of not only the MDS2.0 designated for use in Ohio but also the triggers, resident assessment protocols (RAPs), and "RAP Summary" form.
- (4) "Critical elements" are data items from a resident's minimum data set version 2.0 (MDS2.0) that ~~ODHS~~ ODJFS verifies prior to determining a resident's resource utilization group, version III (RUG III) class.
- (5) "Critical errors" are errors in the MDS2.0 critical elements, ~~such as omissions or out-of-range responses~~, that prevent ~~ODHS~~ ODJFS from determining the resident's RUG III classification.
- (6) "Cost per case mix unit" is calculated by dividing the facility's desk-reviewed, actual, allowable per diem direct care costs for the calendar year preceding the fiscal year in which the rate will be paid by the annual facility average case mix score for the calendar year preceding the fiscal year in which the rate will be paid. The lesser of the facility's cost per case mix unit or the maximum allowable cost per case mix unit for the facility's peer group for the fiscal year shall be used to determine the facility's rate for direct care costs, in accordance with rule 5101:3-3-44 of the Administrative Code.
- (7) "Default group" is RUG III group forty-five, the case mix group assigned to residents for whom missing or inaccurate data precludes classification into RUG III groups one through forty-four.
- (8) "Direct care peer group" is a group of Ohio medicaid-certified NFs determined by ~~ODHS~~ ODJFS to have significant per diem direct care cost differences from the other direct care peer groups due to reasons other than the differences in care needs among the residents. Direct care peer groups are described in rule 5101:3-3-44 of the Administrative Code.

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FILED
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L.S.C.

TN # 00-014 APPROVAL DATE

SEP 18 2000

SUPERSEDES

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JOINT COMMITTEE
ON AGENCY RULE REVIEW

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- (9) "Encoded," when used with reference to a record, means that the record has been recorded in electronic format. The record must be encoded in accordance with the United States health care financing administration (HCFA) uniform data submission document and state specifications.
- (10) "Filing date" is the deadline for submission of the NF's MDS2.0 assessment data that will be used for rate setting purposes. The filing date is the fifteenth calendar day following the reporting period end date.
- (11) "Locked" means a record ~~is considered final and cannot be altered, in accordance with 42 CFR. 483.20 and paragraph (d)(1) of this rule~~ HAS BEEN ACCEPTED INTO THE STATE DATABASE.
- ~~(12) "Medicare required assessment" means the MDS2.0 specified for use in Ohio that is required only for facilities participating in the medicare prospective payment system but does not include the triggers, resident assessment protocols (RAPs), and RAP summary form.~~
- (12) "MDS 2.0 CORRECTION REQUEST FORM" (CRF) IS THE MECHANISM USED TO REQUEST CORRECTION OF ERROR(S), TO IDENTIFY THE INACCURATE RECORD AND TO ATTEST TO THE CORRECTION REQUEST. A CORRECTION REQUEST CAN BE MADE TO EITHER MODIFY OR INACTIVATE AN MDS2.0 ASSESSMENT RECORD OR AN MDS2.0 DISCHARGE OR REENTRY TRACKING FORM THAT HAS BEEN PREVIOUSLY ACCEPTED INTO THE STATE MDS2.0 DATABASE.
- (13) "~~Minimum data set (MDS2.0)~~" is the core set of screening and assessment elements designated by Ohio and approved by HCFA that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in medicaid and medicare. The MDS2.0 provides the resident assessment data which is used to classify the resident into a resource utilization group (RUG) in the RUG III case mix classification system.
- (14) "MEDICARE REQUIRED ASSESSMENT" MEANS THE MDS2.0 SPECIFIED FOR USE IN OHIO THAT IS REQUIRED ONLY FOR FACILITIES PARTICIPATING IN THE MEDICARE PROSPECTIVE PAYMENT SYSTEM BUT DOES NOT INCLUDE THE TRIGGERS, RAPS, AND RAP SUMMARY FORM.
- ~~(14)~~(15) "Payment quarter" is the quarter following the processing quarter and is the quarter in which the direct care rate is paid based on the quarterly facility average case mix score from the reporting quarter's MDS2.0 data.

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- (15)(16) "Processing quarter" is the quarter that follows the reporting quarter and is the quarter in which ~~ODHS~~ ODJFS calculates the quarterly facility average case mix score.
- (16)(17) "Quarterly facility average case mix score" is the facility average case mix score based on data submitted for one reporting quarter and is calculated using the methodology described in rule 5101:3-3-42 of the Administrative Code.
- (17)(18) "Quarterly review assessment" means an assessment that is normally conducted no less than once every three months using the MDS2.0 designated for use in Ohio that does not include the triggers, ~~resident assessment protocols (RAPs)~~, and RAP summary form.
- (18)(19) "Record" means a resident's encoded MDS2.0 assessment as described in paragraphs (B)(1) to (B)(3) of this rule.
- (19)(20) "Relative resource weight" is the measure of the relative costliness of caring for residents in one case mix group versus another, indicating the relative amount and cost of staff time required on average for defined worker classifications to care for residents in a single case mix group. The methodology for calculating relative resource weights is described in rule 5101:3-3-41 of the Administrative Code.
- (20)(21) "Reporting period end date" (RPED) is the last day of the calendar quarter.
- (21)(22) "Reporting quarter" is the calendar quarter in which the MDS2.0 is conducted, as indicated by the assessment reference date in MDS2.0 section A, item 3a, except as specified in paragraphs (C)(7) and (C)(9) of this rule.
- (22)(23) "Resident Assessment Instrument (RAI)" is the instrument used by NFs in Ohio to comply with ~~42 CFR~~ CODE OF FEDERAL REGULATIONS (CFR) section 483.20 and provides a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capabilities and identifies medical problems. The Ohio-specified and federally-approved instrument is composed of the MDS2.0, triggers, resident assessment protocols (RAPs) and the RAP summary form.
- (23)(24) "Resident assessment protocols (RAPs)" are structured, problem-oriented frameworks for organizing MDS information, and forms the basis for individualized care planning.
- (24)(25) The "resident assessment protocol (RAP) summary" form is used to document which RAPs were triggered, whether or not care planning will be done for the

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triggered condition and where summary data from the RAP review process is documented. It is part of the RAI and must be completed for all comprehensive assessments.

~~(25)~~(26) "Resident case mix score" is the relative resource weight for the RUG III group to which the resident is assigned based on data elements from the resident's MDS2.0 assessment.

~~(26)~~(27) "RUG III" is the resource utilization groups, version III system of classifying NF residents into case mix groups described in rule 5101:3-3-41 of the Administrative Code. Resource utilization groups are clusters of NF residents, defined by resident characteristics, that explain resource use.

~~(27)~~(28) "Triggers" are specific resident responses for one or a combination of MDS2.0 elements. These triggers identify residents who require further evaluation using resident assessment protocols designated within the state specified RAI.

(B) For the purpose of determining medicaid payment rates for NFs effective October 1, 1998 2000 and thereafter, ~~ODHS~~ ODJFS shall accept the RAI specified by the state and approved by HCFA effective ~~April 1, 1998~~. Each NF shall assess all residents of medicaid-certified beds, defined in paragraph (C) of this rule, using the MDS2.0 as set forth in Appendix A of this rule.

(1) Comprehensive assessments, medicare-required assessments, quarterly review assessments and significant corrections of quarterly assessments must be conducted in accordance with the requirements and frequency schedule found at 42 CFR section 483.20.

(a) ~~Effective April 1, 1998, comprehensive~~ COMPREHENSIVE assessments, including the MDS2.0, triggers, RAPs and RAPs summary, are required for all initial assessments, significant change assessments, annual assessments and significant correction of previous comprehensive assessments.

(b) ~~Effective April 1, 1998, the~~ THE MDS.2.0 is required for all medicare-required assessments, quarterly assessments, significant corrections of previous quarterly assessments, and significant corrections of previous medicare required assessments.

(2) ~~As set forth in Appendix A, effective April 1, 1998,~~ NFs must use the Ohio-specified MDS2.0, AS SET FORTH IN APPENDIX A, including sections S, T, and U for all comprehensive assessments, medicare-required assessments, quarterly review assessments, significant change assessments and significant correction assessments.

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- (3) ~~Effective April 1, 1998~~, NFs must use the MDS2.0 discharge tracking form as set forth in Appendix B of this rule for any residents who transfer, are discharged or expire, and the MDS2.0 reentry tracking form as set forth in appendix C of this rule for any residents reentering the facility in accordance with 42 CFR section 483.20.
- (C) Effective July 1, 1998, all NFs must submit to the state encoded, accurate, and complete MDS2.0 data for all residents of medicaid-certified NF beds, regardless of pay source or anticipated length of stay.
- (1) MDS2.0 data completed in accordance with paragraphs (B)(1) to (B)(3) of this rule must be encoded in accordance with 42 CFR section 483.20, HCFA's uniform data submission document, and state record layout specifications.
- (2) MDS2.0 data must be submitted in an electronic format via modem and in accordance with the frequency schedule found in 42 CFR section 483.20. The data may be submitted at any time during the reporting quarter that is permitted by instructions issued by the state, but, except as provided in paragraphs (D) and (E) of this rule, all records used in quarterly rate-setting must be submitted by the filing date.
- (3) If a NF submits MDS2.0 data needed for quarterly rate-setting after the filing date, ~~ODHS~~ ODJFS may assign, for a period of not more than one month per quarter, a quarterly facility average case mix score as set forth in paragraph (E) of rule 5101:3-3-42 of the Administrative Code.
- (4) Data submitted electronically by a NF does not meet the requirements for timely and accurate submission if it cannot be processed by ~~ODHS~~ ODJFS (for example, rejection of the entire data file, submission of a blank file, etc.) and may result in assignment of a quarterly average case mix score as set forth in rule 5101:3-3-42 of the Administrative Code.
- (5) The annual and quarterly facility average case mix scores will be calculated using the MDS2.0 record in effect on the reporting period end date for:
- (a) Residents who were admitted to the medicaid certified NF prior to the reporting period end date and continue to be physically present in the NF on the reporting period end date; and
- (b) Residents who were admitted to the NF on the reporting period end date from a non-NF setting (home, hospital, adult care facility, residential care facility, intermediate care facility for the mentally retarded (ICF-MR)); and

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- (c) Residents who were transferred into the NF from another NF on the reporting period end date; and
 - (d) Residents who were temporarily absent on the reporting period end date but are considered residents and for whom a bed is being held for their return from hospital stays, visits with friends or relatives, or participation in therapeutic programs outside the facility.
- (6) Records for residents who were permanently discharged from the NF, transferred to another NF, or expired prior to or on the reporting period end date will not be used for rate setting
- (7) For a resident admitted within fourteen days of the reporting period end date, and whose initial assessment is not due until after the reporting period end date, both of the following shall apply:
- (a) The NF shall submit the appropriate initial assessment as specified in the MDS2.0 manual and in 42 CFR 483.20; and
 - (b) The initial assessment, if completed and submitted timely in accordance with paragraph (C)(7)(a) of this rule, shall be used for rate setting in the quarter the resident entered the facility even if the assessment reference date is after the reporting period end date.
- (8) ~~A resident specific case mix score will be assigned for a resident of the facility on the reporting period end date who was either:~~ FOR A RESIDENT DISCHARGED PRIOR TO THE COMPLETION OF AN INITIAL ASSESSMENT, ALL OF THE FOLLOWING SHALL APPLY:
- (a) ~~Admitted in the final fourteen days of the calendar quarter and whose initial assessment was not completed because the resident was discharged or expired, or~~
THE NF SHALL SUBMIT A DISCHARGE TRACKING FORM WITH THE REASON FOR ASSESSMENT (MDS2.0, ITEM AA8a) CODED AS "EIGHT", DISCHARGED PRIOR TO COMPLETING INITIAL ASSESSMENT".
 - (b) ~~Admitted in the final thirty days of the calendar quarter and returned to the hospital prior to the completion of the initial assessment, and is still in the hospital on the reporting period end date.~~ THE DISCHARGE STATUS (MDS2.0 ITEM R3) SHALL BE CODED ONE" THROUGH "NINE" AS APPROPRIATE.

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- (c) The resident specific case mix score FOR CLINICALLY COMPLEX CATEGORY , GROUP TWENTY TWO, CLASS "CC1" shall be assigned ~~as follows:~~ FOR A RESIDENT OF THE FACILITY ON THE RPED WHO WAS EITHER:
- (i) ~~The facility shall submit the resident's discharge tracking record, and~~ ADMITTED IN THE FINAL FOURTEEN DAYS OF THE CALENDAR QUARTER AND WHOSE INITIAL ASSESSMENT WAS NOT COMPLETED BECAUSE THE RESIDENT WAS DISCHARGED OR EXPIRED.
 - (ii) ~~The reason for assessment (MDS2.0, item AA8a) shall be coded as "eight", "discharged prior to completing initial assessment~~ ADMITTED IN THE FINAL THIRTY DAYS OF THE CALENDAR QUARTER AND WAS ADMITTED TO THE HOSPITAL PRIOR TO THE COMPLETION OF THE INITIAL ASSESSMENT, AND IS STILL IN THE HOSPITAL ON THE RPED.
 - (iii) ~~The discharge status (MDS2.0, item R3) shall be coded "one" through "nine" as appropriate.~~
 - (iv) ~~ODHS shall group the resident into the clinically complex category, group twenty two, class "CC1".~~
- (9) For a resident who had at least one MDS2.0 assessment completed before being transferred to a hospital, reenters the NF within fourteen days of the reporting period end date, and has experienced a significant change in status that requires a comprehensive assessment upon reentry,
- (a) The NF shall submit a significant change assessment within fourteen days of reentry, as indicated by the MDS2.0 assessment reference date (MDS2.0, item A3).
 - (b) The significant change assessment shall be used for rate setting for the quarter in which the resident reentered the facility even if the assessment reference date is after the reporting period end date.
- (D) Corrections to MDS2.0 data must be made in accordance with the requirements in the "Long Term Care Facility (LTCF) RAI User's Manual" version 2.0, THE "LONG TERM CARE RAI VERSION 2.0 PROVIDER INSTRUCTIONS FOR MAKING AUTOMATED CORRECTIONS USING THE NEW MDS2.0 CRF" and the "State Operation Manual" (SOM) issued by HCFA.

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(1) Corrections to ~~clinical~~ MDS2.0 data can be made as follows:

~~(a)~~ Corrections may be made to key fields as specified by HCFA.

~~(b)~~(a) PRIOR TO TRANSMISSION TO THE STATE AND ~~Within~~ WITHIN seven days after completion of the MDS2.0, BY FOLLOWING THE INSTRUCTIONS as specified in the "LTCF RAI User's Manual" version 2.0, THE "LONG TERM CARE RAI VERSION 2.0 PROVIDER INSTRUCTIONS FOR MAKING AUTOMATED CORRECTIONS USING THE NEW MDS CRF" and the SOM issued by HCFA, ~~seven days or transmission to the state, whichever occurs first.~~

(b) FOR RATE-SETTING PURPOSES, THE FACILITY HAS EIGHTY DAYS AFTER THE REPORTING PERIOD END DATE TO TRANSMIT THE APPROPRIATE CORRECTIONS TO THE STATE.

(c) AFTER THE RECORD IS LOCKED, DATA CORRECTIONS AS SPECIFIED IN THE "LONG TERM CARE RAI VERSION 2.0 PROVIDER INSTRUCTIONS FOR MAKING AUTOMATED CORRECTIONS USING THE NEW MDS CRF" AND THE SOM ISSUED BY HCFA.

~~(e)~~(d) After the record is locked, correction to the clinical data IN THE EVENT OF A MAJOR ERROR can only be made by completing a significant correction assessment or, if there has actually been a significant change in status, a comprehensive significant change assessment. These assessments must be completed in accordance with the instructions in the "LTCF RAI User's Manual" version 2.0, THE "LONG TERM CARE RAI VERSION 2.0 PROVIDER INSTRUCTIONS FOR MAKING AUTOMATED CORRECTIONS USING THE NEW MDS CRF" and the SOM as issued by HCFA, and require a new observation period and assessment reference date.

~~(f)~~ (i) For rate-setting purposes, significant correction assessments must have an assessment reference date within the reporting quarter.

~~(e)~~ (ii) For rate-setting purposes, significant change assessments must have an assessment reference date within the reporting quarter except when used to report a significant change in a resident's status upon return from a hospital as specified in paragraph (C)(9) of this rule.

(2) It is the provider's responsibility to submit an accurate, encoded MDS2.0 record for each resident in a medicaid-certified bed on the last day of the calendar quarter.

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- (a) The facility shall transmit MDS2.0 assessments that were completed timely but inadvertently omitted from the previous transmissions, and ~~ODHS~~ ODJFS shall use the actual case mix scores from these assessments for rate setting purposes, if the assessments are transmitted within eighty days after the reporting period end date. If the assessments are not transmitted within eighty days after the reporting period end date, ~~ODHS~~ ODJFS may assign default scores for those records as described in rule 5101:3-3-41 of this Administrative Code.
 - (b) The facility has eighty days after the reporting period end date to transmit the appropriate discharge tracking form to the state, if the facility identified more residents as being in the facility on the reporting period end date (RPED) than the number of its medicaid-certified beds. If the facility does not correct the error within eighty days after the reporting period end date, ~~ODHS~~ ODJFS may assign a facility average case mix score as specified in rule 5101:3-3-42 of the Administrative Code.
 - (c) The facility shall notify ~~ODHS~~ ODJFS within eighty days of the reporting period end date of any records for residents in medicaid-certified beds on the reporting period end date that were not completed timely, and were not transmitted to the state. ~~ODHS~~ ODJFS may assign default scores to those records as described in rule 5101:3-3-41 of the Administrative Code.
 - (d) The facility shall notify ~~ODHS~~ ODJFS within eighty days of the reporting period end date of any residents who were reported to be residents of the facility on the reporting period end date, but who had actually been discharged prior to the reporting period end date. If the facility does not correct the error within eighty days after the reporting period end date, ~~ODHS~~ ODJFS may assign a facility average case mix score as specified in rule 5101:3-3-42 of the Administrative Code.
- (3) If the number of records assigned to the default group in accordance with paragraphs (D)(2)(a) and (D)(2)(c) of this rule is greater than ten per cent, ~~ODHS~~ ODJFS may assign a quarterly facility average case mix score, as set forth in paragraph (E) of rule 5101:3-3-42 of the Administrative Code.
- (E) All NFs submitting MDS2.0 data for rate-setting purposes must be approved for electronic submission in accordance with technical instructions issued by the state.
- (1) NFs are responsible for transmitting all MDS2.0 data used for rate-setting timely and in an approved format. As specified in paragraph (C)(4) of this rule, MDS2.0 records shall not be considered to meet the requirements for timely and accurate submission if they cannot be processed by ~~ODHS~~ ODJFS.

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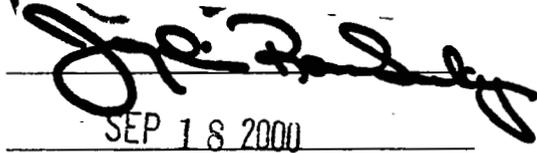
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- (2) NFs requesting an extension of the filing date must submit a written request and supporting documentation to ~~ODHS~~ ODJFS.

Effective date: OCT 01 2000

Review date: 14 JULY 2000, 14 JULY 2005

Certification: 
SEP 18 2000
Date

Promulgated under: Revised Code Chapter 119.
Statutory authority: Revised Code Sections 5111.02, 5111.231.
Rule amplifies: Revised Code Sections 5111.01, 5111.02, 5111.231.
Prior effective dates: 10/1/92 (Emer.), 12/31/92, 4/15/93 (Emer.), 7/1/93, 12/1/93 (Emer.), 3/17/94, 7/1/94 (Emer.), 9/30/94, 7/1/98

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APPENDIX A - ENACTED

Numeric Identifier _____

MINIMUM DATA SET (MDS) — VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1. RESIDENT NAME [Ⓞ]	a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)																				
2. GENDER [Ⓞ]	1. Male		2. Female																					
3. BIRTHDATE [Ⓞ]	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td colspan="3">Month</td> <td colspan="2">Day</td> <td colspan="5">Year</td> </tr> </table>														Month			Day		Year				
Month			Day		Year																			
4. RACE/ [Ⓞ] ETHNICITY	1. American Indian/Alaskan Native		4. Hispanic																					
	2. Asian/Pacific Islander		5. White, not of Hispanic origin																					
	3. Black, not of Hispanic origin																							
5. SOCIAL SECURITY [Ⓞ] AND MEDICARE NUMBERS [Ⓞ] (C in 1 st box if non med. no.)	a. Social Security Number																							
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	b. Medicare number (or comparable railroad insurance number)																							
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6. FACILITY PROVIDER NO. [Ⓞ]	a. State No.																							
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7. MEDICAID NO. ("+" if pending, "N" if not a Medicaid recipient) [Ⓞ]	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>																							
8. REASONS FOR ASSESSMENT	(Note—Other codes do not apply to this form)																							
	<p>a. Primary reason for assessment</p> <ol style="list-style-type: none"> Admission assessment (required by day 14) Annual assessment Significant change in status assessment Significant correction of prior full assessment Quarterly review assessment Significant correction of prior quarterly assessment NONE OF ABOVE <p>b. Codes for assessments required for Medicare PPS or the State</p> <ol style="list-style-type: none"> Medicare 5 day assessment Medicare 30 day assessment Medicare 60 day assessment Medicare 90 day assessment Medicare readmission/return assessment Other state required assessment Medicare 14 day assessment Other Medicare required assessment 																							

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident 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 ensuring that residents receive appropriate and quality care, and 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 I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

TN #22-014 APPROVAL DATE _____
SUPERSEDES
TN #98-10 EFFECTIVE DATE 10/1/00

Ⓞ = Key items for computerized resident tracking
 = When box blank, must enter number or letter a. = When letter in box, check if condition applies