MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home and Swing Bed Tracking (NT/ST) Item Set

Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code

Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code

B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **Not PPS** assessment

Enter Code

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code

E. Is this assessment the first assessment (OBRA, PPS, or Discharge) **since the most recent admission?**
0. **No**
1. **Yes**

Enter Code

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

Resident _____ Identifier _____ Date _____

Section A Identification Information

A0410. Submission Requirement

Enter Code ☐

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

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**

A1200. Marital Status

Enter Code ☐

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1300. Optional Resident Items

A. Medical record number:

B. Room number:

C. Name by which resident prefers to be addressed:

D. Lifetime occupation(s) - put "/" between two occupations**:**

A1600. Entry Date (date of this admission/reentry into the facility)

Month – Day – Year

A1700. Type of Entry

Enter Code

1. **Admission**
2. **Reentry**

A1800. Entered From

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
99. **Other**

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

Month – Day – Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
08. **Deceased**
99. **Other**

Resident _____ Identifier _____ Date _____

Section A Identification Information

A2400. Medicare Stay

Enter Code ☐

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to X0100, Type of Record
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0100. Type of Record

Enter Code ☐

1. **Add new record** → Skip to Z0400, Signature of Persons Completing the Assessment or Entry/Death Reporting
2. **Modify existing record** → Continue to X0150, Type of Provider
3. **Inactivate existing record** → Continue to X0150, Type of Provider

Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider

Enter Code ☐

Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

X0200. Name of Resident on existing record to be modified/inactivated

A. First name: ☐☐☐☐☐☐☐☐☐☐☐☐

C. Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

X0300. Gender on existing record to be modified/inactivated

Enter Code ☐

1. **Male**
2. **Female**

X0400. Birth Date on existing record to be modified/inactivated

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

X0500. Social Security Number on existing record to be modified/inactivated

☐☐☐ – ☐☐ – ☐☐☐☐

X0600. Type of Assessment on existing record to be modified/inactivated

Enter Code ☐☐

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code ☐☐

B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **Not PPS** assessment

Enter Code ☐

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

X0600 continued on next page

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code ☐

D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2
0. **No**
1. **Yes**

Enter Code ☐☐

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

X0700. Date on existing record to be modified/inactivated - Complete one only

A. Assessment Reference Date - Complete only if X0600F = 99
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

B. Discharge Date - Complete only if X0600F = 10, 11, or 12
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. Entry Date - Complete only if X0600F = 01
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request

X0800. Correction Number

Enter Number ☐☐

Enter the number of correction requests to modify/inactivate the existing record, including the present one

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 2)

Check all that apply

☐ **A. Transcription error**
☐ **B. Data entry error**
☐ **C. Software product error**
☐ **D. Item coding error**
☐ **Z. Other error requiring modification**
If "Other" checked, please specify: _____

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (X0100 = 3)

Check all that apply

☐ **A. Event did not occur**
☐ **Z. Other error requiring inactivation**
If "Other" checked, please specify: _____

Resident _____ Identifier _____ Date _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month – Day – Year

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment 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	Title	Sections	Date Section Completed
A.			
B.			
C.			