

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

### BASIC ASSESSMENT TRACKING FORM

#### SECTION AA. IDENTIFICATION INFORMATION

<b>1.</b>	<b>RESIDENT NAME<sup>Ⓞ</sup></b>																																												
		<b>a. (First)</b>	<b>b. (Middle Initial)</b>	<b>c. (Last)</b>	<b>d. (Jr/Sr)</b>																																								
<b>2.</b>	<b>GENDER<sup>Ⓞ</sup></b>	1. Male                      2. Female																																											
<b>3.</b>	<b>BIRTHDATE<sup>Ⓞ</sup></b>	<table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td>Month</td> <td>Day</td> <td colspan="8">Year</td> </tr> </table>														Month	Day	Year																											
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<b>4.</b>	<b>RACE/<sup>Ⓞ</sup> ETHNICITY</b>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">1. American Indian/Alaskan Native</td> <td style="width: 50%;">4. Hispanic</td> </tr> <tr> <td>2. Asian/Pacific Islander</td> <td>5. White, not of Hispanic origin</td> </tr> <tr> <td>3. Black, not of Hispanic origin</td> <td></td> </tr> </table>				1. American Indian/Alaskan Native	4. Hispanic	2. Asian/Pacific Islander	5. White, not of Hispanic origin	3. Black, not of Hispanic origin																																			
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<b>5.</b>	<b>SOCIAL SECURITY<sup>Ⓞ</sup> AND MEDICARE NUMBERS<sup>Ⓞ</sup></b> [C in 1 <sup>st</sup> box if non med. no.]	<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="10"><b>a. Social Security Number</b></td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="10"><b>b. Medicare number (or comparable railroad insurance number)</b></td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>				<b>a. Social Security Number</b>																				<b>b. Medicare number (or comparable railroad insurance number)</b>																			
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<b>6.</b>	<b>FACILITY PROVIDER NO.<sup>Ⓞ</sup></b>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="10"><b>a. State No.</b></td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="10"><b>b. Federal No.</b></td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>				<b>a. State No.</b>																				<b>b. Federal No.</b>																			
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<b>7.</b>	<b>MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient]<sup>Ⓞ</sup></b>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>																																											
<b>8.</b>	<b>REASONS FOR ASSESSMENT</b>	<p>[Note—Other codes do not apply to this form]</p> <p><b>a. Primary reason for assessment</b></p> <ol style="list-style-type: none"> <li>1. Admission assessment (required by day 14)</li> <li>2. Annual assessment</li> <li>3. Significant change in status assessment</li> <li>4. Significant correction of prior full assessment</li> <li>5. Quarterly review assessment</li> <li>10. Significant correction of prior quarterly assessment</li> <li>0. NONE OF ABOVE</li> </ol> <p><b>b. Codes for assessments required for Medicare PPS or the State</b></p> <ol style="list-style-type: none"> <li>1. Medicare 5 day assessment</li> <li>2. Medicare 30 day assessment</li> <li>3. Medicare 60 day assessment</li> <li>4. Medicare 90 day assessment</li> <li>5. Medicare readmission/return assessment</li> <li>6. Other state required assessment</li> <li>7. Medicare 14 day assessment</li> <li>8. Other Medicare required assessment</li> </ol>																																											

<b>9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form</b>		
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
<b>a.</b>		
<b>b.</b>		
<b>c.</b>		
<b>d.</b>		
<b>e.</b>		
<b>f.</b>		
<b>g.</b>		
<b>h.</b>		
<b>i.</b>		
<b>j.</b>		
<b>k.</b>		
<b>l.</b>		

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

Ⓞ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter    a. ☐ = When letter in box, check if condition applies