Resident _____ Identifier _____ Date _____

## LTC Medicaid Information

### S1. Claims Processing Information

| | | |
|---|---|---|
| S1a | DADS Vendor/Site ID Number | |
| S1b | Provider Number | |
| S1c | Service Group<br>1. Nursing Facility<br>10. Swing Bed | |
| S1d | Hospice Provider Number | |
| S1e | Purpose Code<br>E. Missed Assessment<br>M. Coverage Code must be P | |
| S1f | Missed Assessment or Prior Start Date | |
| S1g | Missed Assessment or Prior End Date | |

### S2. PASARR Information

| | | |
|---|---|---|
| S2a | To your knowledge, does the resident have an intellectual disability? Y/N | |
| S2b | To your knowledge, does the resident have a developmental disability? Y/N | |
| S2c | To your knowledge, does the resident have a condition of mental illness according to the PASARR guidelines? Y/N | |
| S2d | Is the resident a danger to himself/herself? Y/N | |
| S2e | Is the resident a danger to others? Y/N | |
| S2f | Are specialized services indicated? Y/N | |

### S3. Physician's Evaluation & Recommendation

| | | |
|---|---|---|
| S3a | Does the MD/DO have plans for the eventual discharge of this resident? Y/N | |
| S3b | Rehabilitative Potential<br>1 good<br>2 fair<br>3 minimal | |
| S3c | Did an MD/DO certify that this resident requires/continues to require nursing facility care? Y/N | |
| S3d | MD/DO Last Name | |
| S3e | MD/DO License # | |
| S3f | MD/DO License State | |
| S3g | MD/DO Military Spec Code # | |
| The following MD/DO information is required if MD/DO is **not** licensed in Texas. | | |
| S3h | MD/DO First Name | |
| S3i | MD/DO Address | |
| | | |
| S3j | MD/DO City | |
| S3k | MD/DO State | |
| S3l | MD/DO ZIP Code | |
| S3m | MD/DO Phone | |

### S4. Licenses

**Provider Certification**: On behalf of this facility, I certify to the completeness of the MDS Assessment.

| | | |
|---|---|---|
| S4a | RN Coordinator Last Name from Z0500A | |
| S4b | RN Coordinator License # | |
| S4c | RN Coordinator License State | |

### S5. Primary Diagnosis

| | | |
|---|---|---|
| S5a | Primary Diagnosis ICD Code | |
| S5b | Primary Diagnosis ICD Description | |

**LTC Medicaid Information**

**S6. Additional MN Information**

| | | |
|---|---|---|
| S6a | Tracheostomy Care<br>1. Less than once a week<br>2. 1 to 6 times a week<br>3. Once a day<br>4. Twice a day<br>5. 3 - 11 times a day<br>6. Every 2 hours<br>7. Hourly / continuous | |
| S6b | Ventilator/Respirator<br>1. Less than once a week<br>2. 1 to 6 times a week<br>3. Once a day<br>4. Twice a day<br>5. 3 - 11 times a day<br>6. 6 - 23 hours<br>7. 24-hour continuous | |
| S6c | Number of hospitalizations in the last 90 days | |
| S6d | Number of emergency room visits in the last 90 days | |
| S6e | Oxygen Therapy<br>1. Less than once a week<br>2. 1 to 6 times a week<br>3. Once a day<br>4. Twice a day<br>5. 3 - 11 times a day<br>6. 6 - 23 hours<br>7. 24-hour continuous | |
| S6f | Special Ports/Central Lines/PICC<br>Y/N/U | |
| S6g | At what developmental level is the resident functioning?<br>1. < 1 Infant<br>2. 1 - 2 Toddler<br>3. 3 - 5 Pre-School<br>4. 6 - 10 School age<br>5. 11 - 15 Young Adolescence<br>6. 16 - 20 Older Adolescence<br>-. Unknown or unable to assess | |

| | | |
|---|---|---|
| S6h | Enter the number of times this resident has fallen in the last 90 days. | |
| S6i | In how many of the falls listed above was the person physically restrained prior to the fall? | |
| S6j | In the falls listed in S6h above, how many had the following contributory factors? (More than one factor may apply to a fall. Indicate the number of falls for each contributory factor.) | |
| S6j1 | Environmental (debris, slick or wet floors, lighting, etc.) | |
| S6j2 | Medication(s) | |
| S6j3 | Major Change in Medical Condition (Myocardial Infarction (MI/Heart Attack), Cerebrovascular Accident (CVA/Stroke), Syncope (Fainting), etc.) | |
| S6j4 | Poor Balance/Weakness | |
| S6j5 | Confusion/Disorientation | |
| S6j6 | Assault by Resident or Staff | |

**S7. For DADS Only**

| | | |
|---|---|---|
| S7a | MN | |
| S7b | RUG | |
| S7c | Effective Date | |
| S7d | Expiration Date | |
| S7e | County | |
| S7f | Region | |

**S8. Resident's Current Address**

| | | |
|---|---|---|
| S8a | Resident's Address | |
| | | |
| S8b | City | |
| S8c | State | |
| S8d | ZIP Code | |
| S8e | Phone | |

**LTC Medicaid Information**

**S9. Medications**

List all medications that the resident received during the last 30 days. Include scheduled medications that are used regularly, but less than weekly.

☐ **Medication Certification:** I certify this resident is taking no medications OR the medications listed below are correct

| 1. Medication Name and Dose Ordered | 2. RA | 3. Freq | 4. PRN-n |
|---|---|---|---|
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## LTC Medicaid Information

### S10. Comments

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| |

### S11. Advance Care Planning

| | | |
|---|---|---|
| S11a | Does the resident report having a legally authorized representative? Y/N | |
| S11b | Does the resident report having a Directive to Physicians and Family or Surrogates? Y/N | |
| S11c | Does the resident report having a Medical Power of Attorney? Y/N | |
| S11d | Does the resident report having an Out-of-Hospital Do Not Resuscitate Order? Y/N | |

### S12. LAR Address

| Required if resident has reported having a legally authorized representative. | | |
|---|---|---|
| S12a | LAR First Name | |
| S12b | LAR Last Name | |
| S12c | Address | |
| | | |
| S12d | City | |
| S12e | State | |
| S12f | ZIP Code | |
| S12g | Phone | |