

471-000-46 Instructions for Completing "MDS 2.0 Re-entry Tracking Form"

USE: The form "MDS 2.0 Re-entry Tracking Form" (previously identified as Form MC-75R) is completed whenever a resident re-enters the nursing home following temporary admission to a hospital or other health care setting. This is the only form that must always be completed at the time of re-entry to the nursing home.

If the resident re-enters the nursing home following a temporary admission to a hospital or other health care setting AND also meets the significant change criteria, a full assessment must be completed. In this case, the resident's file should contain a Re-entry Tracking Form, a Basic Assessment Tracking Form (Section AA), and a Full Assessment (significant change). In this scenario, enter a code of "9" Re-entry for Item 8 (Reason for Assessment) on the Re-entry Tracking Form; enter a code of "3" Significant Change Assessment for Item 8 (Reason for Assessment) on both the Basic Assessment Tracking Form and a Full Assessment form.

Numeric Identifier _____

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

SECTION AA. IDENTIFICATION INFORMATION

1. RESIDENT NAME [Ⓢ]	a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
	1. Male 2. Female			
2. GENDER [Ⓢ]				
3. BIRTHDATE [Ⓢ]	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		6. Hispanic origin	
5. SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1 st box if non med. no.]	a. Social Security Number			
	b. Medicare number (or comparable railroad insurance number)			
6. FACILITY PROVIDER NO. [Ⓢ]	a. State No.			
	b. Federal No.			
7. MEDICAID NO. [1 st box "if pending," "W" if not a Medicaid recipient [Ⓢ]]				
8. REASONS FOR ASSESSMENT	(Note—Other codes do not apply to this form)			
	a. Primary reason for assessment			
	9. Reentry			
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 long-term 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.				

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a. DATE OF REENTRY	Date of reentry
	Month Day Year
4b. ADMITTED FROM (AT REENTRY)	1. Private home/apt. with no home health services
	2. Private home/apt. with home health services
	3. Board and care/assisted living/group home
	4. Nursing home
	5. Acute care hospital
	6. Psychiatric hospital/IR-DC facility
	7. Rehabilitation hospital
	8. Other
6. MEDICAL RECORD NO.	

[Ⓢ] = Key items for computerized resident tracking

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