

471-000-47 Instructions for Completing Form "MDS 2.0 Discharge Tracking Form"

USE: The form "MDS 2.0 Discharge Tracking Form" (previously identified as Form MC-75D) must be completed whenever a resident is discharged from the facility for reasons other than a temporary visit home. This is the only form that must always be completed at the time of any discharge from the nursing home.

Numeric Identifier _____

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

DISCHARGE TRACKING FORM [do not use for temporary visits home]

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 [Ⓢ]	Month	Day	Year	
4. RACE/ ETHNICITY [Ⓢ]	1. American Indian/Alaskan Native		4. Hispanic	
	2. Asian/Pacific Islander		5. White, not of 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. ["+" if pending, "N" if not a Medicaid recipient] [Ⓢ]				
8. REASONS FOR ASSESSMENT	[Note—Other codes do not apply to this form]			
	a. Primary reason for assessment			
9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form	b. Discharged—return not anticipated			
	c. Discharged—return anticipated			
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.				

SECTION AB. DEMOGRAPHIC INFORMATION

[Complete only for stays less than 14 days] (AA8a=8)

1. DATE OF ENTRY	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date
	Month — Day — Year
2. ADMITTED FROM (AT ENTRY)	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, MR/DD facility 7. Rehabilitation hospital 8. Other

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

6. MEDICAL RECORD NO.	
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SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3. DISCHARGE STATUS	a. Code for resident disposition upon discharge
	1. Private home/apartment with no home health services 2. Private home/apartment with home health services 3. Board and care/assisted living 4. Another nursing facility 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other
4. DISCHARGE DATE	b. Optional State Code
	Date of death or discharge
	Month — Day — Year

Ⓢ = Key items for computerized resident tracking

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