Patient Tracking Sheet

(M0010) CMS Certification Number: __ __ __ __ __ __

(M0014) Branch State: __ __

(M0016) Branch ID Number: __ __ __ __ __ __ __ __ __ __

(M0018) National Provider Identifier (NPI) for the attending physician who has signed the plan of care:
__ __ __ __ __ __ __ __ __ __ ☐ **UK - Unknown or Not Available**

(M0020) Patient ID Number: __

(M0030) Start of Care Date: __ __ / __ __ / __ __ __ __ (month / day / year)

(M0032) Resumption of Care Date: __ __ / __ __ / __ __ __ __ (month / day / year) ☐ **NA - Not Applicable**

(M0040) Patient Name: __ (First) (MI)

__ (Last) (Suffix)

(M0050) Patient State of Residence: __ __

(M0060) Patient Zip Code: __ __ __ __ __ - __ __ __ __

(M0063) Medicare Number: __ __ __ __ __ __ __ __ __ __ __ __ (including suffix) ☐ **NA - No Medicare**

(M0064) Social Security Number: __ __ __ - __ __ - __ __ __ __ ☐ **UK - Unknown or Not Available**

(M0065) Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ ☐ **NA - No Medicaid**

(M0066) Birth Date: __ __ / __ __ / __ __ __ __ (month / day / year)

(M0069) Gender:

Enter Code	
☐	1-Male 2-Female

(M0140) Race/Ethnicity: (Mark all that apply)

- ☐ 1 - American Indian or Alaska Native
- ☐ 2 - Asian
- ☐ 3 - Black or African-American
- ☐ 4 - Hispanic or Latino
- ☐ 5 - Native Hawaiian or Pacific Islander
- ☐ 6 – White

(M0150) Current Payment Sources for Home Care: (Mark all that apply)

- ☐ 0 - None; no charge for current services
- ☐ 1 - Medicare (traditional fee-for-service)
- ☐ 2 - Medicare (HMO/managed care/Advantage plan)
- ☐ 3 - Medicaid (traditional fee-for-service)
- ☐ 4 - Medicaid (HMO/managed care)
- ☐ 5 - Workers' compensation
- ☐ 6 - Title programs (e.g., Title III, V, or XX)
- ☐ 7 - Other government (e.g., TriCare, VA, etc.)
- ☐ 8 - Private insurance
- ☐ 9 - Private HMO/managed care
- ☐ 10 - Self-pay
- ☐ 11 - Other (specify)_____
- ☐ UK – Unknown

Clinical Record Items

(M0080) Discipline of Person Completing Assessment:

Enter Code	
☐	1 – RN 2 – PT 3 – SLP/ST 4 – OT

(M0090) Date Assessment Completed: __ __ / __ __ / __ __ __ __ (month / day / year)

(M0100) This Assessment is Currently Being Completed for the Following Reason: Discharge from Agency - Not to an Inpatient Facility

Enter Code	
☐	8 – Death at home

Medications

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

Enter Code	
☐	0 - No 1 - Yes NA - There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

(M0903) Date of Last (Most Recent) Home Visit:

__ __ /__ __ / __ __ __ __
month / day / year

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

__ __ /__ __ / __ __ __ __
month / day / year

Section J: Health Conditions

(J1800) Any Falls Since SOC/ROC, whichever is more recent

Enter Code	Has the patient **had any falls since SOC/ROC,** whichever is more recent?
☐	0 - **No** →*Skip J1900* 1 - **Yes** → *Continue to J1900. Number of Falls Since SOC/ROC, whichever is more recent*

(J1900) Number of Falls Since SOC/ROC, whichever is more recent

Coding: 0. None 1. One 2. Two or more	**Enter Code in Boxes**	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma