DEATH AT HOME

Client's Name:

Client Record No.

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A. DEMOGRAPHIC/GENERAL INFORMATION

1. **(M0010) Agency Medicare Provider Number:** __ __ __ __ __ __

2. **(M0012) Agency Medicaid Provider Number:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Branch Identification (Optional, for Agency Use)

3. **(M0014) Branch State:** __ __

4. **(M0016) Branch ID Number:** __ __ __ __ __ __ __ __ __ __ (Agency-assigned)

5. **(M0020) Patient ID Number:** __

6. **(M0030) Start of Care Date:** __ __ – __ __ – __ __ __ __ (m m d d y y y y)

7. **(M0032) Resumption of Care Date:** __ __ – __ __ – __ __ __ __ (m m d d y y y y) ☐ NA - Not Applicable

8. **(M0040) Patient Name:** _____ (First) _____ (MI) _____ (Last) _____ (Suffix)

9. **Patient Address:** _____ Street, Route, Apt. Number - not P.O. Box

_____ City _____ **(M0050)** State _____ **(M0060)** Zip Code

10. **Patient Phone:** ( ) _____ – _____

11. **(M0063) Medicare Number:** __ __ __ __ __ __ __ __ __ __ __ __ (including suffix if any) ☐ NA - No Medicare

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

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

14. **(M0066) Birth Date:** __ __ – __ __ – __ __ __ __ (m m d d y y y y)

15. **(M0069) Gender:** ☐ 1 - Male ☐ 2 - Female

16. **(M0072) Primary Referring Physician ID:** __ __ __ __ __ __ __ __ __ __ (UPIN#) ☐ UK - Unknown or Not Available

17. **(M0080) Discipline of Person Completing Assessment:**
    - ☐ 1 - RN
    - ☐ 2 - PT
    - ☐ 3 - SLP/ST
    - ☐ 4 - OT

18. **(M0090) Date Assessment Completed:** __ __ – __ __ – __ __ __ __ (m m d d y y y y)

19. **(M0100) This Assessment is Currently Being Completed for the Following Reason:**

Start/Resumption of Care
- 1 - Start of care—further visits planned
- 2 - Start of care—no further visits planned
- 3 - Resumption of care (after inpatient stay)

Follow-Up
- 4 - Recertification (follow-up) reassessment
- 5 - Other follow-up

Transfer to an Inpatient Facility
- 6 - Transferred to an inpatient facility—patient not discharged from agency
- 7 - Transferred to an inpatient facility—patient discharged from agency

Discharge from Agency — Not to an Inpatient Facility
- ☐ **8 - Death at home [Go to *M0150*]**
- 9 - Discharge from agency
- 10 - Discharge from agency—no visits completed after start/resumption of care assessment

20. **(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)
    - ☐ 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., CHAMPUS, VA, etc.)
    - ☐ 8 - Private insurance
    - ☐ 9 - Private HMO/managed care
    - ☐ 10 - Self-pay
    - ☐ 11 - Other (specify) _____

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

__ __ – __ __ – __ __ __ __ (m m d d y y y y)

B. SUMMARY OF CARE PROVIDED DURING HOME CARE EPISODE:

Date of Assessment: _____ Signature of Assessor: _____