

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1279. The expiration date is 12/31/2027. The time required to complete this information collection is estimated to be 0.15 - 0.3 minutes per data element, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. This estimate does not include time for training. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

*****CMS Disclaimer*****Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Annese Abdullah-McLaughlin, National Coordinator, Home Health Quality Reporting Program Centers for Medicare & Medicaid Services.

M0065. Medicaid Number

<input type="text"/>																			
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

NA — No Medicaid

M0069. Gender

Enter Code

1. **Male**
2. **Female**

M0066. Birth Date

<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

A1005. Ethnicity

Are you of Hispanic, Latino/a, or Spanish origin?



Check all that apply

A. **No, not of Hispanic, Latino/a, or Spanish origin**B. **Yes, Mexican, Mexican American, Chicano/a**C. **Yes, Puerto Rican**D. **Yes, Cuban**E. **Yes, another Hispanic, Latino, or Spanish origin**X. **Patient unable to respond**Y. **Patient declines to respond****A1010. Race**

What is your race?



Check all that apply

A. **White**B. **Black or African American**C. **American Indian or Alaska Native**D. **Asian Indian**E. **Chinese**F. **Filipino**G. **Japanese**H. **Korean**I. **Vietnamese**J. **Other Asian**K. **Native Hawaiian**L. **Guamanian or Chamorro**M. **Samoan**N. **Other Pacific Islander**X. **Patient unable to respond**Y. **Patient declines to respond**Z. **None of the above**

M0150. Current Payment Sources for Home Care

↓	Check all that apply
<input type="checkbox"/>	0. None ; no charge for current services
<input type="checkbox"/>	1. Medicare (traditional fee-for-service)
<input type="checkbox"/>	2. Medicare (HMO/managed care/Advantage plan)
<input type="checkbox"/>	3. Medicaid (traditional fee-for-service)
<input type="checkbox"/>	4. Medicaid (HMO/managed care)
<input type="checkbox"/>	5. Worker's compensation
<input type="checkbox"/>	6. Title programs (for example, Title III, V, or XX)
<input type="checkbox"/>	7. Other government (for example, TriCare, VA)
<input type="checkbox"/>	8. Private insurance
<input type="checkbox"/>	9. Private HMO/managed care
<input type="checkbox"/>	10. Self-pay
<input type="checkbox"/>	11. Other (specify)
<input type="checkbox"/>	UK. Unknown