

Care Provider Name: _____
Est. Form Completion Time: _____

PROJECT TO DEVELOP AN OUTCOME-BASED CONTINUOUS
QUALITY IMPROVEMENT SYSTEM AND CORE OUTCOME AND
COMPREHENSIVE ASSESSMENT DATA SET FOR PACE

**DRAFT COCOA DATA SET
INTAKE FORM**

Conducted by:
The Center for Health Services Research

for:

Department of Health and Human Services
Centers for Medicare and Medicaid Services

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 0938-0791. The time required to complete this information collection is estimated to vary from four to six minutes with an average of five minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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, N2-14-26, Baltimore, Maryland 21244-1850.

Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment. Responses to the collection of the information are voluntary.

DRAFT COCOA DATA SET INTAKE FORM OVERVIEW/PROTOCOL

- PURPOSE:** The information is being collected as part of a two-site feasibility test for the purpose of testing the feasibility of data collection using the draft core outcome and comprehensive assessment (COCOA) data set for PACE. Proposed data collection protocols will also be tested. The two-site feasibility test will result in the refinement of data items and protocols as appropriate. Findings from this project are intended to guide the anticipated implementation of a national approach for core comprehensive assessment of participants and outcome-based continuous quality improvement (OBCQI), in which PACE sites will collect data that will be used to determine and profile participant outcomes for their site.
- HOW COLLECTED:** This form will be completed by PACE intake staff at the initial assessment time point for a new program enrollee. For the two-site feasibility test, the form will be completed by intake staff one time during the data collection period.
- WHEN COLLECTED:** This form will be completed for each participant at one time point during the two-site feasibility test.
- INSTRUCTIONS:** The form contains items to be completed by an intake worker at the PACE site. The intake worker should mark the correct response as appropriate or print numbers/answers where requested. All items should be completed unless specifically directed to skip items based on a previous response. The Data Collection Coordinator (DCC) assigned at the site will receive this completed form. The DCC will submit completed forms to the Research Center.

Note: Some data items in this form are also included in other COCOA forms. The forms in which the item appears are noted in brackets next to each item. For example, item 13a-d in this form is included both in this form and the Social Work form, as indicated by [INTAKE, SW] next to the question stem for item 13. The abbreviations for each of the COCOA forms are listed below for quick reference.

Intake = Intake Form; HEA = Home Environment Assessment Form; PCP = Primary Care Provider Form; RN = Nursing Form; REHAB = Rehabilitation Therapy Form; SW = Social Work Form; RT = Recreational Therapy Form; RD = Dietitian Form; PSQ = Participant Satisfaction Form; CSQ = Caregiver Satisfaction Form; EOL = End of Life Form; UTIL = Utilization Form.

**Two-Site Feasibility Test
DRAFT INTAKE FORM
(Initial Assessment Only)**

Site ID _____ Participant ID _____

1. **Participant Name:** [ALL]

(Last) (First) (MI) (Suffix)

2. **Date Form Completed:** [INTAKE, HEA, PCP, RN, REHAB, SW, RT, RD, EOL, UTIL] ____ / ____ / ____
month day year

3. **Program Enrollment Date (Date PACE Services Began):** [INTAKE] ____ / ____ / ____
month day year

4. **Participant Address:** [INTAKE, SW]

Street Address (include house/apt. number)

City State ZIP Code

County: _____

5. **Participant Phone Number:** [INTAKE, SW] (_____) _____ - _____ ext. _____

6. **Participant Social Security Number:** [INTAKE] ____ - ____ - ____

☐ UK - Unknown or Not Available

7. **Gender:** [INTAKE]

- ☐ 1 - Male
☐ 2 - Female

8. **Date of Birth:** [INTAKE] ____ / ____ / ____ ☐ UK - Unknown
month day year

9. **Birthplace:** [INTAKE] _____
City State/Province Country

10. **Citizenship:** [INTAKE, SW] ☐ 1 - United States
☐ 2 - Other (specify: _____)

11. **Race/Ethnicity** (as identified by participant): **(Mark all that apply.)** [INTAKE]

- ☐ 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
☐ UK - Unknown

12. **Source of Referral:** [INTAKE]

- ☐ 1 - Hospital
- ☐ 2 - SNF/ICF
- ☐ 3 - Home health agency/clinic
- ☐ 4 - Social service agency
- ☐ 5 - Individual health professional/clinic
- ☐ 6 - Family or friend
- ☐ 7 - Self-referral
- ☐ 8 - State agency
- ☐ 9 - Sponsoring or affiliated agency
- ☐ 10 - Other (specify: _____)
- ☐ 11 - Undetermined

13a. **Medicare Number:** _____ [INTAKE, SW]
(including suffix)

☐ NA - No Medicare

b. **Medicare Entitlement:**

- ☐ 1 - Part A and Part B
- ☐ 2 - Part A only
- ☐ 3 - Part B only
- ☐ 4 - Not Medicare entitled

c. **Medicaid Number:** _____

☐ NA - No Medicaid

d. **Medicaid Eligibility:**

- ☐ 1 - Medicaid and SSI
- ☐ 2 - Medicaid, no SSI
- ☐ 3 - Not Medicaid eligible

**Please respond to the evaluation questions and return
completed materials to the Data Collection Coordinator at your site.**

Thank you for your participation.