# AGENCY AND PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Assessment Strategy</th>
<th>Data Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Agency NYS License Number</td>
<td>(PS010) Agency NYS License Number: __ __ __ __ L __ __ __</td>
</tr>
<tr>
<td>Agency administrator and billing staff can provide this information. This number can be preprinted on clinical documentation.</td>
<td></td>
</tr>
<tr>
<td>2. Patient ID</td>
<td>(PS020) Patient ID: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __</td>
</tr>
<tr>
<td>Agency-specific patient identifier, assigned to the patient for the purposes of record keeping. Agency medical records department is the usual source of this number.</td>
<td></td>
</tr>
<tr>
<td>3. Patient Name</td>
<td>(PS030) Patient Name: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __</td>
</tr>
<tr>
<td>Patient's full name. Use the patient's legal name.</td>
<td></td>
</tr>
<tr>
<td>4. Start of Care Date</td>
<td>(PS050) Start of Care Date: __ __ / __ __ / __ __ __ __</td>
</tr>
<tr>
<td>Date that care begins. If uncertain as to the start of care date, clarify the date with agency administrative personnel.</td>
<td></td>
</tr>
<tr>
<td>5. Resumption of Care Date</td>
<td>(PS060) Resumption of Care Date: __ __ / __ __ / __ __ __ __</td>
</tr>
<tr>
<td>The date of the first visit following an inpatient stay for a patient already receiving services from the agency. If uncertain as to the resumption of care date, clarify with agency administrative staff.</td>
<td></td>
</tr>
<tr>
<td>6. Date Assessment Completed</td>
<td>(PS070) Date Assessment Visit Completed: __ __ / __ __ / __ __ __ __</td>
</tr>
<tr>
<td>The date that the assessment visit is completed. For assessments that concern patient transfer to an inpatient facility or death at home, record the date that the agency learns of the transfer or death.</td>
<td></td>
</tr>
</tbody>
</table>
AGENCY AND PATIENT INFORMATION

7. **Reason for Assessment**
   Why is the assessment being completed? What has happened to the patient that indicates there is a need for an assessment?

7. (PS080) This Assessment is Being Completed for the Following Reason:
   - 1 - Start of care
   - 2 - Resumption of care
   - 3 - Reassessment
   - 4 - Transferred to an inpatient facility
   - 5 - Death at home [Complete PS090, Then Skip Remainder of Form]
   - 6 - Discharge from agency

8. **Discharge/Transfer/Death Date**
   This item identifies the actual date of discharge, transfer, or death at home. Agency policy or physician order may establish discharge date. Telephone contact with the family or medical service provider may be required to verify the date of transfer to an inpatient facility or death at home. The transfer date is the actual date the patient was transferred to an inpatient facility. The death date is the actual date of the patient’s death at home.

8. (PS090) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.
   ___/___/____
   month day year

PATIENT DESCRIPTION

9. **Changes Since Last Assessment**
   Check "No" if no changes have occurred to the information reported in the items in the Patient Description section (Items PS040, PS120, PS130, PS140, PS150). If changes have occurred to any of these items, check "Yes" and complete the items for which new or updated information is available. Patient Description items for which no changes have occurred can be left blank. If this is the patient's first assessment using the PESO data set, complete all of the items in the Patient Description section, regardless of whether changes have occurred since the patient's last clinical assessment.

9. (PS000) Changes Since Last Assessment: Since the last PESO assessment, have changes occurred to the information reported in the items in the Patient Description section (Items PS040, PS120, PS130, PS140, PS150)? If no changes have occurred, check "No" and go to Item PS810. If changes have occurred, check "Yes," complete any item for which updated information is available, and then go to Item PS810.
   - 0 - No [Go to Item PS810]
   - 1 - Yes [Complete Items that Have Changed, then Go to Item PS810]

10. **Medicaid Number**
    If the patient has Medicaid, ask to see the patient's Medicaid card or other verifying documentation. Be sure that the coverage is still in effect. If the patient does not have Medicaid coverage, mark "NA - No Medicaid."

10. (PS040) Medicaid Number:
    ________________
    NA - No Medicaid
## PATIENT DESCRIPTION

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<tr>
<td>11. Birth Date</td>
<td>11. (PS120) Birth Date: __ __ /__ __ /__ __ __ __ month day year</td>
</tr>
<tr>
<td>If the patient is unable to respond to this item, ask a family member or the physician's staff. The date also might be available from other legal documents (for example, driver's license, state-issued ID card). Enter dashes for any unknown information (for example, if a patient was born in December 1954, but the precise date is not known, enter 12/ – – /1954).</td>
<td></td>
</tr>
<tr>
<td>12. Gender</td>
<td>12. (PS130) Gender:</td>
</tr>
<tr>
<td>Patient gender as determined through observation or interview.</td>
<td></td>
</tr>
<tr>
<td>13. Race/Ethnicity</td>
<td>13. (PS140) Race/Ethnicity (as identified by patient): (Mark all that apply.)</td>
</tr>
<tr>
<td>Determine through interview of patient or caregiver. These categories are those used by the US Census Bureau. The patient may self-identify with more than one group. Mark all categories that are mentioned. If you choose &quot;UK - Unknown,&quot; no other options should be marked.</td>
<td></td>
</tr>
<tr>
<td>14. Current Payment Sources for Home Care</td>
<td>14. (PS150) Current Payment Sources for Home Care: (Mark all that apply.)</td>
</tr>
<tr>
<td>Referral source may provide information regarding payment, which can be verified with the patient or caregiver. Agency billing office also may have this information.</td>
<td></td>
</tr>
<tr>
<td>Payment sources for the care your agency is providing.</td>
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</table>
### UTILIZATION OF SERVICES

#### Assessment Strategy

<table>
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<tr>
<th>Data Item</th>
<th>15. (PS810) Emergent Care: Since the last time assessment data were collected, has the patient utilized any emergency services?</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>□ 0 - No [ Go to Item PS830 ] □ 1 - Yes</td>
</tr>
</tbody>
</table>

Emergency services are defined as unscheduled medical visits or services provided within 24 hours of scheduling.

### 15. Emergent Care

Ask the patient or caregiver if the patient has had any services for emergent care since the last assessment. Reviewing the patient's medical record also may provide the information needed to answer this item. Emergent care reflects all unscheduled visits for medical care as well as medical appointments that occur within 24 hours of scheduling. Care could have been received in settings other than an emergency room. Services provided by the home care agency are not considered emergent.

### 16. Emergent Care Reason

Ask the patient or caregiver to state all the symptoms and reasons for which he/she sought emergent care. A phone call to the doctor's office or emergency room may be required to clarify the reason(s) for emergent care.

#### Options
- Acute mental/behavioral health problem
- Hypo/hyperglycemia, diabetes out of control
- Improper medication administration, medication side effects, toxicity, anaphylaxis
- Injury caused by fall or accident at home
- Injury while straying unsupervised from a protective environment
- Nausea, dehydration, malnutrition, constipation, impaction
- Pneumonia
- Pressure ulcer (new or deterioration)
- Respiratory problems (for example, shortness of breath, respiratory infection other than pneumonia, obstruction)
- Uncontrolled pain
- Urinary tract infection
- Wound or tube site infection, deteriorating wound status, new wound (other than pressure ulcer)
- Other (specify) __________________________________________________________________________
- Reason unknown

### 17. Inpatient Facility

Often the family or medical service provider informs the agency that the patient has been admitted to an inpatient facility. Clarify with this informant as to which type of facility the patient has been admitted. You may have to contact the facility to determine how it is licensed.

#### Options
- Hospital
- Rehabilitation facility
- Nursing home
- Hospice
18. **Reason(s) for Hospitalization**

Interview the patient, family, or medical service provider to determine the conditions requiring acute hospital admission.

18. (PS840) **Reason(s) for Hospitalization:** (Mark all that apply.)

- [ ] NA - Patient has not been hospitalized
- [ ] 1 - Acute mental/behavioral health problem
- [ ] 2 - Bowel/intestinal obstruction
- [ ] 3 - Hypo/hyperglycemia, diabetes out of control
- [ ] 4 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- [ ] 5 - Injury caused by fall or accident at home
- [ ] 6 - Injury while straying unsupervised from a protective environment
- [ ] 7 - Pneumonia
- [ ] 8 - Pressure ulcer (new or deterioration)
- [ ] 9 - Respiratory problems (for example, shortness of breath, respiratory infection other than pneumonia, obstruction)
- [ ] 10 - Scheduled surgical procedure
- [ ] 11 - Unscheduled or emergency surgery
- [ ] 12 - Scheduled non-surgical procedure (for example, chemotherapy, diagnostic tests)
- [ ] 13 - Uncontrolled pain
- [ ] 14 - Urinary tract infection
- [ ] 15 - Wound or tube site infection, deteriorating wound status, new wound (other than pressure ulcer)
- [ ] 16 - Other (specify) __________________________
- [ ] UK - Reason unknown