OUTCOME ASSESSMENT INFORMATION SET VERSION E (OASIS-E)

Start of Care (SOC)

Section A	Administrative Information

M0018. National Provider Identifier (NPI) for the attending physician who has signed the plan of care

1 2 3 2 1 | ☐ UK – Unknown or Not Available

M0010. CMS Certification Number

c M 1 2 6

M0014. Branch State

C A

M0016. Branch ID Number

B R A N C H 1 2

M0020. Patient ID Number

I D 9 9 9 9 9 0 0 0 0

M0030. Start of Care Date

0 3 - 1 8 - 2 0 2 5

Month Day Year

M0040. Patient Name

J a s o n | ☐ | B o u r n e

(First) (MI) (Last)

M0050. Patient State of Residence

C A

M0060. Patient ZIP Code

9 4 5 5 8 -

M0064. Social Security Number

1 1 1 - 1 2 - 3 3 3 3 | ☐ UK – Unknown or Not Available

M0063. Medicare Number

M E D 7 7 7 | ☐ NA – No Medicare

M0065. Medicaid Number

| ☒ NA – No Medicaid

M0069. Gender

Enter Code: 1

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

M0066. Birth Date	
	0 1 - 1 9 - 1 9 7 0 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**
☐	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** (for example, Title III, V, or XX)
☐	7. **Other government** (for example, TriCare, VA)
☐	8. **Private insurance**
☐	9. **Private HMO/managed care**
☐	10. **Self-pay**
☐	11. **Other** (specify)
☐	UK. **Unknown**

A1110. Language

Enter Code: 1

A. **What is your preferred language?**

Spanish

B. **Do you need or want an interpreter to communicate with a doctor or health care staff?**

0. **No**
1. **Yes**
9. **Unable to determine**

M0080. Discipline of Person Completing Assessment

Enter Code: 4

1. **RN**
2. **PT**
3. **SLP/ST**
4. **OT**

M0090. Date Assessment Completed

15 - 14 - 2026

Month Day Year

M0100. This Assessment is Currently Being Completed for the Following Reason

Enter Code: 9

Start/Resumption of Care

1. **Start of care –** 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**
9. **Discharge from agency**

M0102. Date of Physician-ordered Start of Care (Resumption of Care)

If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

Month - Day - Year → *Skip to M0110, Episode Timing, if date entered*

☐ NA – No specific SOC/ROC date ordered by physician

M0104. Date of Referral

Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

Month - Day - Year