

**DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION**  
**HOSPITAL INPATIENT**  
**MANUAL ABSTRACT REPORTING FORM**  
**Effective with Discharges on or after January 1, 2023**

Page 1 of 4

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements  
(Title 22, Sections 97216 through 97234)

<b>TYPE OF CARE</b> 1 Acute      5 Chem Dep <input type="checkbox"/> 3 SN/IC      6 Physical Rehab <input type="checkbox"/> 4 Psychiatric	<b>FACILITY ID NUMBER</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>DATE OF BIRTH</b> <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 (4-digit)	<b>SEX</b> M Male <input type="checkbox"/> F Female U Unknown
<b>ETHNICITY</b> E1 Hispanic or Latino <input type="text"/> <input type="text"/> E2 Non Hispanic or Latino 99 Unknown	<b>RACE</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> R1 American Indian or Alaska Native  R2 Asian  R3 Black or African American  R4 Native Hawaiian or Other Pacific Islander </div> <div style="width: 45%;"> R5 White  R9 Other  99 Unknown </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> a. <input type="text"/> <input type="text"/>  b. <input type="text"/> <input type="text"/>  c. <input type="text"/> <input type="text"/> </div> <div style="width: 45%;"> d. <input type="text"/> <input type="text"/>  e. <input type="text"/> <input type="text"/> </div> </div>		
<b>ADDRESS NUMBER AND STREET NAME</b> <input style="width: 100%;" type="text"/> <i>If the address is not part of the United States, leave blank</i>			
<b>CITY</b> <input style="width: 100%;" type="text"/> <i>If the city is not part of the United States, leave blank</i>			
<b>STATE</b> <input type="text"/> <input type="text"/>	<b>ZIP CODE</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> XXXXXX = Unknown YYYYYY = Does not reside in the U.S.	<b>COUNTRY CODE</b> Use an ISO 3166 alpha-2, two-digit country code from the list available at <a href="http://www.iso.org/iso-3166-country-codes.html">www.iso.org/iso-3166-country-codes.html</a> <input type="text"/> <input type="text"/>	
<b>HOMELESSNESS INDICATOR</b> Y Yes <input type="checkbox"/> N No U Unknown	<b>ADMISSION DATE</b> <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 (4-digit)		
<b>SOURCE OF ADMISSION</b> POINT OF ORIGIN <u>With Type of Admission other than "Newborn"</u> 1 Non-Health Care Facility 2 Clinic of Physician's Office 4 Hospital (Different Facility) 5 SNF, ICF or ALF 6 Another Health Care Facility 8 Court/Law Enforcement 9 Information Not Available D One Distinct Unit to another Distinct Unit		<div style="display: flex;"> <div style="flex: 1;"> E Ambulatory Surgery Center  F Hospice Facility  G Designated Disaster Alternate Care Site      <input type="checkbox"/> </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 10px;"> <b>ROUTE OF ADMISSION</b>  1 Your ED  2 Another ED  3 Not Admitted from an ED </div> </div> <div style="margin-top: 10px;"> <u>With Type of Admission "Newborn"</u>  5 Born Inside this Hospital  6 Born Outside of this Hospital </div>	

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**TYPE OF ADMISSION**

- |             |                             |                          |
|-------------|-----------------------------|--------------------------|
| 1 Emergency | 5 Trauma                    | <input type="checkbox"/> |
| 2 Urgent    | 6 Information Not Available |                          |
| 3 Elective  |                             |                          |
| 4 Newborn   |                             |                          |

**DISCHARGE DATE**

Month		Day		Year (4-digit)			

**PATIENT'S SOCIAL SECURITY NUMBER**

Report 000 00 0001 if SSN is Unknown							

**DISPOSITION OF PATIENT**

☐

- 01 Discharged to home or self care (routine discharge)
- 02 Discharged/transferred to a short term general hospital for inpatient care
- 03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care
- 04 Discharged/transferred to a facility that provides custodial or supportive care (includes Intermediate Care Facility)
- 05 Discharged/transferred to a designated cancer center or children's hospital
- 06 Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care
- 07 Left against medical advice or discontinued care
- 20 Expired
- 21 Discharged/transferred to court/law enforcement
- 43 Discharged/transferred to a federal health care facility
- 50 Hospice - Home
- 51 Hospice - Medical facility (certified) providing hospice level of care
- 61 Discharged/transferred to a hospital-based Medicare approved swing bed
- 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including a rehabilitation distinct part units of a hospital
- 63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
- 64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- 66 Discharged/transferred to a Critical Access Hospital (CAH)
- 69 Discharged/transferred to a Designated Disaster Alternate Care Site
- 70 Discharged/transferred to another type of health care institution not defined elsewhere in this code list
- 81 Discharged to home or self care with a planned acute care hospital inpatient readmission
- 82 Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission
- 83 Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission
- 84 Discharged/transferred to a facility that provides custodial or supportive care (includes Intermediate Care Facility) with a planned acute care hospital inpatient readmission
- 85 Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
- 86 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care with a planned acute care hospital inpatient readmission
- 87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission
- 88 Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
- 89 Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission
- 90 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital acute care hospital inpatient readmission
- 91 Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission
- 92 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal) but not certified under Medicare with a planned acute care hospital inpatient readmission
- 93 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
- 94 Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission
- 95 Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission
- 00 Other

## Page 3 of 4

**TOTAL CHARGES**

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**ABSTRACT RECORD NUMBER (Optional)**

[illegible]

## DNR orders at admission or within 24 hrs of admission

Y Yes

N Nc

7

## PAYER CATEGORY

- |                             |                   |
|-----------------------------|-------------------|
| 01 Medicare                 | 07 Other Indigent |
| 02 Medi-Cal                 | 08 Self Pay       |
| 03 Private Coverage         | 09 Other Payer    |
| 04 Workers' Compensation    |                   |
| 05 County Indigent Programs |                   |
| 06 Other Government         |                   |

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## TYPE OF COVERAGE

- 1 Managed Care - Knox - Keene/COHS
- 2 Managed Care - Other
- 3 Traditional Coverage

7

## NAME OF PLAN

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0001 - 9999 Plan Code Number

Enter a valid 3-letter PLS Code from HCAI's list of PLS Codes in the Inpatient Reporting Manual, Section 97234. If the language is not on the list, then consult the ISO 639-2 at [www.loc.gov/standards/iso639-2](http://www.loc.gov/standards/iso639-2)

If the patient's preferred language is not listed in the ISO 639-2, then enter the language spoken in the space provided.

[illegible]

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7

Y = Yes

N = No













U = Unknown

W = Clinically Undetermined

blank = Exempt from POA reporting

## OTHER DIAGNOSIS

**PRESENT ON ADMISSION**

- a. 
- b. 
- c. 
- d. 
- e. 
- f. 
- g. 
- h. 
- i. 
- j. 
- k. 
- l. 

[illegible]

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| u. |  |  |
| v. |  |  |
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| x. |  |  |

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**PRINCIPAL PROCEDURE AND DATE**

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Month | Day | Year (4-digit)

**OTHER PROCEDURES AND DATES**

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**EXTERNAL CAUSES OF MORBIDITY**

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**PRESENT ON ADMISSION**

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
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Y = Yes  
 N = No  
 U = Unknown  
 W = Clinically Undetermined  
 blank = Exempt from POA reporting

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