REQUEST FOR RECORDS DISPOSITION AUTHORITY

To NATIONAL ARCHIVES & RECORDS ADMINISTRATION
8601 ADELPHI ROAD COLLEGE PARK, MD 20740-6001

1 FROM (Agency or establishment)
Department of Health and Human Services

2 MAJOR SUBDIVISION
Centers for Medicare & Medicaid Services

3 MINOR SUBDIVISION
Office of Clinical Standards and Quality
Shannon Flood (410) 786-2583

4 NAME OF PERSON WITH WHOM TO CONFER
Vickie Robey, CMS Records Officer
(410) 786-7883

1 TELEPHONE NUMBER
(410) 786-7883

DATE

ARCHIVIST OF THE UNITED STATES

2 AGENCY CERTIFICATION
I hereby certify that I am authorized to act for this agency in matters pertaining to the disposition of its records and that the records proposed for disposal on the attached 2 page(s) are not needed now for the business for this agency or will not be needed after the retention periods specified, and that written concurrence from the General Accounting Office, under the provisions of Title 8 of the GAO Manual for Guidance of Federal Agencies,

X is not required □ is attached, or □ has been requested

8/31/11
Vickie Robey for HHS Records Officer

TITLE
CMS Records Officer

7 ITEM NO
8 DESCRIPTION OF ITEM AND PROPOSED DISPOSITION
1 Electronic Record Schedule for the Continuity Assessment and Record Evaluation (CARE) System (retired in April 2011)

9 GRS OR SUPERSEDED JOB CITATION

10 ACTION TAKEN
(NARA USE ONLY)

STANDARD FORM 115 (REV 3-91)
Prewsed by NARA 36 CFR 1228
Attachment to SF-115 for CMS Electronic Record Schedule

**Continuity Assessment Record and Evaluation (CARE)**

CARE is an internet-based application designed, developed and implemented to automate the Continuity Assessment Record and Evaluation (CARE) patient assessment instrument to uniformly measure and compare Medicare beneficiaries’ health and function status, across provider settings, over time, and to test the instrument’s usefulness in a 3-year Post Acute Care-Payment Reform Demonstration (PAC-PRD) starting in 2008, with a Report to Congress in 2011.

The CARE database contains Medicare patient assessment information which details information captured about a patient during admission, discharge, or major change in status (e.g., death). The information captured and stored includes administrative information, Admission information, medical information, cognitive status information, impairments, functional status, plan of care information and discharge status.

**DISPOSITION:** Delete/destroy data and all related documentation 10 years after the final report to Congress is released, or when no longer needed for Agency business, whichever is longer.