HAS 105A ARMY ADMISSIONS AND DISPOSITION PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. **For Temporary Disability Retired List, what is the maximum duration when the disability date is prior to December 2016?**

   A. 3 years

   B. 4 years

   C. 5 years

   D. 2 years

2. **An individual who was married to the same active-duty service member for 20 years to become eligible for healthcare is called?**

   A. Current Spouse

   B. Surviving Spouse

   C. Former Spouse

   D. Dependent

3. **What are the steps when a patient dies in hospital?**

   A. Document death, notify relevant parties, complete death certificate, arrange for remains per policy, and provide bereavement resources.

   B. Notify family only and discharge.

   C. Record death in EMR but no further action.

   D. Transfer to another facility.

4. **Which statement about de-identified data is true?**

   A. It contains personal identifiers.

   B. It cannot be used for research.

   C. It is data stripped of personal identifiers and used for research while protecting privacy.

   D. It requires patient consent for use.

5. **An active duty patient admitted to a local civilian facility is categorized as which admission type?**

   A. Direct Admission

   B. Direct Admission from Absent Sick

   C. APA

   D. Absent Sick (ABS)

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6. What is discharge planning and why is it essential?

A. A multidisciplinary process ensuring safe and effective transition from hospital to home or another care setting, including meds, follow-up, and education

B. A nursing shift change procedure

C. A bookkeeping task to close the chart

D. A financial clearance activity

7. Which term describes outpatient care leading to inpatient admission later?

A. Carded for Record Only (CRO)

B. New Born (NB)

C. Pre-admission

D. Remain Overnight (RON)

8. How are patient identifiers verified upon admission?

A. Two identifiers (e.g., full name and date of birth) per safety protocols; sometimes MRN.

B. A single identifier is sufficient.

C. Identifiers are not checked until discharge.

D. Verification relies only on the patient's room number.

9. What is the term for a written document that states a patient's wishes should they become incapable of participating in medical decisions?

A. Advance directive

B. Living Wills

C. Durable power of attorney

D. Do Not Resuscitate

10. A patient awaiting transfer to another facility who does not require medical care is categorized as which status?

A. Pre-admission

B. New Born (NB)

C. Carded for Record Only (CRO)

D. Remain Overnight (RON)

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Answers

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1. C
2. C
3. C
4. C
5. D
6. A
7. C
8. D
9. A
10. D

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Explanations

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1. For Temporary Disability Retired List, what is the maximum duration when the disability date is prior to December 2016?

A. 3 years

B. 4 years

C. 5 years

D. 2 years

Temporary Disability Retired List is used for service members who have a disability likely to improve. They're placed on TDRL and must be reevaluated periodically to see if they've recovered enough to be removed, or if the disability has become permanent. For disabilities with an onset date before December 2016, the maximum time you can stay on TDRL is five years. That 60-month window gives the medical and personnel review boards time to reassess the condition and decide whether to convert to a permanent retirement with a lasting disability rating or to separate if the disability no longer supports service. So, the longest allowed duration in this scenario is five years. The other options would not align with that established limit. (After December 2016, policies have been updated, but the question refers to the prior rule.)

2. An individual who was married to the same active-duty service member for 20 years to become eligible for healthcare is called?

A. Current Spouse

B. Surviving Spouse

C. Former Spouse

D. Dependent

This item tests how TRICARE handles healthcare eligibility for spouses after a marriage ends. When someone was married to a service member for a long period that overlapped with the member's active-duty service, they can qualify as a former spouse for healthcare purposes even after divorce. In this case, the marriage lasted 20 years while the service member was on active duty, which fits the scenario for former-spouse eligibility. That designation is used specifically for someone who was the service member's spouse but is not currently married to them. A current spouse would still be married, a surviving spouse applies after the service member's death, and a dependent is typically a child or other dependent, not an ex-spouse. So the correct term is former spouse.

3. What are the steps when a patient dies in hospital?

A. Document death, notify relevant parties, complete death certificate, arrange for remains per policy, and provide bereavement resources.

B. Notify family only and discharge.

C. Record death in EMR but no further action.

D. Transfer to another facility.

Recording the death in the electronic medical record is the essential first step because it formalizes the event within the hospital system and triggers the established post-death workflows. This creates an official, time-stamped record that everything else is built from, such as notifying the appropriate departments, initiating mortality documentation, and guiding the handling of remains and bereavement resources per policy. In real practice, those subsequent actions are carried out according to hospital policy, but the critical, immediate action is to document the death in the EMR so the process can proceed in a controlled, auditable way.

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4. Which statement about de-identified data is true?

A. It contains personal identifiers.

B. It cannot be used for research.

C. It is data stripped of personal identifiers and used for research while protecting privacy.

D. It requires patient consent for use.

De-identified data means removing or concealing personal identifiers so the dataset can be used for research without exposing individuals. The statement that best fits this idea is that the data is stripped of personal identifiers and used for research while protecting privacy. With these identifiers removed, researchers can examine patterns and outcomes while the risk of identifying someone is greatly reduced. In practice, de-identification can follow standards such as HIPAA's Safe Harbor, which removes a specific set of identifiers, or an expert determination method that minimizes re-identification risk. Because the protective identifiers are gone, consent isn't typically required to use the data for research, though institutions may have their own policies. If the data still contained personal identifiers, it wouldn't be de-identified, and the privacy protections wouldn't be in place. The option that says it cannot be used for research contradicts the purpose of de-identified data, and the view that consent is always required does not align with how de-identified data is commonly handled.

5. An active duty patient admitted to a local civilian facility is categorized as which admission type?

A. Direct Admission

B. Direct Admission from Absent Sick

C. APA

D. Absent Sick (ABS)

Absent Sick describes a service member who is away from their unit due to illness or injury and is receiving medical treatment. If the active-duty patient is admitted to a local civilian facility, that status remains their designation of Absent Sick because they are still on medical care and unavailable for duty, even though the care is outside a military facility. Direct Admission would apply if the patient were admitted directly to a military facility or through the military medical system from the duty station, which isn't the case here. APA isn't the appropriate designation for this civilian-care scenario.

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6. What is discharge planning and why is it essential?

A. A multidisciplinary process ensuring safe and effective transition from hospital to home or another care setting, including meds, follow-up, and education

B. A nursing shift change procedure

C. A bookkeeping task to close the chart

D. A financial clearance activity

Discharge planning is a coordinated, team-based process to prepare a patient for a safe, smooth transition from hospital to home or another care setting. It involves managing medications, arranging follow-up care, and educating the patient and family about what to expect, how to take medicines, warning signs, and self-care tasks. This planning starts during the hospital stay and continues through discharge, with the aim of ensuring the patient has the right meds, understands how to take them, knows when and how to follow up, and has the supports or services needed after leaving. Why it's essential: thorough discharge planning reduces medication errors and gaps in care, helps patients understand and manage their health after discharge, lowers the chance of complications and readmissions, and supports safer, faster recovery. It also clarifies responsibilities after discharge and connects patients with necessary services, equipment, and follow-up. Other options don't fit because discharge planning is not about nursing shift changes, closing charts, or financial clearance—those are administrative tasks separate from coordinating post-discharge care.

7. Which term describes outpatient care leading to inpatient admission later?

A. Carded for Record Only (CRO)

B. New Born (NB)

C. Pre-admission

D. Remain Overnight (RON)

Pre-admission describes the process of evaluating someone as an outpatient in advance of an inpatient admission. It covers the initial assessment, necessary tests, and administrative steps done before the decision is made to admit the patient as an inpatient. This terminology specifically fits a situation where outpatient care occurs first, with the plan to admit to the hospital later. The other terms don't fit this flow. Carded for Record Only is used when the encounter is documented but does not lead to admission; New Born refers to a newborn patient; Remain Overnight implies an overnight stay but doesn't capture the outpatient-to-inpatient sequence that pre-admission describes.

8. How are patient identifiers verified upon admission?

A. Two identifiers (e.g., full name and date of birth) per safety protocols; sometimes MRN.

B. A single identifier is sufficient.

C. Identifiers are not checked until discharge.

D. Verification relies only on the patient's room number.

Verifying patient identity on admission relies on checking two independent identifiers to ensure the patient matches the medical record and orders. This approach significantly reduces the risk of wrong-patient errors, especially in busy admission settings. Common identifiers include the patient's full name and date of birth. The medical record number (MRN) may be used as an additional verification if available, but it should not replace the two primary identifiers. Relying on the room number alone is unsafe because room assignments can change, be shared, or be misread, and room numbers do not uniquely identify a patient. In practice, staff complete identity checks at multiple points (e.g., at check-in and before medications or procedures) to maintain accuracy.

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9. What is the term for a written document that states a patient's wishes should they become incapable of participating in medical decisions?

A. Advance directive

B. Living Wills

C. Durable power of attorney

D. Do Not Resuscitate

Advance directives are written statements of a patient's wishes for medical care if they become incapable of participating in decisions. They protect patient autonomy by guiding clinicians when the patient cannot speak for themselves. This category includes living wills and durable power of attorney for health care, which are specific forms or components that fall under the broader concept. A Do Not Resuscitate is a particular instruction about whether to perform resuscitation, not a general plan for all medical decisions. A living will is a type of advance directive that outlines preferences for treatments in specific situations, while a durable power of attorney designates someone to make decisions on the patient's behalf. So, the best term for the overall written document describing the patient's wishes is advance directive.

10. A patient awaiting transfer to another facility who does not require medical care is categorized as which status?

A. Pre-admission

B. New Born (NB)

C. Carded for Record Only (CRO)

D. Remain Overnight (RON)

In this context, admissions statuses describe how a patient is being managed and what their immediate needs are. When a patient is waiting to be transferred to another facility and does not require medical care at the moment, the appropriate designation is Remain Overnight. This status indicates the patient will occupy a bed overnight purely for administrative reasons while awaiting transfer, without any active treatment or monitoring. The other options don't fit the scenario: Pre-admission is reserved for patients scheduled to be admitted for ongoing care; New Born applies to neonatal patients; Carded for Record Only is used for documentation purposes without clinical care.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

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We wish you the very best on your exam journey. You've got this!

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