

## **PRA Disclosure Statement**

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## Hospice Item Set - Admission

<b>Section A</b>	<b>Administrative Information</b>																								
<b>A0050. Type of Record</b>																									
Enter Code <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> <li>1. Add new record</li> <li>2. Modify existing record</li> <li>3. Inactivate existing record</li> </ol>																								
<b>A0100. Facility Provider Numbers. Enter code in boxes provided.</b>																									
	<p><b>A. National Provider Identifier (NPI):</b></p> <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25px;"></td> </tr> </table> <p><b>B. CMS Certification Number (CCN):</b></p> <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px; background-color: #cccccc;"></td> </tr> </table>																								
<b>A0205. Site of Service at Admission</b>																									
Enter Code <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> <li>01. Hospice in patient's home/residence</li> <li>02. Hospice in Assisted Living facility</li> <li>03. Hospice provided in Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)</li> <li>04. Hospice provided in a Skilled Nursing Facility (SNF)</li> <li>05. Hospice provided in Inpatient Hospital</li> <li>06. Hospice provided in Inpatient Hospice Facility</li> <li>07. Hospice provided in Long Term Care Hospital (LTCH)</li> <li>08. Hospice in Inpatient Psychiatric Facility</li> <li>09. Hospice provided in a place not otherwise specified (NOS)</li> <li>10. Hospice home care provided in a hospice facility</li> </ol>																								
<b>A0220. Admission Date</b>																									
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<b>A0245. Date Initial Nursing Assessment Initiated</b>																									
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<b>A0250. Reason for Record</b>																									
Enter Code <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> <li>01. Admission</li> <li>09. Discharge</li> </ol>																								



**Section A****Administrative Information****A1802. Admitted From.** Immediately preceding this admission, where was the patient?

Enter Code

01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care)
02. Long-term care facility
03. Skilled Nursing Facility (SNF)
04. Hospital emergency department
05. Short-stay acute hospital (IPPS)
06. Long-term care hospital (LTCH)
07. Inpatient rehabilitation hospital or unit (IRF)
08. Psychiatric hospital or unit
09. ID/DD Facility
10. Hospice
99. None of the Above

**Section F****Preferences****F2000. CPR Preference**

Enter Code

**A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)?** - Select the most accurate response

0. **No** → Skip to F2100, Other Life-Sustaining Treatment Preferences  
1. **Yes, and discussion occurred**  
2. **Yes, but the patient/responsible party refused to discuss**

**B. Date the patient/responsible party was first asked about preference regarding the use of CPR:**

Month

Day

Year

**F2100. Other Life-Sustaining Treatment Preferences**

Enter Code

**A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR?** - Select the most accurate response

0. **No** → Skip to F2200, Hospitalization Preference  
1. **Yes, and discussion occurred**  
2. **Yes, but the patient/responsible party refused to discuss**

**B. Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR:**

Month

Day

Year

**F2200. Hospitalization Preference**

Enter Code

**A. Was the patient/responsible party asked about preference regarding hospitalization?** - Select the most accurate response

0. **No** → Skip to F3000, Spiritual/Existential Concerns  
1. **Yes, and discussion occurred**  
2. **Yes, but the patient/responsible party refused to discuss**

**B. Date the patient/responsible party was first asked about preference regarding hospitalization:**

Month

Day

Year

**F3000. Spiritual/Existential Concerns**

Enter Code

**A. Was the patient/caregiver asked about spiritual/existential concerns?** - Select the most accurate response

0. **No** → Skip to I0100, Principal Diagnosis  
1. **Yes, and discussion occurred**  
2. **Yes, but the patient/caregiver refused to discuss**

**B. Date the patient/caregiver was first asked about spiritual/existential concerns:**

Month

Day

Year

**Section I****Active Diagnoses****I0010. Principal Diagnosis**

Enter Code

- 01. Cancer
- 02. Dementia/Alzheimer's
- 99. None of the above

**Section J**

**Health Conditions**

**Pain**

**J0900. Pain Screening**

Enter Code

**A. Was the patient screened for pain?**

- 0. No → Skip to J2030, Screening for Shortness of Breath
- 1. Yes

**B. Date of first screening for pain:**

Month		Day		Year			

Enter Code

**C. Type of standardized pain screening tool used:**

- 1. Numeric
- 2. Verbal descriptor
- 3. Patient visual
- 4. Staff observation
- 9. No standardized tool used

Enter Code

**D. The patient's pain severity was:**

- 0. None
- 1. Mild
- 2. Moderate
- 3. Severe
- 9. Pain not rated

**J0910. Comprehensive Pain Assessment**

Enter Code

**A. Was a comprehensive pain assessment done?**

- 0. No → Skip to J2030, Screening for Shortness of Breath
- 1. Yes

**B. Date of comprehensive pain assessment:**

Month		Day		Year			

**C. Comprehensive pain assessment included:**

↓ Check all that apply

1. Location

2. Severity

3. Character

4. Duration

5. Frequency

6. What relieves/worsens pain

7. Effect on function or quality of life

9. None of the above

**Section J****Health Conditions****Respiratory Status****J2030. Screening for Shortness of Breath**

Enter Code

**A. Was the patient screened for shortness of breath?**

0. No → Skip to N0500, Scheduled Opioid  
 1. Yes

**B. Date of first screening for shortness of breath:**

Month

Day

Year

Enter Code

**C. Did the screening indicate the patient had shortness of breath?**

0. No → Skip to N0500, Scheduled Opioid  
 1. Yes

**J2040. Treatment for Shortness of Breath**

Enter Code

**A. Was treatment for shortness of breath initiated? - Select the most accurate response**

0. No → Skip to N0500, Scheduled Opioid  
 1. No, patient declined treatments offered → Skip to N0500, Scheduled Opioid  
 2. Yes

**B. Date treatment for shortness of breath initiated:**

Month

Day

Year

**C. Type(s) of treatment for shortness of breath initiated:**

↓ Check all that apply

1. Opioids

2. Other medication

3. Oxygen

4. Non-medication

**Section N****Medications****N0500. Scheduled Opioid**

Enter Code

**A. Was a scheduled opioid initiated or continued?**

0. No → Skip to N0510, PRN Opioid  
1. Yes

**B. Date scheduled opioid initiated or continued:**

Month

Day

Year

**N0510. PRN Opioid**

Enter Code

**A. Was a PRN opioid initiated or continued?**

0. No → Skip to N0520, Bowel Regimen  
1. Yes

**B. Date PRN opioid initiated or continued:**

Month

Day

Year

**N0520. Bowel Regimen**

Complete only if N0500A or N0510A = 1

Enter Code

**A. Was a bowel regimen initiated or continued? - Select the most accurate response**

0. No → Skip to Z0400, Signature(s) of Person(s) Completing the Record  
1. No, but there is documentation of why a bowel regimen was not initiated or continued → Skip to Z0400, Signature(s) of Person(s) Completing the Record  
2. Yes

**B. Date bowel regimen initiated or continued:**

Month

Day

Year

**Section Z****Record Administration****Z0400. Signature(s) of Person(s) Completing the Record**

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information will lead to a 2 percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

**Z0500. Signature of Person Verifying Record Completion****A. Signature:**

\_\_\_\_\_

**B. Date:**

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Month

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Day

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Year