## PRA Disclosure Statement

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# Hospice Item Set - Admission

## Section A — Administrative Information

### A0050. Type of Record

Enter Code ☐

1. Add new record
2. Modify existing record
3. Inactivate existing record

### A0100. Facility Provider Numbers. Enter code in boxes provided.

**A. National Provider Identifier (NPI):**

☐☐☐☐☐☐☐☐☐☐

**B. CMS Certification Number (CCN):**

☐☐☐☐☐☐☐☐☐☐☐☐

### A0205. Site of Service at Admission

Enter Code ☐☐

01. Hospice in patient's home/residence
02. Hospice in Assisted Living facility
03. Hospice provided in Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)
04. Hospice provided in a Skilled Nursing Facility (SNF)
05. Hospice provided in Inpatient Hospital
06. Hospice provided in Inpatient Hospice Facility
07. Hospice provided in Long Term Care Hospital (LTCH)
08. Hospice in Inpatient Psychiatric Facility
09. Hospice provided in a place not otherwise specified (NOS)
10. Hospice home care provided in a hospice facility

### A0220. Admission Date

☐☐ Month ☐☐ Day ☐☐☐☐ Year

### A0245. Date Initial Nursing Assessment Initiated

☐☐ Month ☐☐ Day ☐☐☐☐ Year

### A0250. Reason for Record

Enter Code ☐☐

01. Admission
09. Discharge

## Section A Administrative Information

### A0500. Legal Name of Patient

A. **First name:**

B. **Middle initial:**

C. **Last name:**

D. **Suffix:**

### A0600. Social Security and Medicare Numbers

A. **Social Security Number:**

___ - __ - ____

B. **Medicare number** (or comparable railroad insurance number)**:**

### A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid Recipient

### A0800. Gender

Enter Code

1. Male
2. Female

### A0900. Birth Date

Month Day Year

### A1000. Race/Ethnicity

↓ **Check all that apply**

| | |
|---|---|
| ☐ | A. American Indian or Alaska Native |
| ☐ | B. Asian |
| ☐ | C. Black or African American |
| ☐ | D. Hispanic or Latino |
| ☐ | E. Native Hawaiian or Other Pacific Islander |
| ☐ | F. White |

## Section A | Administrative Information

**A1802. Admitted From.** Immediately preceding this admission, where was the patient?

| Enter Code | |
|---|---|
| Enter Code [ ][ ] | 01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care)<br>02. Long-term care facility<br>03. Skilled Nursing Facility (SNF)<br>04. Hospital emergency department<br>05. Short-stay acute hospital<br>06. Long-term care hospital (LTCH)<br>07. Inpatient rehabilitation facility or unit (IRF)<br>08. Psychiatric hospital or unit<br>09. ID/DD Facility<br>10. Hospice<br>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 and/or caregiver asked about spiritual/existential concerns? -** Select the most accurate response

0. **No** → Skip to I0010, Principal Diagnosis
1. **Yes, and discussion occurred**
2. **Yes, but the patient and/or caregiver refused to discuss**

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

Month | Day | Year

# Section I — Active Diagnoses

## I0010. Principal Diagnosis

| Enter Code | |
|---|---|
| ☐☐ | 01. Cancer<br>02. Dementia/Alzheimer's<br>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. The patient's pain severity was:**
- 0. None → Skip to J2030, Screening for Shortness of Breath
- 1. Mild
- 2. Moderate
- 3. Severe
- 9. Pain not rated

Enter Code ☐ **D. Type of standardized pain tool used:**
- 1. Numeric
- 2. Verbal descriptor
- 3. Patient visual
- 4. Staff observation
- 9. No standardized tool used

#### 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 treatment** → 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 may 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 provider 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:** [ ][ ] Month [ ][ ] Day [ ][ ][ ][ ] Year