HIS-Discharge

**PRA Disclosure Statement**

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OMB Control Number: 0938-1153

Expiration Date: XX/XXXX

Hospice Item Set – Discharge

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| **Section A** | **Administrative Information** |

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| **A0050. Type of Record** | |
| Enter Code   |  | | --- | |  | | 1. Add new record 2. Modify existing record 3. Inactivate existing record |
| **A0100. Fac** | **ility Provider Numbers.** Enter code in boxes provided. |
|  | 1. **National Provider Identifier (NPI):**  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |      1. **CMS Certification Number (CCN):**  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  | |
| **A0220. Ad** | **mission Date** |
|  | Month Day Year |
| **A0250. Rea** | **son for Record** |
| |  |  | | --- | --- | |  |  |   Enter Code | 01. Admission  09. Discharge |
| **A0270. Dis** | **charge Date** |
|  | Month Day Year |
| **A0500. Leg** | **al Name of Patient** |
|  | 1. **First name:**  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |      1. **Middle initial:**  |  | | --- | |  |      1. **Last name:**  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      1. **Suffix:**  |  |  |  | | --- | --- | --- | |  |  |  | |

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| **Section A** | **Administrative Information** |

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| **A0600. Social Security and Medicare Numbers** | |
|  | 1. **Social Security Number:**  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  | - |  |  | - |  |  |  |  |      1. **Medicare number** (or comparable railroad insurance number)**:**  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  | |
| **A0700. Me** | **dicaid Number** - Enter "+" if pending, "N" if not a Medicaid Recipient |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| **A0800. Gen** | **der** |
| Enter Code   |  | | --- | |  | | 1. Male 2. Female |
| **A0900. Birt** | **h Date** |
|  | Month Day Year |
| **A2115. Rea** | **son for Discharge** |
| Enter Code   |  |  | | --- | --- | |  |  | | 1. Expired 2. Revoked 3. No longer terminally ill 4. Moved out of hospice service area 5. Transferred to another hospice 6. Discharged for cause |

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| **Section O** | **Service Utilization** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **O5000. Level of care in final 3 days**    Complete only if A2115, Reason for Discharge = 01 Expired | | | | | | | | | | | | | | | | |
| Enter Code   |  | | --- | |  | | Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 3 days of life?   1. **No** 2. **Yes**  Skip to Z0400, Signature(s) of Person(s) Completing the Record | | | | | | | | | | | | | | | |
| **O5010. Number of hospice visits in final 3 days**  Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated. | | | | | | | | | | | | | | | | |
|  | | | | | | **Visits on day of death**  **(A0270)** | | | | | **Visits one day prior to death**  **(A0270 minus 1)** | | | **Visits two days prior to death**  **(A0270 minus 2)** | | |
| **A. Registered Nurse** | | | | | |  | | | | |  | | |  | | |
|  | |  | |  |  |  |  |  |  |  |
|  | |  |  |
| **B. Physician (or Nurse Practitioner or**  **Physician Assistant)** | | | | | |  | |  | |  |  |  |  |  |  |  |
|  | |  |  |
| **C. Medical Social Worker** | | | | | |  | | | | |  | | |  | | |
|  | |  | |  |  |  |  |  |  |  |
|  | |  |  |
| **D. Chaplain or Spiritual Counselor** | | | | | |  | | | | |  | | |  | | |
|  | |  | |  |  |  |  |  |  |  |
|  | |  |  |
| **E. Licensed Practical Nurse** | | | | | |  | | | | |  | | |  | | |
|  | |  | |  |  |  |  |  |  |  |
|  | |  |  |
| **F. Aide** | | | | | | |  | | --- | |  | | | | | | |  | | --- | |  | | | | |  | | --- | |  | | | |
| **O5020. Level of care in final 7 days**    Complete only if A2115, Reason for Discharge = 01 Expired | | | | | | | | | | | | | | | | |
| Enter Code   |  | | --- | |  | | Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 7 days of life?   1. **No** 2. **Yes**  Skip to Z0400, Signature(s) of Person(s) Completing the Record | | | | | | | | | | | | | | | |
| **O5030. Number of hospice visits in 3 to 6 days prior to death**  Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated. | | | | | | | | | | | | | | | | |
|  | | **Visits three days prior to**  **death (A0270 minus 3)** | | | **Visits four days prior to**  **death (A0270 minus 4)** | | | | | | **Visits five days prior to death**  **(A0270 minus 5)** | | | **Visits six days prior to death**  **(A0270 minus 6)** | | |
| **A. Registered Nurse** | |  |  |  |  | |  | |  | |  |  |  |  |  |  |
| **B. Physician (or Nurse Practitioner or Physician**  **Assistant)** | | |  | | --- | |  | | | | |  | | --- | |  | | | | | | | |  | | --- | |  | | | | |  | | --- | |  | | | |
| **C. Medical Social Worker** | |  |  |  |  | |  | |  | |  |  |  |  |  |  |
| **D. Chaplain or Spiritual Counselor** | |  | | |  | | | | | |  | | |  | | |
|  |  |  |  | |  | |  | |  |  |  |  |  |  |
|  |  | |  |  |
| **E. Licensed Practical Nurse** | |  |  |  |  | |  | |  | |  |  |  |  |  |  |
| **F. Aide** | |  |  |  |  | |  | |  | |  |  |  |  |  |  |

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| **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 | | | | | |  |