PRA Disclosure Statement

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OMB Control Number: 0938-1153

Expiration Date: XX/XXXX

Hospice Item Set – Discharge

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):

A0220. Admission Date

Month Day Year

A0250. Reason for Record

Enter Code

01. Admission
09. Discharge

A0270. Discharge Date

Month Day Year

A0500. Legal Name of Patient

A. First name:

B. Middle initial:

C. Last name:

D. Suffix:

Section A Administrative Information

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
A2115. Reason 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

Section O Service Utilization

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? 0. **No** 1. **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?
☐	0. **No** 1. **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	☐	☐	☐	☐

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