OMB Control Number: 0938-1153
Expiration Date: XX-XX-XXXX

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:

A0550. Patient ZIP Code. Enter code in boxes provided.

Patient ZIP Code:

-

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

Section A Administrative Information

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

A1400. Payor Information

↓ **Check all that apply**

☐	A. Medicare (traditional fee-for-service)
☐	B. Medicare (managed care/Part C/Medicare Advantage)
☐	C. Medicaid (traditional fee-for-service)
☐	D. Medicaid (managed care)
☐	G. Other government (e.g., TRICARE, VA, etc.)
☐	H. Private Insurance/Medigap
☐	I. Private managed care
☐	J. Self-pay
☐	K. No payor source
☐	X. Unknown
☐	Y. Other

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 06. Long-term care hospital (LTCH) 07. Inpatient rehabilitation facility 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 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
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 J0905, Pain Active Problem
1. **Yes**

B. Date of first screening for pain:

☐☐ Month ☐☐ Day ☐☐☐☐ Year

Enter Code ☐

C. The patient's pain severity was:

0. None
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

J0905. Pain Active Problem

Enter Code ☐

Is pain an active problem for the patient?

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

Section J Health Conditions

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

PRA Disclosure Statement:
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1153. The time required to complete this information collection is estimated to average 19 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.