

## Hospice Item Set – Discharge

| Section A  |   | Administrative Information   |  |
|--|---|--|--|
| <b>A0050. Type of Record</b>   |   |  |  |
| Enter Code<br><input type="checkbox"/>                                 | 1. Add new record<br>2. Modify existing record<br>3. Inactivate existing record |  |  |
| <b>A0100. Facility Provider Numbers. Enter code in boxes provided.</b> |   |  |  |
|  |   | <b>A. National Provider Identifier (NPI):</b><br><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>   |  |
|  |   | <b>B. CMS Certification Number (CCN):</b><br><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>   |  |
| <b>A0220. Admission Date</b>   |   |  |  |
|  |   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>Month                      Day                      Year  |  |
| <b>A0250. Reason for Record</b>  |   |  |  |
| Enter Code<br><input type="text"/> <input type="text"/>                | 01. Admission<br>09. Discharge  |  |  |
| <b>A0270. Discharge Date</b>   |   |  |  |
|  |   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>Month                      Day                      Year  |  |
| <b>A0500. Legal Name of Patient</b>                                    |   |  |  |
|  |   | <b>A. First name:</b><br><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>   |  |
|  |   | <b>B. Middle initial:</b><br><input type="text"/>  |  |
|  |   | <b>C. Last name:</b><br><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |  |
|  |   | <b>D. Suffix:</b><br><input type="text"/> <input type="text"/> <input type="text"/>  |  |

**Section A****Administrative Information****A0600. Social Security and Medicare Numbers****A. Social Security Number:**

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

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

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**A0800. Gender**

Enter Code

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1. Male
2. Female

**A0900. Birth Date**

|       |  |     |  |      |  |  |  |  |  |  |  |
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| Month |  | Day |  | Year |  |  |  |  |  |  |  |

**A2115. Reason for Discharge**

Enter Code

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01. Expired
02. Revoked
03. No longer terminally ill
04. Moved out of hospice service area
05. Transferred to another hospice
06. Discharged for cause

**Section 0****Service Utilization****05000. 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

**05010. 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   | <input type="checkbox"/>       | <input type="checkbox"/>                      | <input type="checkbox"/>                       |
| B. Physician (or Nurse Practitioner or Physician Assistant) | <input type="checkbox"/>       | <input type="checkbox"/>                      | <input type="checkbox"/>                       |
| C. Medical Social Worker                                    | <input type="checkbox"/>       | <input type="checkbox"/>                      | <input type="checkbox"/>                       |
| D. Chaplain or Spiritual Counselor                          | <input type="checkbox"/>       | <input type="checkbox"/>                      | <input type="checkbox"/>                       |
| E. Licensed Practical Nurse                                 | <input type="checkbox"/>       | <input type="checkbox"/>                      | <input type="checkbox"/>                       |
| F. Aide   | <input type="checkbox"/>       | <input type="checkbox"/>                      | <input type="checkbox"/>                       |

**05020. Level of care in final 7 days**

Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code

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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

**05030. 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   | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/>                       |
| B. Physician (or Nurse Practitioner or Physician Assistant) | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/>                       |
| C. Medical Social Worker                                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/>                       |
| D. Chaplain or Spiritual Counselor                          | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/>                       |
| E. Licensed Practical Nurse                                 | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/>                       |
| F. Aide   | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/>                       |

**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:**

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**B. Date:**

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Day

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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 14 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.