

PRA Disclosure Statement

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Hospice Item Set - Admission

Section A	Administrative Information
A0050. Type of Record	
Enter Code <input style="width: 20px; height: 20px;" type="checkbox"/>	<ol style="list-style-type: none"> 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): <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
	B. CMS Certification Number (CCN): <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
A0205. Site of Service at Admission	
Enter Code <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 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	
	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 60px; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>
A0245. Date Initial Nursing Assessment Initiated	
	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 60px; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>
A0250. Reason for Record	
Enter Code <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 01. Admission 09. Discharge

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
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I0010. Principal Diagnosis	
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<p>Enter Code</p> <table border="1"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			<p>01. Cancer</p> <p>02. Dementia/Alzheimer's</p> <p>99. None of the above</p>

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:

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Month

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Day

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Year