

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 **9 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.

Hospice Item Set – Discharge

Section A	Administrative Information																				
A0050. Type of Record																					
Enter Code <input style="width: 20px; height: 20px;" type="text"/>	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: 100px; height: 20px;" type="text"/>																				
	B. CMS Certification Number (CCN): <input style="width: 100px; height: 20px;" type="text"/>																				
A0220. Admission Date																					
	<table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="6">Year</td> </tr> </table>											Month		Day		Year					
Month		Day		Year																	
A0250. Reason for Record																					
Enter Code <input style="width: 20px; height: 20px;" type="text"/>	01. Admission 09. Discharge																				
A0270. Discharge Date																					
	<table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="6">Year</td> </tr> </table>											Month		Day		Year					
Month		Day		Year																	
A0500. Legal Name of Patient																					
	A. First name: <input style="width: 100%; height: 20px;" type="text"/>																				
	B. Middle initial: <input style="width: 20px; height: 20px;" type="text"/>																				
	C. Last name: <input style="width: 100%; height: 20px;" type="text"/>																				
	D. Suffix: <input style="width: 30px; height: 20px;" type="text"/>																				

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