

PRA Disclosure Statement

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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	
	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 40px; 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"/>	01. Admission 09. Discharge
A0270. Discharge Date	
	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>
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 A**Administrative Information****A0600. Social Security and Medicare Numbers****A. Social Security Number:**

<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"/>
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B. Medicare number (or comparable railroad insurance number):

<input type="text"/>																			
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A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid Recipient

<input type="text"/>																			
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A0800. Gender

Enter Code

1. Male
2. Female

A0900. Birth Date

<input type="text"/>									
Month		Day		Year					

A2115. Reason for Discharge

Enter Code

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 <input type="checkbox"/>	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
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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 <input type="checkbox"/>	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
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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:**

B. Date:

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Month

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Day

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Year