PRA Disclosure Statement

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ADMISSION TIMEPOINT - HOPE

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

A. **National Provider Identifier (NPI):**

☐☐☐☐☐☐☐☐☐☐

B. **CMS Certification Number (CCN):**

☐☐☐☐☐☐■■■■■■

A0215. Site of Service at Admission

Enter Code ☐☐

01. Patient's Home/Residence
02. Assisted Living Facility
03. Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)
04. Skilled Nursing Facility (SNF)
05. Inpatient Hospital
06. Inpatient Hospice Facility (General Inpatient (GIP))
07. Long Term Care Hospital (LTCH)
08. Inpatient Psychiatric Facility
09. Hospice Home Care (Routine Home Care (RHC)) Provided in a Hospice Facility
99. Not listed

A0220. Admission Date

☐☐ ☐☐ ☐☐☐☐

Month Day Year

A0250. Reason for Record

Enter Code ☐

1. Admission (ADM)
2. HOPE Update Visit 1 (HUV1)
3. HOPE Update Visit 2 (HUV2)
9. Discharge (DC)

A0500. Legal Name of Patient

A. **First name:**

B. **Middle initial:**

C. **Last name:**

D. **Suffix:**

A0550. Patient Zip Code

–

A0600. Social Security and Medicare Numbers

A. **Social Security Number:**

– –

B. **Medicare Number:**

A0700. Medicaid Number

Enter " +" if pending, "N" if not a Medicaid Recipient

A0810. Sex

Enter Code

1. Male
2. Female

A0900. Birth Date

Month Day Year

A1005. Ethnicity

Are you of Hispanic, Latino/a, or Spanish origin?

↓ Check all that apply	
☐	A. No, not of Hispanic, Latino/a, or Spanish origin
☐	B. Yes, Mexican, Mexican American, Chicano/a
☐	C. Yes, Puerto Rican
☐	D. Yes, Cuban
☐	E. Yes, Another Hispanic, Latino, or Spanish origin
☐	X. Patient unable to respond
☐	Y. Patient declines to respond

A1010. Race

What is your race?

↓ Check all that apply	
☐	A. White
☐	B. Black or African American
☐	C. American Indian or Alaska Native
☐	D. Asian Indian
☐	E. Chinese
☐	F. Filipino
☐	G. Japanese
☐	H. Korean
☐	I. Vietnamese
☐	J. Other Asian
☐	K. Native Hawaiian
☐	L. Guamanian or Chamorro
☐	M. Samoan
☐	N. Other Pacific Islander
☐	X. Patient unable to respond
☐	Y. Patient declines to respond
☐	Z. None of the above

A1110. Language

Enter Code

☐

A. **What is your preferred language?**

B. **Do you need or want an interpreter to communicate with a doctor or health care staff?**

0. No
1. Yes
9. Unable to determine

A1400. Payer Information	
↓ Check all existing payer sources that apply at the time of this assessment	
☐	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 payer source
☐	X. Unknown
☐	Y. Other

A1805. Admitted From	
Enter Code ☐☐	**Immediately preceding this admission, where was the patient?** 01. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) 02. Nursing Home (long-term care facility) 03. Skilled Nursing Facility (SNF, swing beds) 04. Short-Term General Hospital (acute hospital, IPPS) 05. Long-Term Care Hospital (LTCH) 06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit) 07. Inpatient Psychiatric Facility (psychiatric hospital or unit) 08. Intermediate Care Facility (ID/DD facility) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 99. Not Listed

A1905. Living Arrangements	
Enter Code ☐	**Identify the patient's living arrangement at the time of this admission.** 1. Alone (no other residents in the home) 2. With others in the home (e.g., family, friends, or paid caregiver) 3. Congregate home (e.g., assisted living or residential care home) 4. Inpatient facility (e.g., skilled nursing facility, nursing home, inpatient hospice, hospital) 5. Does not have a permanent home (e.g., has unstable housing or is experiencing homelessness)

A1910. Availability of Assistance	
Enter Code ☐	**Code the level of in-person assistance from available and willing caregiver(s), excluding hospice and facility staff, at the time of this admission.** 1. Around-the-clock (24 hours a day with few exceptions) 2. Regular daytime (all day every day with few exceptions) 3. Regular nighttime (all night every night with few exceptions) 4. Occasional (intermittent) 5. No assistance available

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 I0100, Principal Diagnosis
1. **Yes, and discussion occurred**
2. **Yes, but the patient/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 (including Alzheimer's disease) 03. Neurological Condition (e.g., Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS)) 04. Stroke 05. Chronic Obstructive Pulmonary Disease (COPD) 06. Cardiovascular (excluding heart failure) 07. Heart Failure 08. Liver Disease 09. Renal Disease 99. None of the above

Comorbidities and Co-existing Conditions	
↓ **Check all that apply**	
	Cancer
☐	I0100. Cancer
	Heart/Circulation
☐	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
☐	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐	I0950. Cardiovascular (excluding heart failure)
	Gastrointestinal
☐	I1101. Liver disease (e.g., cirrhosis)
	Genitourinary
☐	I1510. Renal disease
	Infections
☐	I2102. Sepsis
	Metabolic
☐	I2900. Diabetes Mellitus (DM)
☐	I2910. Neuropathy
	Neurological
☐	I4501. Stroke
☐	I4801. Dementia (including Alzheimer's disease)
☐	I5150. Neurological Conditions (e.g., Parkinson's disease, multiple sclerosis, ALS)
	I5401. Seizure Disorder
	Pulmonary
☐	I6202. Chronic Obstructive Pulmonary Disease (COPD)
	Other
☐	I8005. Other Medical Condition

Section J Health Conditions

J0050. Death is Imminent

Enter Code	
☐	**At the time of this assessment and based on your clinical assessment, does the patient appear to have a life expectancy of 3 days or less?** 0. **No** 1. **Yes**

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
☐	C. **The patient's pain severity was:** 0. None 1. Mild 2. Moderate 3. Severe 9. Pain not rated
☐	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**

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

J0915. Neuropathic Pain

Enter Code	
☐	**Does the patient have neuropathic pain (e.g., pain with burning, tingling, pins and needles, hypersensitivity to touch)?** 0. **No** 1. **Yes**

J2030. Screening for Shortness of Breath

Enter Code	
☐	A. **Was the patient screened for shortness of breath?** 0. **No** — Skip to J2050, Symptom Impact Screening 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 J2050, Symptom Impact Screening 1. **Yes**

J2040. Treatment for Shortness of Breath

Enter Code	
☐	A. **Was treatment for shortness of breath initiated?** 0. **No** — Skip to J2050, Symptom Impact Screening 1. **No, patient declined treatment** — Skip to J2050, Symptom Impact Screening 2. **Yes** B. **Date treatment for shortness of breath initiated:** ☐☐ ☐☐ ☐☐☐☐ Month Day Year

J2050. Symptom Impact Screening

Enter Code	
☐	A. **Was a symptom impact screening completed?** 0. **No** — Skip to M1190, Skin Conditions 1. **Yes** B. **Date of symptom impact screening:** ☐☐ ☐☐ ☐☐☐☐ Month Day Year

J2051. Symptom Impact

Over the past 2 days, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.

Coding:

0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment
1. Slight
2. Moderate
3. Severe
9. Not applicable (the patient is not experiencing the symptom)

	Enter Code ↓
A. **Pain**	☐
B. **Shortness of breath**	☐
C. **Anxiety**	☐
D. **Nausea**	☐
E. **Vomiting**	☐
F. **Diarrhea**	☐
G. **Constipation**	☐
H. **Agitation**	☐

J2052. Symptom Follow-up Visit (SFV) (complete only if any response to J2051 Symptom Impact = 2. Moderate or 3. Severe)

An in-person **Symptom Follow-up Visit (SFV)** should occur within 2 calendar days as a follow-up for any moderate or severe pain or non-pain symptom identified during Symptom Impact assessment at Admission or HOPE Update Visit (HUV).

Enter Code

A. **Was an in-person SFV completed?**
   0. **No** — Skip to J2052C. Reason SFV Not Completed.
   1. **Yes**

B. **Date of in-person SFV** — Complete and skip to J2053, SFV Symptom Impact.

Month Day Year

Enter Code

C. **Reason SFV not completed** — Skip to M1190, Skin Conditions.
   1. Patient and/or caregiver declined an in-person visit.
   2. Patient unavailable (e.g., in ED, hospital, travel outside of service area, expired).
   3. Attempts to contact patient and/or caregiver were unsuccessful.
   9. None of the above

J2053. SFV Symptom Impact

Since the last Symptom Impact assessment was completed, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.

Coding:
0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment
1. Slight
2. Moderate
3. Severe
9. Not applicable (the patient is not experiencing the symptom)

	Enter Code ↓
A. **Pain**	
B. **Shortness of breath**	
C. **Anxiety**	
D. **Nausea**	
E. **Vomiting**	
F. **Diarrhea**	
G. **Constipation**	
H. **Agitation**	

Section M | Skin Conditions

M1190. Skin Conditions	
Enter Code	**Does the patient have one or more skin conditions?**
☐	0. **No** - Skip to N0500, Scheduled Opioid 1. **Yes**

M1195. Types of Skin Conditions	
Indicate which following skin conditions were identified at the time of this assessment.	
↓ Check all that apply	
☐	A. Diabetic foot ulcer(s)
☐	B. Open lesion(s) other than ulcers, rash, or skin tear (cancer lesions)
☐	C. Pressure Ulcer(s)/Injuries
☐	D. Rash(es)
☐	E. Skin tear(s)
☐	F. Surgical wound(s)
☐	G. Ulcers other than diabetic or pressure ulcers (e.g., venous stasis ulcer, Kennedy ulcer)
☐	H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
☐	Z. None of the above were present

M1200. Skin and Ulcer/Injury Treatments	
Indicate the interventions or treatments in place at the time of this assessment.	
↓ Check all that apply	
☐	A. Pressure reducing device for chair
☐	B. Pressure reducing device for bed
☐	C. Turning/repositioning program
☐	D. Nutrition or hydration intervention to manage skin problems
☐	E. Pressure ulcer/injury care
☐	F. Surgical wound care
☐	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
☐	H. Application of ointments/medications other than to feet
☐	I. Application of dressings to feet (with or without topical medications)
☐	J. Incontinence Management
☐	Z. None of the above were provided

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 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 payment reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Signatures	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