

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. HOPE is a patient assessment instrument that intends to collect data during a hospice patient's stay. Data collected using this instrument will be used to measure the quality of care provided by a hospice provider. The valid OMB control number for this information collection is XXXX-XXXX. Submission of this data is required by Section 1814(i)(5) of the Social Security Act. The time required to complete this data collection is estimated to average XX minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the data collected. Submitted patient-level data will remain confidential and is protected from public dissemination in accordance with the Privacy Act of 1974, as amended. 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.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Jermama Keys, National Coordinator, Hospice Quality Reporting Program Centers for Medicare & Medicaid Services, at Jermama.Keys@cms.hhs.gov.

**HOSPICE OUTCOME AND PATENT EVALUATION (HOPE) VERSION 1
All Items**

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	
---	--

	A. National Provider Identifier (NPI): <table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td> </tr> </table> B. CMS Certification Number (CCN): <table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td> </tr> </table>																																

A0215. Site of Service at Admission	
--	--

Enter Code <input style="width:20px; height:20px;" type="text"/>	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	
------------------------------	--

	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; text-align:center;"> <table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr><td style="width:10%;"></td><td style="width:10%;"></td></tr> </table> Month </td> <td style="width:20%; text-align:center;"> <table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr><td style="width:10%;"></td><td style="width:10%;"></td></tr> </table> Day </td> <td style="width:60%; text-align:center;"> <table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr> <td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td> </tr> </table> Year </td> </tr> </table>	<table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr><td style="width:10%;"></td><td style="width:10%;"></td></tr> </table> Month			<table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr><td style="width:10%;"></td><td style="width:10%;"></td></tr> </table> Day			<table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr> <td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td> </tr> </table> Year						
<table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr><td style="width:10%;"></td><td style="width:10%;"></td></tr> </table> Month			<table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr><td style="width:10%;"></td><td style="width:10%;"></td></tr> </table> Day			<table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr> <td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td> </tr> </table> Year								

A0250. Reason for Record	
---------------------------------	--

Enter Code <input style="width:20px; height:20px;" type="text"/>	1. Admission (ADM) 2. HOPE Update Visit 1 (HUV1) 3. HOPE Update Visit 2 (HUV2) 9. Discharge (DC)
--	---

A0270. Discharge Date	
------------------------------	--

	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; text-align:center;"> <table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr><td style="width:10%;"></td><td style="width:10%;"></td></tr> </table> Month </td> <td style="width:20%; text-align:center;"> <table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr><td style="width:10%;"></td><td style="width:10%;"></td></tr> </table> Day </td> <td style="width:60%; text-align:center;"> <table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr> <td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td> </tr> </table> Year </td> </tr> </table>	<table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr><td style="width:10%;"></td><td style="width:10%;"></td></tr> </table> Month			<table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr><td style="width:10%;"></td><td style="width:10%;"></td></tr> </table> Day			<table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr> <td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td> </tr> </table> Year						
<table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr><td style="width:10%;"></td><td style="width:10%;"></td></tr> </table> Month			<table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr><td style="width:10%;"></td><td style="width:10%;"></td></tr> </table> Day			<table border="1" style="width:100%; height:20px; border-collapse: collapse;"> <tr> <td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td><td style="width:16.6%;"></td> </tr> </table> Year								

A0500. Legal Name of Patient

A. First name:	<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. Middle initial:	<input type="text"/>
C. Last name:	<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"/> <input type="text"/> <input type="text"/>
D. Suffix:	<input type="text"/> <input type="text"/> <input type="text"/>

A0550. Patient Zip Code

<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"/>
---	---	---

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"/> <input type="text"/>
B. Medicare 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"/> <input type="text"/>

A0700. Medicaid Number

Enter "+" if pending, "N" if not a Medicaid Recipient
<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"/>

A0800. Gender

Enter Code <input type="text"/>	1. Male 2. Female
---	----------------------

A0900. Birth Date

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

A1005. Ethnicity

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

↓ Check all that apply

<input type="checkbox"/>	A. No, not of Hispanic, Latino/a, or Spanish origin
<input type="checkbox"/>	B. Yes, Mexican, Mexican American, Chicano/a
<input type="checkbox"/>	C. Yes, Puerto Rican
<input type="checkbox"/>	D. Yes, Cuban
<input type="checkbox"/>	E. Yes, Another Hispanic, Latino, or Spanish origin
<input type="checkbox"/>	X. Patient unable to respond
<input type="checkbox"/>	Y. Patient declines to respond

A1010. Race

What is your race?

↓ Check all that apply

<input type="checkbox"/>	A. White
<input type="checkbox"/>	B. Black or African American
<input type="checkbox"/>	C. American Indian or Alaska Native
<input type="checkbox"/>	D. Asian Indian
<input type="checkbox"/>	E. Chinese
<input type="checkbox"/>	F. Filipino
<input type="checkbox"/>	G. Japanese
<input type="checkbox"/>	H. Korean
<input type="checkbox"/>	I. Vietnamese
<input type="checkbox"/>	J. Other Asian
<input type="checkbox"/>	K. Native Hawaiian
<input type="checkbox"/>	L. Guamanian or Chamorro
<input type="checkbox"/>	M. Samoan
<input type="checkbox"/>	N. Other Pacific Islander
<input type="checkbox"/>	X. Patient unable to respond
<input type="checkbox"/>	Y. Patient declines to respond
<input type="checkbox"/>	Z. None of the above

A1110. Language

Enter Code <input type="checkbox"/>	A. What is your preferred language? <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. 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

<input type="checkbox"/>	A. Medicare (traditional fee-for-service)
<input type="checkbox"/>	B. Medicare (managed care/Part C/Medicare Advantage)
<input type="checkbox"/>	C. Medicaid (traditional fee-for-service)
<input type="checkbox"/>	D. Medicaid (managed care)
<input type="checkbox"/>	G. Other government (e.g., TRICARE, VA, etc.)
<input type="checkbox"/>	H. Private Insurance/Medigap
<input type="checkbox"/>	I. Private managed care
<input type="checkbox"/>	J. Self-pay
<input type="checkbox"/>	K. No payer source
<input type="checkbox"/>	X. Unknown
<input type="checkbox"/>	Y. Other

A1805. Admitted From

Enter Code	Immediately preceding this admission, where was the patient?
<input type="text"/> <input type="text"/>	<ol style="list-style-type: none"> 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.
<input type="text"/>	<ol style="list-style-type: none"> 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.
<input type="text"/>	<ol style="list-style-type: none"> 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

A2115. Reason for Discharge

Enter Code	
<input type="text"/>	<ol style="list-style-type: none"> 1. Expired 2. Revoked 3. No longer terminally ill 4. Moved out of hospice service area 5. Transferred to another hospice 6. Discharged for cause

Section F

Preferences for Customary Routine and Activities

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:**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

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:**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

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:**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

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:**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Month

Day

Year

Section I	Active Diagnoses
------------------	-------------------------

I0010. Principal Diagnosis	
-----------------------------------	--

Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	<ul style="list-style-type: none"> 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
<input type="checkbox"/>	I0100. Cancer
	Heart/Circulation
<input type="checkbox"/>	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
<input type="checkbox"/>	I0950. Cardiovascular (excluding heart failure)
	Gastrointestinal
<input type="checkbox"/>	I1101. Liver disease (e.g., cirrhosis)
	Genitourinary
<input type="checkbox"/>	I1510. Renal disease
	Infections
<input type="checkbox"/>	I2102. Sepsis
	Metabolic
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM)
<input type="checkbox"/>	I2910. Neuropathy
	Neurological
<input type="checkbox"/>	I4501. Stroke
<input type="checkbox"/>	I4801. Dementia (including Alzheimer’s disease)
<input type="checkbox"/>	I5150. Neurological Conditions (e.g., Parkinson’s disease, multiple sclerosis, ALS)
<input type="checkbox"/>	I5401. Seizure Disorder
	Pulmonary
<input type="checkbox"/>	I6202. Chronic Obstructive Pulmonary Disease (COPD)
	Other
<input type="checkbox"/>	I8005. Other Medical Condition

Section J	Health Conditions
------------------	--------------------------

J0050. Death is Imminent	
---------------------------------	--

Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	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 <input style="width: 30px; height: 20px;" type="checkbox"/>	A. Was the patient screened for pain? 0. No — Skip to J0905, Pain Active Problem 1. Yes B. Date of first screening for pain <table style="margin-left: 40px; border-collapse: collapse;"> <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="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> <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 style="text-align: center; padding: 2px;">Month</td> <td style="text-align: center; padding: 2px;">Day</td> <td colspan="6" style="text-align: center; padding: 2px;">Year</td> </tr> </table>									Month	Day	Year					
Month	Day	Year															

Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	C. The patient's pain severity was: 0. None 1. Mild 2. Moderate 3. Severe 9. Pain not rated
---	---

Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	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 <input style="width: 30px; height: 20px;" type="checkbox"/>	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 <input type="checkbox"/>	<p>A. Was a comprehensive pain assessment done?</p> <p>0. No — Skip to J2030, Screening for Shortness of Breath 1. Yes</p> <p>B. Date of Comprehensive pain assessment:</p> <table border="1" style="margin-left: 40px;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td colspan="2" style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table> <p>C. Comprehensive pain assessment included:</p>									Month		Day		Year			
Month		Day		Year													

↓ Check all that apply

<input type="checkbox"/>	1. Location
<input type="checkbox"/>	2. Severity
<input type="checkbox"/>	3. Character
<input type="checkbox"/>	4. Duration
<input type="checkbox"/>	5. Frequency
<input type="checkbox"/>	6. What relieves/worsens pain
<input type="checkbox"/>	7. Effect on function or quality of life
<input type="checkbox"/>	9. None of the above

J0915. Neuropathic Pain

Enter Code <input type="checkbox"/>	<p>Does the patient have neuropathic pain (e.g., pain with burning, tingling, pins and needles, hypersensitivity to touch)?</p> <p>0. No 1. Yes</p>
---	--

J2030. Screening for Shortness of Breath

Enter Code <input type="checkbox"/>	<p>A. Was the patient screened for shortness of breath?</p> <p>0. No — Skip to J2050, Symptom Impact Screening 1. Yes</p> <p>B. Date of first screening for shortness of breath:</p> <table border="1" style="margin-left: 40px;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td colspan="2" style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>									Month		Day		Year			
Month		Day		Year													

Enter Code <input type="checkbox"/>	<p>C. Did the screening indicate the patient had shortness of breath?</p> <p>0. No — Skip to J2050, Symptom Impact Screening 1. Yes</p>
---	--

J2040. Treatment for Shortness of Breath

Enter Code <input type="checkbox"/>	<p>A. Was treatment for shortness of breath initiated?</p> <p>0. No — Skip to J2050, Symptom Impact Screening 1. No, patient declined treatment — Skip to J2050, Symptom Impact Screening 2. Yes</p> <p>B. Date treatment for shortness of breath initiated:</p> <table border="1" style="margin-left: 40px;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td colspan="2" style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>									Month		Day		Year			
Month		Day		Year													

J2050. Symptom Impact Screening

<p>Enter Code</p> <input type="checkbox"/>	<p>A. Was a symptom impact screening completed?</p> <p>0. No — Skip to M1190, Skin Conditions</p> <p>1. Yes</p> <p>B. Date of symptom impact screening:</p> <table border="1" style="margin-left: 20px;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td colspan="2" style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>									Month		Day		Year			
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	<input type="checkbox"/>
B. Shortness of breath	<input type="checkbox"/>
C. Anxiety	<input type="checkbox"/>
D. Nausea	<input type="checkbox"/>
E. Vomiting	<input type="checkbox"/>
F. Diarrhea	<input type="checkbox"/>
G. Constipation	<input type="checkbox"/>
H. Agitation	<input type="checkbox"/>

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

<p>Enter Code</p> <input type="checkbox"/>	<p>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).</p> <p>A. Was an in-person SFV completed?</p> <p>0. No — Skip to J2052C, Reason SFV Not Completed.</p> <p>1. Yes</p> <p>B. Date of in-person SFV — Complete and skip to J2053, SFV Symptom Impact.</p> <table border="1" style="margin-left: 20px;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td colspan="2" style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table> <p>C. Reason SFV Not Completed — Skip to M1190, Skin Conditions.</p> <p>1. Patient and/or caregiver declined an in-person visit.</p> <p>2. Patient unavailable (e.g., in ED, hospital, travel outside of service area, expired).</p> <p>3. Attempts to contact patient and/or caregiver were unsuccessful.</p> <p>9. None of the above</p>									Month		Day		Year			
Month		Day		Year													
<p>Enter Code</p> <input type="checkbox"/>																	

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	<input type="checkbox"/>
B. Shortness of breath	<input type="checkbox"/>
C. Anxiety	<input type="checkbox"/>
D. Nausea	<input type="checkbox"/>
E. Vomiting	<input type="checkbox"/>
F. Diarrhea	<input type="checkbox"/>
G. Constipation	<input type="checkbox"/>
H. Agitation	<input type="checkbox"/>

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 <input style="width: 30px; height: 20px;" type="checkbox"/>	<p>A. Was a scheduled opioid initiated or continued?</p> <p>0. No — Skip to N0510, PRN Opioid</p> <p>1. Yes</p> <p>B. Date scheduled opioid initiated or continued:</p> <table style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <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="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> <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 style="text-align: center; font-size: small;">Month</td> <td style="text-align: center; font-size: small;">Day</td> <td colspan="6" style="text-align: center; font-size: small;">Year</td> </tr> </table>									Month	Day	Year					
Month	Day	Year															

N0510. PRN Opioid																	
Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	<p>A. Was PRN opioid initiated or continued?</p> <p>0. No — Skip to N0520, Bowel Regimen</p> <p>1. Yes</p> <p>B. Date PRN opioid initiated or continued:</p> <table style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <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="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> <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 style="text-align: center; font-size: small;">Month</td> <td style="text-align: center; font-size: small;">Day</td> <td colspan="6" style="text-align: center; font-size: small;">Year</td> </tr> </table>									Month	Day	Year					
Month	Day	Year															

N0520. Bowel Regimen (Complete only if N0500A or N0510A=1)																	
Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	<p>A. Was a bowel regimen initiated or continued? - Select the most accurate response</p> <p>0. No — Skip to Z0400. Signature(s) of Person(s) Completing the Record</p> <p>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</p> <p>2. Yes</p> <p>B. Date bowel regimen initiated or continued:</p> <table style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <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="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> <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 style="text-align: center; font-size: small;">Month</td> <td style="text-align: center; font-size: small;">Day</td> <td colspan="6" style="text-align: center; font-size: small;">Year</td> </tr> </table>									Month	Day	Year					
Month	Day	Year															

Section Z	Assessment Administration
------------------	----------------------------------

Z0350. Date Assessment was Completed

	<table style="margin: auto;"> <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="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> <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 style="text-align: center; padding: 0 5px;">Month</td> <td style="text-align: center; padding: 0 5px;">Day</td> <td colspan="2" style="text-align: center; padding: 0 5px;">Year</td> <td colspan="4"></td> </tr> </table>									Month	Day	Year					
Month	Day	Year															

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

	<p>A. Signature</p> <p>_____</p> <p>B. Date</p> <table style="margin: auto;"> <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="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> <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 style="text-align: center; padding: 0 5px;">Month</td> <td style="text-align: center; padding: 0 5px;">Day</td> <td colspan="2" style="text-align: center; padding: 0 5px;">Year</td> <td colspan="4"></td> </tr> </table>									Month	Day	Year					
Month	Day	Year															