

### **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](mailto:Jermama.Keys@cms.hhs.gov).**

## ADMISSION TIMEPOINT - HOPE Version 1

### 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

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**A0800. Gender**

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

<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

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"/>	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"/>	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"/>	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 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:**

--	--	--	--	--	--	--	--

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

<b>Section I</b>	<b>Active Diagnoses</b>
------------------	-------------------------

I0010. Principal Diagnosis	
<b>Enter Code</b>  <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>	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

<b>Section J</b>	<b>Health Conditions</b>
------------------	--------------------------

<b>J0050. Death is Imminent</b>
---------------------------------

<b>Enter Code</b>  <input style="width: 30px; height: 20px;" type="text"/>	<b>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?</b>  0. <b>No</b> 1. <b>Yes</b>
--	--

<b>J0900. Pain Screening</b>
------------------------------

<b>Enter Code</b>  <input style="width: 30px; height: 20px;" type="text"/>	<b>A. Was the patient screened for pain?</b> 0. <b>No</b> — Skip to J0905, Pain Active Problem 1. <b>Yes</b> <b>B. Date of first screening for pain</b>  <table style="margin-left: 40px;"> <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;">Month</td> <td></td> <td style="text-align: center;">Day</td> <td></td> <td style="text-align: center;">Year</td> <td></td> <td></td> <td></td> </tr> </table>									Month		Day		Year			
Month		Day		Year													
<b>Enter Code</b>  <input style="width: 30px; height: 20px;" type="text"/>	<b>C. The patient's pain severity was:</b> 0. None 1. Mild 2. Moderate 3. Severe 9. Pain not rated																
<b>Enter Code</b>  <input style="width: 30px; height: 20px;" type="text"/>	<b>D. Type of standardized pain tool used:</b> 1. Numeric 2. Verbal descriptor 3. Patient visual 4. Staff observation 9. No standardized tool used																

<b>J0905. Pain Active Problem</b>
-----------------------------------

<b>Enter Code</b>  <input style="width: 30px; height: 20px;" type="text"/>	<b>Is pain an active problem for the patient?</b>  0. <b>No</b> — Skip to J2030, Screening for Shortness of Breath 1. <b>Yes</b>
--	---

<b>J0910. Comprehensive Pain Assessment</b>
---

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

<b>↓ Check all that apply</b>	
<input style="width: 20px; height: 20px;" type="checkbox"/>	1. Location
<input style="width: 20px; height: 20px;" type="checkbox"/>	2. Severity
<input style="width: 20px; height: 20px;" type="checkbox"/>	3. Character
<input style="width: 20px; height: 20px;" type="checkbox"/>	4. Duration
<input style="width: 20px; height: 20px;" type="checkbox"/>	5. Frequency
<input style="width: 20px; height: 20px;" type="checkbox"/>	6. What relieves/worsens pain
<input style="width: 20px; height: 20px;" type="checkbox"/>	7. Effect on function or quality of life
<input style="width: 20px; height: 20px;" type="checkbox"/>	9. None of the above



J0915. Neuropathic Pain	
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px auto;"></div>	Does the patient have neuropathic pain (e.g., pain with burning, tingling, pins and needles, hypersensitivity to touch)?  0. <b>No</b> 1. <b>Yes</b>

  

J2030. Screening for Shortness of Breath	
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px auto;"></div>	<p>A. <b>Was the patient screened for shortness of breath?</b></p> <p>0. <b>No</b> — Skip to J2050, Symptom Impact Screening  1. <b>Yes</b></p> <p>B. <b>Date of first screening for shortness of breath:</b></p> <div style="display: flex; justify-content: center; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> <div style="display: flex; justify-content: center; align-items: center; gap: 20px; margin-top: 5px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px auto;"></div>	<p>C. <b>Did the screening indicate the patient had shortness of breath?</b></p> <p>0. <b>No</b> — Skip to J2050, Symptom Impact Screening  1. <b>Yes</b></p>

  

J2040. Treatment for Shortness of Breath	
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px auto;"></div>	<p>A. <b>Was treatment for shortness of breath initiated?</b></p> <p>0. <b>No</b> — Skip to J2050, Symptom Impact Screening  1. <b>No, patient declined treatment</b> — Skip to J2050, Symptom Impact Screening  2. <b>Yes</b></p> <p>B. <b>Date treatment for shortness of breath initiated:</b></p> <div style="display: flex; justify-content: center; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> <div style="display: flex; justify-content: center; align-items: center; gap: 20px; margin-top: 5px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>

  

J2050. Symptom Impact Screening	
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px auto;"></div>	<p>A. <b>Was a symptom impact screening completed?</b></p> <p>0. <b>No</b> — Skip to M1190, Skin Conditions  1. <b>Yes</b></p> <p>B. <b>Date of symptom impact screening:</b></p> <div style="display: flex; justify-content: center; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> <div style="display: flex; justify-content: center; align-items: center; gap: 20px; margin-top: 5px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>

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

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

Enter Code

☐

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).

**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

☐

<b>Section M</b>	<b>Skin Conditions</b>
------------------	------------------------

**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

<input type="checkbox"/>	A. Diabetic foot ulcer(s)
<input type="checkbox"/>	B. Open lesion(s) other than ulcers, rash, or skin tear (cancer lesions)
<input type="checkbox"/>	C. Pressure Ulcer(s)/Injuries
<input type="checkbox"/>	D. Rash(es)
<input type="checkbox"/>	E. Skin tear(s)
<input type="checkbox"/>	F. Surgical wound(s)
<input type="checkbox"/>	G. Ulcers other than diabetic or pressure ulcers (e.g., venous stasis ulcer, Kennedy ulcer)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
<input type="checkbox"/>	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

<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Pressure ulcer/injury care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Application of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	J. Incontinence Management
<input type="checkbox"/>	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

<b>Section Z</b>	<b>Assessment Administration</b>
------------------	----------------------------------

<b>Z0400. Signature(s) of Person(s) Completing the Record</b>
---

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.			

<b>Z0500. Signature of Person Verifying Record Completion</b>
---

	A. <b>Signature</b>																
	_____																
	B. <b>Date</b>																
	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2">Month</td><td colspan="2">Day</td><td colspan="4">Year</td></tr></table>									Month		Day		Year			
Month		Day		Year													