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.

DISCHARGE 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):**

☐☐☐☐☐☐■■■■■■

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)

A0270. Discharge Date

☐☐ ☐☐ ☐☐☐☐

Month Day Year

A0500. Legal Name of Patient

A. **First name:**

B. **Middle initial:**

C. **Last name:**

D. **Suffix:**

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

A2115. Reason for Discharge	
Enter Code ☐	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 Z Assessment 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**

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Month Day Year