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Chart: 1 Benefit Period: 1

This assessment includes the **Hospice Outcomes and Patient Evaluation (HOPE) Data Set** - OMB Control Number 0938-1153

Section A

Administrative Information

(A0100. Facility Provider Numbers.) Enter code in boxes provided.

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

34-1511

(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

(A0215) Site of Service at Admission

- 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.)



Test-HP Team B
Hospice Admission Data Set

Patient: Kruger, Freddy-MR#100832

Caregiver: Olmeda, Kelly (IPU Nursing) Visit Date: 10/01/2025

10/01/2025

(A0250) Reason for Record

01. Admission (ADM)

(A0500. Legal Name of Patient)

A. First name:

Freddy

B. Middle initial:

C. Last name:

Kruger

D. Suffix:

(A0550) Patient Zip Code:

27401

(A0600) Social Security and Medicare Numbers

A. Social Security Number:

999999999

B. Medicare number:

(A0900. Birth Date)

6/6/1960

(A0810) Sex

1. Male
 2. Female

(A0700. Medicaid Number) - Enter "+" if pending, "N" if not a Medicaid Recipient

(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:

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

(A1110) Language

- 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

(A1905) Living Arrangements

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)

*IPU Living arrangement is Inpatient hospice at time of the admission

(A1910) Availability of Assistance

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

IPU- how frequent is someone visiting (not IPU Staff) Chaplains & Volunteers count. Are visitors in and out, staying around the clock?

Section I

Active Diagnoses, Comorbidities, and Co-existing Conditions

(I0010) Principal Diagnosis

- 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

Please fill in as many as you know, use hospital records and Hospital Liaison notes to get this information. For comorbidities.

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)



Test-HP Team B
Hospice Admission Data Set

Patient: Kruger, Freddy-MR#100832

Caregiver: Olmeda, Kelly (IPU Nursing) Visit Date: 10/01/2025

<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

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Caregiver Signature:

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Chart: 1 Benefit Period: 1

Section F	Preferences
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(F2000. CPR Preference)

A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? - Select the most accurate response

- 0. No → Skip F2000B
- 1. Yes, and discussion occurred (specify details):
- 2. Yes, but the patient/responsible party refused to discuss

* "DNR" does not indicate discussion. If the Hospital Liaison or Intake Nurse documented the discussion then it is sufficient to note this, though it is best practice to attempt the discussion again.

B. Date the patient/responsible party was first asked about preference regarding the use of CPR:

(F2100. Other Life-Sustaining Treatment Preferences)

A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR? - Select the most accurate response

- 0. No → Skip F2100B
- 1. Yes, and discussion occurred (specify details):
- 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:

(F2200. Hospitalization Preference)

A. Was the patient/responsible party asked about preference regarding hospitalization? - Select the most accurate response

- 0. No → Skip F2200B
- 1. Yes, and discussion occurred (specify details):
- 2. Yes, but the patient/responsible party refused to discuss

B. Date the patient/responsible party was first asked about preference regarding hospitalization:

(F3000. Spiritual/Existential Concerns)

A. Was the patient and/or caregiver asked about spiritual/existential concerns? - Select the most accurate response

- 0. No → Skip F3000B
- 1. Yes, and discussion occurred (specify details):
- 2. Yes, but the patient/caregiver refused to discuss

* We can never, ever answer "0. No" because we must always attempt to have the discussion or have evidence that the Liaison or Intake Nurse had the discussion.

* Denoting a patient's affiliation or their acceptance/denial of Chaplain services is not sufficient to prove we discussed "concerns."

B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:

* There is not documentation from the Hospital Liaisons or Intake Nurses about spiritual concerns, so that cannot be the answer for this question.

Section J	Health Conditions
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Pain

(J0050) Death is imminent

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

* If the patient is unable to have a discussion about any of these items and there is no family at all available to have the discussion, then you may mark option "2. Pt/Family refused to discuss," simply because their unavailability equals refusal and there is no other way to note this.

(J0900. Pain Screening)

A. Was the patient screened for pain?

- 0. No → Skip J0900B, J0900C and J0900D
- 1. Yes

B. Date of first screening for pain:

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)

A. Is pain an active problem for the patient?

- 0. No → Skip J0910A, J0910B, J0910C and J0915
- 1. Yes

Comments:

(J0910. Comprehensive Pain Assessment)

A. Was a comprehensive pain assessment done?

- 0. No → Skip J0910B, J0910C, and J0915
- 1. Yes

B. Date of comprehensive pain assessment:

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

Does the patient have neuropathic pain (e.g., pain with burning, tingling, pins and needles, hypersensitivity to touch)?

- 0. No
- 1. Yes

Must check all boxes for pain

Respiratory Status

(J2030. Screening for Shortness of Breath)

A. Was the patient screened for shortness of breath?

- 0. No → Skip J2030B, J2030C and J2040A - J2040B
- 1. Yes

B. Date of first screening for shortness of breath:

C. Did the screening indicate the patient had shortness of breath?

- 0. No → Skip J2040A, J2040B
- 1. Yes

(J2040) Treatment for Shortness of Breath

A. Was treatment for shortness of breath initiated?

- 0. No → Skip B - Date treatment initiated
- 1. No, patient declined treatment → Skip B - Date treatment initiated
- 2. Yes

B. Date treatment for shortness of breath initiated:

Section J	Health Conditions(Continued)
SYMPTOM IMPACT SCREENING	
(J2050) Symptom Impact Screening	
A. Was a symptom impact screening completed?	
<ul style="list-style-type: none"> <input type="radio"/> 0. No → Skip B - Date of AND symptom impact screening <input checked="" type="radio"/> 1. Yes 	
B. Date of symptom impact screening:	



Test-HP Team B
Hospice Admission Data Set

Patient: Kruger, Freddy-MR#100832

Caregiver: Olmeda, Kelly (IPU Nursing) Visit Date: 10/01/2025

(J2051) Symptom Impact

IF J2051 A-H have any "2-Moderate" or "3-Severe" responses, complete J2052 & J2053 after results of Symptom Follow Up Visit obtained

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)

*If the patient does not have the symptom put NOT APPLICABLE

Not at all means they DO have the symptom but it is not impacting their quality of life.

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

Complete section below (J2052 & J2053) AFTER results of Symptom Follow Up Visit obtained

SFV Symptom Impact Data Report - HOPE

SYMPTOM FOLLOW UP VISIT RESULTS

DO NOT COMPLETE J2052 / J2053 DURING THE ADMISSION VISIT

(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)

A. Was an in-person SFV completed?

- 0. No → Skip J2052B
- 1. Yes

B. Date of in-person SFV → Complete and skip J2052C

C. Reason SFV Not Completed → Skip J2053

- 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
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(M1190) Skin Conditions

Does the patient have one or more skin conditions?

- 0. No → Skip M1195 and M1200
- 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
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(N0500) Scheduled Opioid

A. Was a scheduled opioid initiated or continued?

- 0. No → Skip to N0510, PRN Opioid
- 1. Yes

B. Date scheduled opioid initiated or continued:

(N0510) PRN Opioid

A. Was a PRN opioid initiated or continued?

- 0. No → Skip to N0520, Bowel Regimen
- 1. Yes

B. Date PRN opioid initiated or continued:

(N0520. Bowel Regimen) Bowel Regimen - Complete only if N0500A or N0510A = 1

A. Was a bowel regimen initiated or continued? - Select the most accurate response

- 0. No → Skip N0520B
- 1. No, but there is documentation of why a bowel regimen was not initiated or continued → Skip N0520B
- 2. Yes (specify details):

* Bowel Regimen Initiated - "per protocol" or "see MAR" is not sufficient. The actual medication/treatment/intervention must be referenced here. *

B. Date bowel regimen initiated or continued:

Section Z	Record Administration
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(Z0400. Signature(s) of Person(s) Completing the Record)



Test-HP Team B

Hospice Admission Data Set

Patient: Kruger, Freddy-MR#100832

Caregiver: Olmeda, Kelly (IPU Nursing) Visit Date: 10/01/2025

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.

Name / Signature	Title	Sections	Date Section Completed
A. / See electronic signature below			
B. / See electronic signature below			
C. / See electronic signature below			
D. / See electronic signature below			
E. / See electronic signature below			
F. / See electronic signature below			
G. / See electronic signature below			
H. / See electronic signature below			
I. / See electronic signature below			
J. / See electronic signature below			
K. / See electronic signature below			
L. / See electronic signature below			

Section Z (Signatures) - In the first line (Z0400) in the Sections column, enter "All but SFV" if an SFV is required. Enter "All" if an SFV is not required.

(Z0500. Signature of Person Verifying Record Completion)

(Z0500), please leave this section blank. This line is for QA only.

A. Name / Signature

/ See electronic signature below

B. Date:

PRA Disclosure Statement

Hospice Outcomes and Patient Evaluation (HOPE) [Item Set name] (Abbreviation) OMB Control Number 0938-1153 Expiration 03/31/2028 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 **0938-1153**. Submission of this data is required by Section 1814(i)(5) of the Social Security Act. The time required to complete this data collection per item set is estimated to average **41 minutes for the Admission, 22 minutes for the Hope Update Visit, and 9 minutes for the Discharge**, 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.

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