Test-ASH Team A

Hospice Admission Data Set

Patient: Malone, Post-MR#100294 Caregiver: Olmeda, Kelly (SuperAdmin) Visit Date: 05/13/2026

< **Previous** **1** 2 3 Next >

Chart: 1 Benefit Period: 4

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):

1225017759

B.CMS Certification Number (CCN):

34-1511

These should populate automatically.

(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
- [x] 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

Be sure to ask if ethnicity is uncertain.

(A1010) Race

What is your race?

↓ **Check all that apply**

- [x] 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

Be sure to ask or check the medical record if ethnicity is uncertain.

(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

Where is the patient receiving hospice services at the time of your assessment?

Test-ASH Team A

Hospice Admission Data Set

Patient: Malone, Post-MR#100294 Caregiver: Olmeda, Kelly (SuperAdmin) Visit Date: 05/13/2026

(A0220. Admission Date.)
05/13/2026

These should populate automatically.

(A0250) Reason for Record
- (●) 01. Admission (ADM)

(A0500. Legal Name of Patient)
A.First name:
Post

B.Middle initial:

C.Last name:
Malone

D.Suffix:

(A0550) Patient Zip Code:
27317

(A0600) Social Security and Medicare Numbers
A. Social Security Number:
122365554

B. Medicare number:

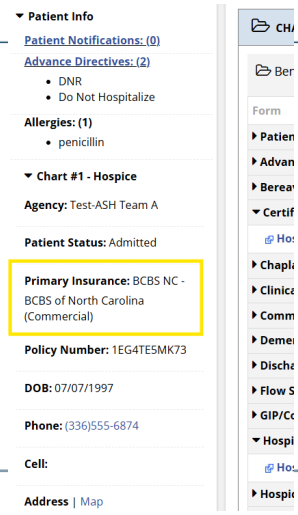
(A0900. Birth Date)
07/07/1997

(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**
- [x] 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

Look at the Patient Chart in MyUnity-Clinical. The primary payer will be listed on the left side of the screen. Medicare is always traditional fee-for-service.



(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)

Where was the patient before the date hospice services began?

- 10. Hospice (institutional facility)
- 11. Critical Access Hospital (CAH)
- 99. Not Listed

(A1110) Language

A. What is your preferred language?

English

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

Be sure to ask if uncertain.

(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)

Where is the patient receiving services at the time of your assessment?

(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

How often are family/friends visiting? This also applies for emotional support, not just hands-on care.

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

Current hospice primary diagnosis

Comorbidities and Co-existing Conditions

Check all co-morbidities and other conditions.

↓ **Check all that apply**

Cancer

- [ ] I0100. Cancer

Heart/Circulation

- [x] I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
- [x] I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- [ ] I0950. Cardiovascular (excluding heart failure)

Gastrointestinal

- [ ] I1101. Liver disease (e.g., cirrhosis)

Genitourinary

- [x] I1510. Renal disease

Infections

- [ ] I2102. Sepsis

Metabolic

- [x] 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

Caregiver Signature:

All preferences questions must be asked. If the patient is unable to respond, ask the family. If the family is not present, attempt to contact them. Document all attempts to ask the questions in your narrative summary or shift notes. Only answer "2. Yes, but the patient/responsible party refused to discuss" if they actually refuse or if you have exhausted all attempts to ask family.

Section F — Preferences

(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):* **Confirmed family's desire to avoid CPR**
- ○ 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:
05/13/2026

CPR, life-sustaining treatment, hospitalizations may have been discussed by the Liaison, but only use that information for your details if there is documentation of the discussion in the chart.

(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):* **Confirmed Family's wishes for comfort measures only**
- ○ 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:
05/13/2026

(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):* **Family stated they wish to avoid hospitalization**
- ○ 2. **Yes, but the patient/responsible party refused to discuss**

B. Date the patient/responsible party was first asked about preference regarding hospitalization:
05/13/2026

(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):* **Family reports they feel patient is at peace and they have no spiritual concerns**
- ○ 2. **Yes, but the patient/caregiver refused to discuss**

B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:05/13/2026

Document proof of discussion re: spiritual concerns, not just whether the pt/family want Chaplain services.

Section J — Health Conditions

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

(J0900. Pain Screening)

A. Was the patient screened for pain?

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

This answer is always Yes.

B. Date of first screening for pain:05/13/2026

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

Always measure pain severity. If the patient is unable to report, use another method, such as a PAINAD, FLACC, or even your own observation. The form even allows Staff observation or Patient visual as an acceptable pain tool.

The patient may be comfortable during your assessment (you might mark No above) because their pain meds or interventions are helping. This means that pain is still an active problem we are addressing, so you would mark Yes to active problem below.

(J0905 - Pain Active Problem)

A. Is pain an active problem for the patient?

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

Comments:Patient grimaces occasionally

(J0910. Comprehensive Pain Assessment)

A. Was a comprehensive pain assessment done?

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

If pain is an active problem requiring interventions, a full comprehensive pain assessment must be completed.

B. Date of comprehensive pain assessment:05/13/2026

C. Comprehensive pain assessment included:

↓ Check all that apply

- [x] 1. Location
- [x] 2. Severity
- [x] 3. Character
- [x] 4. Duration
- [x] 5. Frequency
- [x] 6. What relieves/worsens pain
- [x] 7. Effect on function or quality of life
- [ ] 9. None of the above

All 7 domains must be checked. If you cannot get answers, but you intend to assess and try to find answers, that is sufficient to check the box.

(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

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**

Always Yes - all patients must be screened for shortness of breath.

B. Date of first screening for shortness of breath:
05/13/2026

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

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

-If patient has interventions to manage dyspnea, answer Yes.
-If the patient is comfortable because they have on O2 and/or have received medication, then dyspnea is an active problem and you will answer Yes.
-If the patient *would* experience dyspnea if you removed their oxygen/meds, the answer is Yes.
-If you would answer Yes to the *treatment* for shortness of breath question, then you should answer Yes to the patient having shortness of breath.
-If the patient is unable to report, you may rely on your judgment.

(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:
05/13/2026

Section J	Health Conditions(Continued)

SYMPTOM IMPACT SCREENING

(J2050) Symptom Impact Screening

A. Was a symptom impact screening completed?

- 0. No → Skip B - Date of AND symptom impact screening
- 1. Yes

Always Yes.

B. Date of symptom impact screening:

05/13/2026

(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)

Patient has an active problem but our interventions are working and they are comfortable.

Patient does not have this problem. No interventions are required.

Enter Code ↓	
1. Slight	A. Pain
0. Not at all	B. Shortness of breath
2. Moderate	C. Anxiety
9. Not applicable	D. Nausea
9. Not applicable	E. Vomiting
9. Not applicable	F. Diarrhea
1. Slight	G. Constipation
2. Moderate	H. Agitation

Pain is an active problem and patient is not quite comfortable.

Dyspnea is an active problem but Pt is comfortable with interventions.

SFV required. Go ahead and add that to the Patient Smart Calendar (Home Care).

Patient does not have these symptoms at all. No active interventions.

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

SFV Symptom Impact Data Repor - HOPE

Use this look-back tool with your SFVs and HUVs for reference.

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

05/14/2026

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 observations and/or 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 ↓	
1. Slight	**A. Pain**
0. Not at all	**B. Shortness of breath** Symptom has improved with ongoing interventions.
0. Not at all	**C. Anxiety**
9. Not applicable	**D. Nausea**
9. Not applicable	**E. Vomiting**
9. Not applicable	**F. Diarrhea**
9. Not applicable	**G. Constipation**
0. Not at all	**H. Agitation** Symptom has improved with ongoing interventions.

Section M — Skin Conditions

(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

Test-ASH Team A

Hospice Admission Data Set

Patient: Malone, Post-MR#100294 Caregiver: Olmeda, Kelly (SuperAdmin) Visit Date: 05/13/2026

Initiated or continued means the patient has been instructed to use the medication. This does not apply to "just in case" comfort meds stored in the home for future/ potential needs.

Section N — Medications

(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:05/13/2026

(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:05/13/2026

If opioids are initiated or continued, there must be a bowel regimen. This could include medications, diet, fiber supplements, etc.

(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):* **PRN Bisacodyl**

B. Date bowel regimen initiated or continued:05/13/2026 Initiated/continued should always be the date of your assessment.

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.

	Name / Signature	Title	Sections	Date Section Completed
A.	**YOUR NAME** / See electronic signature below	**RN**	**All but SFV**	**05/13/2026**
B.	**Cherie Van De Warker** / See electronic signature below	**QA**	**SFV transcribed**	**05/14/2026**
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			

Complete all 4 columns in the signature line.

(Z0500. Signature of Person Verifying Record Completion)

A. Name / Signature	B. Date:
Cherie Van De Warker, LPN / See electronic signature below	**05/14/2026**

PRA Disclosure Statement Not your name. This is for QA only, verifying the record is ready to submit to CMS.

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.

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