Hospice Community Care
"The Heart of Your Community"

HOSPICE INFORMED CONSENT

PATIENT NAME: _____ **MR#:** _____

INSTRUCTIONS: This form is used to acknowledge receipt of our Orientation Booklet and confirm your understanding and agreement with its contents. Your signature below indicates your approval.

1. My attending physician is _____. My physician advised me that I have a terminal illness, and that while my life may be prolonged for some period, my health cannot be restored or my disease cured. My physician has also advised me that certain supportive care can be given to alleviate pain and suffering and efforts made to keep me comfortable.
2. I understand that care given by Hospice Community Care is not directed to extending the length of life or to the reversal of the disease from which I am suffering, which has been diagnosed by my physician as terminal. However, the hospice program is directed to the greater degree of symptom control, including the relief of pain, and to the creation of an environment for myself and my family designed to relieve stress and to promote support and understanding.
3. I fully understand that in the care rendered me in the hospice program, extraordinary life saving measures will not be provided. This includes cardiopulmonary resuscitation. This includes artificial nutrition and hydration that prolongs the dying process. I request admission to the program with full knowledge and understanding of these limits.
4. When admitted to Hospice Community Care, I understand that my attending physician will prescribe the extent and nature of my care and treatment, and that Hospice Community Care is not liable for any act or omission in following his instructions.
5. I authorize Hospice Community Care to obtain personal/medical information and/or release this information to any appropriate health care organization or physician.
6. I fully understand that the responsibility of primary caregiver remains with _____. I understand that the hospice services provided by Hospice Community Care staff is not to take the place of the care provided by the primary caregiver. The primary caregiver is an important part of the hospice team and participates in all decisions related to patient care. Routine care procedures will be taught to the primary caregiver. The primary caregiver will be responsible to oversee the patient's safe use of medications. Consult from a hospice nurse is available 24-hours a day, 7 days a week. I will consult a hospice nurse in case of emergency.
7. With full knowledge of the above facts, I consent to my care and treatment in the hospice program under the above conditions, and I hereby release Hospice Community Care, its officers and employees from all liability in following my wishes that care in the program be limited to that care outlined above, which is aimed at relieving my pain and making me comfortable.
8. I give my permission for hospice staff members to attend resident care conferences held on my behalf.

I acknowledge that I have been given ample opportunity to ask questions that I have concerning the Hospice Community Care program. I acknowledge that I have been provided with a written copy of my rights and responsibilities as a patient. A hospice representative has discussed them with me and I understand them. I certify the following information has been provided and explained to me and/or my family/caregiver: hospice on-call phone number and how to reach the hospice after normal business hours; information on advance directives; standard precautions, home infection control and safety information, procedure for scheduling visits, and the procedure for obtaining medication, equipment and supplies.

My signature acknowledges that I have received a copy of Hospice Community Care's Notice of Privacy Practices. I have been provided with opportunity to discuss concerns I have regarding the privacy of my health information.

I understand that I am free to change my mind at any time about the method of care which is furnished me in the program and can request that complete acute care be given me, including measures and attempts to reverse the disease from which I am suffering, and that if such care is not available in the program, I may be transferred from it.

I state that I have read the above Consent to Admission, under the nature and extent of the care available in the program and state that I have signed this consent as my own free act and deed.

Patient Signature	Date	Responsible Person or Legal Guardian Signature
Hospice Representative Signature	Date	Relationship of Person Above to Patient

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STATEMENT OF MEDICARE/MEDICAID ELECTION OF BENEFITS

PATIENT NAME: _____ **MR#:** _____

ADDRESS: _____ **DATE OF BIRTH:** _____

NEAREST RELATIVE: _____ **RELATIONSHIP:** _____

I understand that I or my representative have the right to choose my attending physician. I state that my chosen attending physician, *(name)* _____ *(address)* _____, has advised me that I have a terminal illness, my health cannot be restored or my disease cured. My physician has also advised me that certain supportive care can be given to alleviate pain and suffering and efforts made to keep me comfortable through Hospice Community Care.

I understand that the Medicare/Medicaid Hospice benefit provides an additional benefit through Medicare/Medicaid Certified Hospice Program, a medically directed, interdisciplinary group approach to provide palliative care and support to my family and me.

The Hospice Informed Consent Form has been explained to me and I understand the limitations set forth are not curative, but meant to keep me comfortable and improve the quality of the time I have remaining.

I further understand that my election of Medicare/Medicaid Hospice Benefits constitutes a waiver of any further aggressive treatment for my terminal illness, reimbursable through standard Medicare/Medicaid Benefits.

Hospice Election Periods

I understand that there is Hospice Election Periods, two (2) - 90-day periods, followed by unlimited 60-day periods. At the end of each election period, I will be evaluated and re-certified as needing hospice services by meeting the hospice admission criteria.

I may revoke the Hospice Medicare/Medicaid Benefit at any time. Once I have revoked the Medicare/Medicaid Benefit, I forfeit the remaining days in that election period while keeping the remaining election periods intact. I understand that I may transfer to another Medicare/Medicaid Certified Hospice Program once during any election period without having a break in service and that this is not considered a revocation.

I understand that a decision to pursue aggressive treatment affecting my terminal illness is not covered in the hospice plan of care. I have the option to pay for these services or revoke the Hospice Medicare/Medicaid Benefit and assume coverage under traditional Medicare/Medicaid.

Hospice Medicare/Medicaid Benefit Coverage

The patient and primary caregiver participates in formulating a plan of care with the Hospice team outlining services, equipment, drugs and supplies needed to care for the patient's terminal illness.

- **Routine Home Care:** Intermittent visits by hospice team members to assist in management and care for the Hospice patient.
- **Continuous Care:** A minimum of 8 hours of care per day may be provided during periods of crisis to maintain the patient at home.
- **Inpatient Respite Care:** Up to 5 days of care provided at a contractual hospital, nursing care facility or inpatient hospice facility in order to provide rest for family members and caregivers.
- **General Inpatient Care:** Admission to a contractual hospital, skilled nursing facility or inpatient hospice facility for patients who need pain control or acute/chronic symptom management which cannot be managed in other settings.
- **Team Member Visits:** 100% coverage
- **Pharmacy Items:** 100% coverage of drugs and biologicals related to pain and symptom management.
- **Supplies and Equipment:** 100% coverage when related to pain and symptom management and provided by Hospice Community Care.
- **General Inpatient Care, Respite Care and Continuous Care:** 100% coverage when prior arrangements are made and authorized by Hospice Community Care.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act as amended for Hospice care is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf beginning: _____ (date).

_____	_____	_____
Patient Signature	Date	Responsible Person or Legal Guardian Signature
_____	_____	_____
Hospice Representative Signature	Date	Relationship of Person Above to Patient

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EXPLANATION/ASSIGNMENT OF INSURANCE BENEFITS

PATIENT NAME: _____ **MR#:** _____

Patient's Date of Birth: _____ Patient's Social Security #: _____
Relationship to Policy Holder: ☐ Wife ☐ Husband ☐ Child ☐ Other: _____
Policy Holder's Name: _____
Policy Holder's Social Security #: _____
Policy Holder's Workplace: Company: _____
Address: _____
_____
Phone: _____

INSURANCE COMPANY INFORMATION:
Name of Company: _____
Address: _____
_____
Billing Address: _____
_____
Billing Contact: Name: _____
Phone: _____ Fax: _____
Type of Policy: ☐ HMO ☐ PPO ☐ Other: _____
Policy #: _____
Group #: _____
Case Manager: _____
Phone: _____ Fax: _____

AUTHORIZATION FOR SERVICES: #: _____
Dates of Authorization: _____
Updates Required: ☐ Yes ☐ No
If Yes, how often: _____

COVERED SERVICES:
Per Diem Rate of: _____
Per Visit Rate of: ☐ RN: _____ ☐ Hospice Aide: _____
☐ SW: _____
☐ Spiritual Counselor: _____
Maximum Lifetime Benefit: ☐ Yes ☐ No Amount: _____
DME: ☐ Hospice Responsible ☐ Insurance Company Responsible
Medications: ☐ Hospice Responsible ☐ Insurance Company Responsible

COMMENTS: _____
_____
_____
_____

I authorize the release of information to Hospice Community Care in order to process this claim. I authorize the above-named insurance company to pay benefits to Hospice Community Care for this patient. I understand that Hospice Community Care is not a party to this insurance contract, and any amount, up to and including the full balance, not paid by the insurance company within 60 days is my responsibility.

_____ _____ _____
Policy Holder or Responsible Party Signature Date Address

_____

_____ _____
Hospice Representative Signature Date

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MEDICARE SECONDARY PAYOR WORKSHEET

PATIENT NAME: _____ **MR#:** _____

MEDICARE #: _____ **EFFECTIVE DATE:** _____

PART I

1. Is the patient age 65 or over? ☐ Yes ☐ No
2. Is the patient under 65 and a disabled Medicare beneficiary? ☐ Yes ☐ No
3. Is the patient employed and covered by an employer's HMO or large group-health plan?** ☐ Yes ☐ No
4. Is the patient's spouse employed and covered by a large group health plan?** ☐ Yes ☐ No
5. Is the patient receiving benefits from the health plan of an employer for whom he/she used to work?** ☐ Yes ☐ No
   - Is the patient covered under this policy? ☐ Yes ☐ No
   - Is it a Medicare supplemental policy?** ☐ Yes ☐ No
6. Is the patient receiving benefits from another family member other than the spouse?** ☐ Yes ☐ No
7. Is the patient retired? ☐ Yes ☐ No
   - Date of retirement: _____/_____/_____
8. Is the patient's spouse retired? ☐ Yes ☐ No
   - Date of retirement: _____/_____/_____
9. Was illness/injury due to a work related accident/condition? ** ☐ Yes ☐ No
10. Is this illness/injury covered by Federal Black Lung Compensation? ** ☐ Yes ☐ No
11. Is this illness/injury due to a non-work related accident? ** ☐ Yes ☐ No
12. Are you receiving Veteran's benefits for this illness/injury? ☐ Yes ☐ No
13. Are you entitled to Medicare solely as a result of End Stage Renal Disease? ☐ Yes ☐ No
    If yes, date entitlement began: _____/_____/_____

**** If answer is Yes, please complete Part II.**

PART II

If the answer to questions 3, 4, 5 or 6 is yes, please complete the following:

Name of Insurance Company: _____

Address: _____

City/State/ZIP: _____ Telephone: _____

Policy #: _____ Group #: _____

Name of Policy Holder: _____ Relationship: _____

If the answer to questions 9,10 or 11 is Yes, please complete the following:

Date of Accident/Date Illness Began: _____/_____/_____ Claim #: _____

Insurance Company/Insurer: _____

Responsible Party (non-work related accident): _____

Employer: _____

Address: _____

City/State/ZIP: _____ Telephone: _____

_____ _____

Hospice Representative Signature Date

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RELEASE OF MEDICAL INFORMATION

I hereby authorize Hospice Community Care to contact my physician(s), treating hospital, SNF and/or Home Health Agency to obtain information and/or records concerning my physical and mental condition and to release the following information to Hospice Community Care for the limited purpose of determining eligibility for hospice services and to provide continuity of care.

Information Requested From:

Name of MD, Hospital, SNF, Home Health Agency: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Patient Information:

Print Name: _____

Address: _____

City, State, ZIP: _____

Social Security Number: _____ Date of Birth: _____

Information Requested:

- ☐ History and Physical
- ☐ Insurance/Medicare/Medicaid Information
- ☐ Assignment of Benefits
- ☐ Medical Assessment
- ☐ Medical Plan of Treatment
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Consultations
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Social Worker Notes
- ☐ Nursing Notes
- ☐ Aide/CNA Notes
- ☐ PT Notes ☐ OT Notes ☐ ST Notes
- ☐ Chaplain/Spiritual Counselor Notes
- ☐ Other: _____
- ☐ All of the above

Send Information to:

Name of Facility: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Information to be released will not be further disclosed nor used for any purpose other than that stated in this authorization. It is understood that I have the right to revoke this consent in writing at any time. Any revocation shall be in writing, signed by my legal representative or me. No written revocation of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior thereto. I understand that I have the right to inspect and copy the information released. I further understand that refusal to consent to the release of information specified will prevent disclosure of such information to the hospice, and may result in the hospice being unable to establish eligibility to receive services.

This authorization is valid until _____ (not more than 2 years from today's date).

Patient Signature	Date	Responsible Person or Legal Guardian Signature
Hospice Representative Signature	Date	Relationship of Person Above to Patient

RELEASE OF MEDICAL INFORMATION

A Release of Medical Information is obtained at the time of admission. This form is used to obtain medical information about the patient in order to document diagnosis and prognosis or to request additional information after admission.

This form is photocopied and the photocopy is placed in the chart before it is mailed to obtain information.