Harbor Light HOSPICE

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. I state that my physician, _____, has 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 Harbor Light Hospice 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 as well as 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 Harbor Light Hospice, I understand that my attending physician will prescribe the extent and nature of my care and treatment and that Harbor Light Hospice is not liable for any act or omission in following his or her instructions.
5. I authorize Harbor Light Hospice 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 Harbor Light Hospice 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 Harbor Light Hospice, 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 Harbor Light Hospice 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; the procedure for scheduling visits and the procedure for obtaining medication, equipment and supplies.

My signature acknowledges that I have received a copy of Harbor Light Hospice'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, I understand the nature and extent of the care available in the program and 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

Harbor Light HOSPICE

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 Harbor Light Hospice.

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.

If over the age of twenty-one, 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. If I am under the age of twenty-one and receiving Medicaid hospice services, curative treatment may be covered and paid separately to other Medicaid providers.

Hospice Election Periods

I understand that there are Hospice Election Periods, two 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 Medicare/Medicaid Hospice Benefit at any time. Once I have revoked the Medicare/Medicaid Hospice 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.

If over the age of twenty-one, 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 Medicare/Medicaid Hospice Benefit and assume coverage under traditional Medicare/Medicaid. If I am under the age of twenty-one and receiving Medicaid hospice services, curative treatment may be covered and paid separately to other Medicaid providers.

Medicare/Medicaid Hospice 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 Harbor Light Hospice.
- **General Inpatient Care, Respite Care and Continuous Care:** 100% coverage when prior arrangements are made and authorized by Harbor Light Hospice.

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

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

Harbor Light HOSPICE

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 or 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

DNR COMFORT CARE

DNR IDENTIFICATION FORM

❑ DNRCC

(If this box is checked the DNR Comfort Care Protocol is activated immediately.)

❑ DNRCC—Arrest

(If this box is checked, the DNR Comfort Care Protocol is implemented in the event of a cardiac arrest or a respiratory arrest.)

Patient Name:_____

Address:_____

City_____ State_____ Zip _____

Birthdate_____ Gender ❑ M ❑ F

Signature_____ (optional)

Certification of DNR Comfort Care Status (to be completed by the physician)*

(Check only one box)

❑ **Do-Not-Resuscitate Order**—My signature below constitutes and confirms a formal order to emergency medical services and other health care personnel that the person identified above is to be treated under the State of Ohio DNR Protocol. I affirm that this order is not contrary to reasonable medical standards or, to the best of my knowledge, contrary to the wishes of the person or of another person who is lawfully authorized to make informed medical decisions on the person's behalf. I also affirm that I have documented the grounds for this order in the person's medical record.

❑ **Living Will (Declaration) and Qualifying Condition**—The person identified above has a valid Ohio Living will (declaration) and has been certified by two physicians in accordance with Ohio law as being terminal or in a permanent unconscious state, or both.

Printed name of physician*:_____

Signature_____ Date _____

Address:_____ Phone_____

City/State_____ Zip_____

* A DNR order may be issued by a certified nurse practitioner or clinical nurse specialist when authorized by section 2133.211 of the Ohio Revised Code.

See reverse side for DNR Protocol

DO NOT RESUSCITATE COMFORT CARE PROTOCOL

After the State of Ohio DNR Protocol has been activated for a specific DNR Comfort Care patient, the Protocol specifies that emergency medical services and other health care workers are to do the following:

WILL:

- Suction the airway
- Administer oxygen
- Position for comfort
- Splint or immobilize
- Control bleeding
- Provide pain medication
- Provide emotional support
- Contact other appropriate health care providers such as hospice, home health, attending physician/CNS/CNP

WILL NOT:

- Administer chest compressions
- Insert artificial air way
- Administer resuscitative drugs
- Defibrillate or cardiovert
- Provide respiratory assistance {other than that listed above)
- Initiate resuscitative IV
- Initiate cardiac monitoring

If you have responded to an emergency situation by initiating any of the **WILL NOT** actions prior to confirming that the DNR Comfort Care Protocol should be activated, discontinue them when you activate the Protocol. You may continue respiratory assistance, IV medications, etc., that have been part of the patient's ongoing course of treatment for an underlying disease.