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. **Initials:** _____

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 Hospice Informed Consent, 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	Printed Name and Relationship of Person Above

Harbor Light HOSPICE

STATEMENT OF MEDICARE/MEDICAID ELECTION OF BENEFITS

☐ MEDICARE
☐ MEDICAID

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)* _____ *(NPI#)* _____, 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 benefits be made on my behalf beginning: _____ (date).

Patient Signature	Date	Responsible Person or Legal Guardian's Signature
Hospice Representative Signature	Date	Printed Name and Relationship of Person Above

FOR OFFICE USE ONLY - Terminal/Principal Diagnosis: _____ **ICD Code:** _____

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

Harbor Light HOSPICE

RELEASE OF MEDICAL INFORMATION

I hereby authorize Harbor Light Hospice 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 Harbor Light Hospice 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	Authorized Party Signature
_____	_____	_____
Hospice Representative Signature	Date	Printed Name and Relationship of Person Above

NOTE: 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

Harbor Light HOSPICE

PATIENT CONTACT LIST AND HIPAA RELEASE

PATIENT NAME: _____ **PATIENT ID:** _____

I agree that the agency may share my PHI with emergency officials or others involved in my care to assist in disaster relief efforts.
☐ Yes ☐ No

I authorize the following to receive information regarding my care and follow up support.

Power of Attorney for Health Care *(if applicable)*: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Fax: _____ Other: _____

I wish to receive follow up support. ☐ Yes ☐ No

Primary Contact #1: _____ Relationship: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Alternate Contact #1: _____ Relationship: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Alternate Contact #2_____ Relationship: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

_____ _____ _____
Patient Signature Date Responsible Person or Legal Guardian Signature

_____ _____ _____
Agency Representative Signature Date Printed Name and Relationship of Person Above

☐ *Patient unable to sign due to:* _____

Harbor Light HOSPICE

DISCLOSURE STATEMENT

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

Harbor Light Hospice supports the concept of family/community oriented health care and is committed to the premise that all individuals and families have the right to self-determination in achieving their maximum potential. Therefore, Harbor Light Hospice recognizes that patients and their families have several rights. These rights include: participation in health care decisions and planning of future activities; obtaining high quality health care assistance in the process of dying; and assistance in achieving and maintaining comfort and human dignity. The patient or the patient's representative has the right to refuse any component of hospice services offered by Harbor Light Hospice.

In meeting a patient's health-related goals and ensuring maximum comfort and dignity, Harbor Light Hospice provides the following Core Services:

- Physician Services
- Nursing Services
- Medical Social Services
- Counseling Services (Bereavement, Spiritual, Dietary)

Other services provided by Harbor Light Hospice are:

- Physical Therapy Services
- Occupational Therapy Services
- Volunteer Services
- Speech-language Services
- Bereavement Services
- Respite Services
- Short Term Inpatient Care
- Hospice Aide/Homemaker Services

As part of its mandate for patient care, Harbor Light Hospice can also provide certain medical supplies to patients, based on the physician's orders and the patient's plan of care. Listed below are supplies that will be provided, when appropriate:

- Medications related to the terminal diagnosis.
- Durable medical equipment to include such items as hospital bed, special mattress, wheelchair, walker and commode, when appropriate.
- Medical equipment to include such items as oxygen and related supplies, dressing supplies and incontinence pads when appropriate.

Generally, supplies are delivered to the home. In some cases arrangements can be made for pick-up. The hospice will meet with the patient/family to determine which supplies will be needed and the hospice will explain how they will be provided. The patient/family and Harbor Light Hospice will reach an agreement prior to the start of services. **Services and supplies shall be dispensed to the patient based solely on the individual's needs. The physician must be in agreement that services and supplies are needed and indicate this by written order(s). When requested, Harbor Light Hospice will provide a monthly, itemized statement of services and supplies delivered to the patient, as submitted to that patient's payer.**

A hospice employee may personally provide supplies to the hospice program's patient or patient's family in addition to the supplies provided by the hospice program. The hospice employee may only be reimbursed for the supplies by providing a written receipt to the hospice patient or the patient's family.

If the patient, or their legal representative, disagree with a service provided or action(s) taken by Harbor Light Hospice, or if an individual wishes to register a complaint regarding the quality or nature of the care and/or supplies received, a phone call may be made to: Hospice Administrator: 1-888-227-6543. In addition, a complaint may also be registered by obtaining a Complaint Form from: Hospice Administrator, Harbor Light Hospice, at 677 H Alpha Drive, Highland Heights, OH 44143.

Once the Hospice Administrator receives the formal complaint, he/she will initiate an internal investigation into the matter and based upon that investigation will write a brief report of the allegations, whether those allegations were substantiated and what action, if any, the hospice will take as a result.

If an individual disagrees with the findings or actions taken, an appeal may be issued to:

President, Harbor Light Hospice, 1N131 Country Farm Road, Winfield, IL 60190

The findings and actions will be reviewed and a written statement will be issued either confirming the initial findings or reversing the findings and ordering new action to be taken.

Harbor Light Hospice is part of a regulated community, overseen by the Ohio Department of Health. Any questions or complaints that are not addressed to an individual's satisfaction by Harbor Light Hospice may be addressed by calling the state's toll-free hospice complaint hotline at 1-800-342-0553 .

_____ _____

Patient's or Nearest Relative/Responsible Person Signature | Date

_____ _____

Hospice Representative Signature | Date

DNR ORDER FORM

A printed copy of this order form or other authorized DNR identification must accompany the patient during transports and transfers between facilities.

Patient Name:	Patient Birth Date:
Optional Patient or Authorized Representatives Signature	
Printed name of Physician, APRN or PA*	Date
REQUIRED Signature of Physician, APRN or PA	Phone
REQUIRED for APRN or PA: Name of the supervising physician (PA) or collaborating physician (APRN) for this patient and the physician's NPI, DEA or Ohio medical license number.	

CHECK ONLY ONE BOX BELOW

☐ **DNR Comfort Care — Arrest:** Providers will treat patient as any other without a DNR order until the point of cardiac or respiratory arrest at which point all interventions will cease and the DNR Comfort Care protocol will implemented.

☐ **DNR Comfort Care:** The following DNR protocol is effective immediately.

DNR PROTOCOL

Providers Will:

- Conduct an initial assessment
- Perform Basic Medical Care
- Clear airway of obstruction or suction
- If necessary for comfort or to relieve distress, may administer oxygen, CPAP or BiPAP
- If necessary, may obtain IV access for hydration or pain medication to relieve discomfort, but not to prolong death
- If possible, may contact other appropriate health care providers (hospice, home health, physician, APRN or PA)

Providers Will Not:

- Perform CPR
- Administer resuscitation medications with the intent of restarting the heart or breathing
- Insert an airway adjunct
- De-fibrillate, cardiovert or initiate pacing
- Initiate continuous cardiac monitoring

Physicians, emergency medical services personnel, and persons acting under the direction of or with the authorization of a physician, APRN or PA who participate in the withholding or withdrawal of CPR from the person possessing the DNR identification are provided **immunities under section 2133.22 of the Revised Code.** This DNR order is effective until revoked and may not be altered. Any medical orders, instructions or information other than those required elements of the form itself, that are written on this order form are not transportable and are not provided protections or immunities.

* A DNR may be issued by an Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) when authorized by section 2133.211 of the Ohio Revised Code.

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