

PROGRAM GOALS

I, the patient or patient's legal representative, request admission to the **Hospice of Palm Beach County, Inc.** program of care and consent and agree to the following:

GOALS OF HOSPICE CARE

I understand that the goal of hospice care is to improve quality of life, to control physical symptoms, including pain, and to meet the emotional and spiritual needs of the patient and family. **I acknowledge that I, the patient or patient's representative, have been given a full understanding of the palliative, rather than curative, nature of hospice care, as it relates to the terminal illness.**

HOSPICE PROGRAM OF CARE AND COVERED SERVICES

Hospice provides four levels of care: routine home care, general inpatient care, continuous care, and respite care. Most hospice care is provided at the patient's residence (private home or long term care facility), **under the routine home level of care.** During periods of crisis, short term **general inpatient hospice care** may be provided in a hospice inpatient unit, an acute care hospital-based unit, or a skilled nursing facility. If the patient or family prefers to remain at their place of residence during a period of crisis, the **continuous level of hospice care** provides additional nursing support for short term symptom management. The **respite level of care** is available for a period of up to five (5) days and is provided in a skilled nursing facility or hospice inpatient unit. I understand that the professional hospice team makes the determination that a level of care change is needed.

The hospice is responsible to provide any and all services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions. Covered services include: nursing, medical social work, physician, counseling and home health aide services; physical therapy, occupational therapy, and speech-language pathology services, when provided for symptom control or to maintain basic functional skills; medical appliances and supplies, including drugs and biologicals, that are part of the written plan of care and used primarily for the relief of pain and symptom control related to the individual's terminal illness.

I further understand that I may be financially responsible for any medical treatment related to the life-limiting illness, which is not arranged by Hospice of Palm Beach County and not included in the hospice plan of care. This includes treatment in a physician office, as well as emergency medical care, hospitalization, care provided by another hospice, or other medical treatment.

RIGHTS AND RESPONSIBILITIES

I have been given written materials about my rights and responsibilities as a patient of Hospice of Palm Beach County. I understand that I have the right to formulate Advance Directives, but that I am not required to have an Advance Directive in order to receive services. I further understand that any Advance Directive I have executed will be followed by Hospice of Palm Beach County, Inc., to the extent permitted by law.

I have executed the following:

- Living Will
- Durable Power of Attorney
- Designation of Health Care Surrogate
- I have not formulated Advance Directives at this time

I understand that, depending on my needs, I may be transported by a non-medical transport company. Should I desire and need immediate medical attention during the trip, I understand that I will be transported to the nearest emergency room. _____ Initials of Responsible Party

I understand that nursing facility room and board payment is the responsibility of the patient/family. Should I apply for Medicaid for nursing facility room and board, I accept responsibility for participating fully in the application process. _____ Initials of Responsible Party

I authorize an employee of Hospice of Palm Beach County, Inc. to pick up my prescription medication at any pharmacy, as may be needed in the event a family member or legal representative is unavailable. I request that my medications and prescriptions be packaged in containers without child-resistant closures. _____ Initials of Responsible Party

RELEASE OF RECORDS

I understand that Hospice of Palm Beach County may need to obtain or release my medical records and related information to/from hospitals, skilled nursing facilities, physicians, pharmacies, home health agencies, insurance companies, health care benefit plans, or others in order to assure continuity of care and proper reimbursement. I authorize the above persons and entities to release to Hospice of Palm Beach County, Inc. all medical records and related information for purposes of my health care or to obtain payment for services and supplies rendered to me. I authorize Hospice of Palm Beach County to release all portions of my medical record in order to assure continuity of care and proper reimbursement. I understand and agree that these authorizations specifically include my permission and consent to release any information regarding a diagnosis of AIDS or results of Human Immunodeficiency Virus (HIV) tests. A photocopy of this authorization shall be as valid as the original.

Patient Name _____

Case Number _____

RECEIPT OF INFORMATION

Hospice services have been explained to us; our questions regarding the Hospice program of care have been answered to our satisfaction. We have been provided the following materials: Information Handbook, a copy of Patient's Rights; Advance Directive and written material explaining a patient's legal rights to accept or refuse medical treatments and to prepare an Advance Directive for health care, and policies for implementing those rights.

I have been informed of my rights and have been given information regarding medical privacy under The Health Insurance Portability and Accountability Act ("HIPAA").

Initials of
Responsible Party

INSURANCE COVERAGE

I hereby authorize that payment be made on my behalf directly to Hospice of Palm Beach County for health insurance benefits otherwise payable to me for the professional or medical expense benefits allowable under my current insurance policy. If my current policy prohibits direct payment to provider, I instruct and direct the insurance company to make out the check to me and mail it as follows:

Hospice of Palm Beach County, Inc., 5300 East Avenue, West Palm Beach, FL, 33407

I hereby authorize Hospice of Palm Beach County to endorse the payment and deposit into their account and use as payment towards the charges for services rendered to me. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I understand that I may be responsible to Hospice of Palm Beach County for any balance of service charges over and above this insurance payment.

I understand that I am fully responsible for all services rendered by HPBC, subject to the following:

- If I am eligible for Medicare or Medicaid hospice benefits, all costs will be paid under these programs and I will have no financial obligation.
- If I am not eligible for Medicare or Medicaid hospice benefits, but I have hospice benefits under a commercial medical insurance policy, I will be responsible for all or a portion of those costs not paid under the policy, i.e., deductibles, co-payments, and costs that exceed policy limits. The actual amount of these costs for which I am responsible will be determined based on a personal assessment of my finances and/or my family's finances.
- If I am not eligible for Medicare or Medicaid hospice benefits and I have no commercial insurance coverage, I will be responsible for all or a portion of the cost for hospice services based on a financial assessment to be performed on me and/or my family.

FOR MEDICARE/MEDICAID RECIPIENTS ONLY

1. I understand that in accepting the Medicare/Medicaid Hospice Benefit, **I waive my rights to regular Medicare/Medicaid benefits** except for the payments to (1)my attending physician and (2) treatment for medical conditions unrelated to my terminal illness.
2. I understand that I may revoke the Hospice Benefit at any time. This revocation of the Medicare/Medicaid hospice benefit must be in writing. All previously held Medicare/Medicaid benefits are fully restored immediately upon my signature.
3. The election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as I remain in the care of hospice and do not revoke the election.

MEDICARE SECONDARY PAYOR QUESTIONNAIRE

1. Are you currently working full or part-time? Yes No Is your spouse working full or part-time? Yes No
2. Are you entitled to Black Lung medical benefits? Yes No
3. Was this service for treatment of a work related injury or illness? Yes No

If YES, please provide the name and address of worker's comp agency, insurance company, and your employer.

4. Is this service for treatment of an illness or injury, which resulted from an automobile or other accident? Yes No
If YES, please provide the name/address and policy number of the auto or non-auto liability or no-fault insurer.

5. Have you received a kidney transplant? Yes No Are you on dialysis? Yes No

6. Have you received maintenance dialysis treatments? Yes No

7. Do you have a fee service card from the Department of VA Affairs? Yes No

Acknowledging and understanding the above, I elect the Medicare Hospice Benefit Medicaid Hospice Benefit--Florida

I authorize hospice services from Hospice of Palm Beach County, Inc. effective _____ (Date)

Signature of Patient or Legal Representative Date

Address of Legal Representative (if applicable) Relationship to Patient

Signature of Hospice Representative Date

Patient Name Medicare #: _____

Case Number Medicaid #: _____

Patient Label Here
Patient Label Here -

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