

AGAPE

Hospice Services

Informed Consent and Benefit Election

Patient Name: _____

Medicare #: _____ Medicaid #: _____

Program Purpose

The Agape Hospice Services program is palliative (comfort-oriented), not curative, in its goals. The program emphasizes the relief of symptoms such as pain and physical discomfort. It addresses the emotional and spiritual needs of both patient and family, which may accompany a life-threatening illness. Hospice care does not include heroic or resuscitative measures.

Services

Services are delivered wherever the patient calls home by a team of hospice professionals and volunteers. Home is defined as a private home, skilled nursing facility, assisted living, hospital or other living arrangement. Services are available both on a scheduled basis and as needed twenty-four (24) hours a day, seven (7) days a week.

Services may include but are not limited to *nursing care, physician care, medical social work services, counseling services, spiritual care, home health aide services, homemaker services, volunteer services, physical therapy, occupational therapy, speech therapy, nutrition counseling, medical supplies, durable medical equipment, and medications for palliation of symptoms related to the terminal diagnosis*. All care is directed through the patient's independent attending physician and the Medical Director for Agape Hospice Services.

The exact services offered to an individual patient are determined by the medically directed interdisciplinary team and recorded in the patient's plan of care. They will be based on a multitude of factors including patient and family need and insurance coverage.

Bereavement follow-up will be offered for a period of thirteen months. Bereavement services may include counseling, support groups, and bereavement literature.

Patient/ Legal Decision Maker Initials: _____

Certification and Benefit Periods

The Medicare Hospice Benefit consists of two initial 90-day benefit periods and an unlimited number of 60-day benefit periods if the patient does not revoke or is not discharged. Initial and ongoing assessment of hospice appropriateness will occur for certification of terminal illness prior to admission and re-certification prior to each subsequent benefit period. The benefit periods must be used in order.

Care Plan

The patient and family are encouraged to participate with the hospice team in establishing the variety, frequency, and intensity of services utilized. The patient understands that he/she has access to the hospice plan of care and may attend hospice team meetings to hear and participate in discussions about the services utilized or needed.

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Caregiver

Hospice services are not intended to take the place of care provided by family members, physician, nursing home staff, or others. Agape Hospice Services believes a patient has the right to remain in his/her own home if that is his/her choice and every effort will be made to facilitate that choice.

Level of Care

Medicare/Medicaid hospice services are provided at one of four predetermined levels of care based on the current needs of the patient/family.

Routine care is the most common level of care provided. If necessary, the hospice and attending physician may coordinate short-term inpatient care. Two levels of inpatient care exist including respite care for the relief of caregivers and general inpatient care for pain control or symptom management. Inpatient care related to the terminal diagnosis would be arranged in a skilled nursing facility with which the hospice has a contract. Continuous care at home may be provided for a period of eight (8) or more hours during a period of crisis, and only as necessary to maintain the patient at home.

Financial Responsibility

The Medicare/Medicaid Hospice Benefit and private health insurance reimbursable charges for hospice care have been explained to me and I understand the services offered. I have been given the opportunity to discuss any financial concerns I may have. I understand that consideration for admission to the program will be given regardless of ability to pay.

I understand that hospice only pays for services, equipment, medication, and supplies that are related to the patient's terminal diagnosis and included in the individualized plan of care. I understand that I am financially responsible for services, equipment, medication, and supplies related to the terminal illness that I might seek beyond what is considered medically necessary, not pre-authorized by hospice and/or outside of the plan of care regardless of whether the services are palliative or curative in nature. Agape Hospice Services is not responsible for any care not approved by the hospice team. Medicare/Medicaid will continue to make payment to the independent attending physician for services if the physician is neither a hospice employee nor receiving payment for Agape Hospice Services. I understand that the Medicare Hospice Benefit takes the place of Medicare Part A or the Medicare HMO plan for treatment of the patient's terminal illness and I waive my rights to Medicare benefits related to the terminal illness while enrolled in hospice.

I understand that under routine care Agape Hospice Services does not pay for room and board in a skilled nursing facility. Agape Hospice Services may be responsible for pre-authorized ambulance services only.

Patient/ Legal Decision Maker Initials: _____

Withdrawal/Discharge

I understand that hospice care may be discontinued at any time without prejudice or penalty by completing a revocation statement. If hospice care is revoked during a benefit period, the remaining days in that benefit period will be lost. I may elect hospice again for the remaining benefit periods. I may transfer services to another hospice program only once per benefit period. To change programs, I must obtain confirmation of admission from another hospice, and then I must inform Agape Hospice Services of my wishes so

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arrangements for transfer can be made. I must specify a date to discontinue care from Agape Hospice Services, the name of the hospice from which I wish to receive care, and the date care will start. Changing to another hospice program will lose no benefit days. I understand hospice may discharge me from the program because: 1) *I am no longer hospice appropriate.* 2) *I move outside the geographically defined service area.* 3) *It is determined that there is a situation that is seriously impairing the delivery of care.* When discharged from the Medicare hospice program, regular Medicare benefits are reinstated.

Patient/ Legal Decision Maker Initials: _____

Release of Information

I authorize Agape Hospice Services to obtain copies of medical records and to document and maintain records, which include necessary personal information about my medical condition and family during the time I am under care. This information may be obtained from or given to health institutions including, but not limited to, hospitals, home health agencies, hospices, skilled nursing/assisted living facilities, health organizations, private physicians, and/or third party payers. I hereby release Agape Hospice Services from any liability and all claims pertaining to the disclosure of pertinent medical and nursing information to my insurance company from my medical record.

Advance Medical Directives

Agape Hospice Services recognizes that all persons have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care. Colorado statutes recognize that all competent persons have the right to control decisions related to their own medical care. Competent individuals have the right to make a declaration expressing wishes regarding end of life care and/or to designate another competent person to make treatment decisions. Hospice encourages individuals and their families to participate in decisions regarding their care and treatment. I have been offered material explaining how to prepare an advance directive for health care. If I have previously prepared advance directives I agree to provide a copy of my advance directives to Agape Hospice Services.

I have prepared an advance medical directive. Yes No

Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Agape Hospice Services' Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Agape Hospice Services and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Patient/ Legal Decision Maker Initials: _____

Assignment of Benefits

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I authorize any third party payers to make payment directly to Agape Hospice Services for all services relating to my terminal illness.

I understand that if I am dually eligible for Medicare and Medicaid services, that election of either the Medicare or the Medicaid Hospice benefit is an election to both programs. Likewise a revocation from either program is a revocation from both programs.

Informed Consent

I have been informed that Agape Hospice Services offers hospice care under the Medicare and Medicaid hospice benefit programs and some third party insurance carriers to those who have been certified by a physician to have a terminal illness. I have been given a full explanation that the services are palliative rather than curative in nature as they relate to the terminal illness.

Acknowledging and understanding the above, I choose and consent to have Agape Hospice Services provide for my care under the Medicare / Medicaid Hospice Benefit Third Party Insurance

Date hospice services to begin: _____

Patient Name: _____

Patient's Signature: _____ Date: _____

If patient is unable to sign:

Legal Decision Maker Signature: _____ Date: _____

Print Name: _____ Relationship: _____

Reason patient is unable to sign: _____

I have explained the Hospice program and answered all related questions asked by the patient or the legal decision maker on behalf of the patient.

AHS Representative Signature: _____ Date: _____