Admission Financial Hospice House Agreement

Hospice of Marion County, Inc.
P.O. Box 4860 * Ocala, FL 34478-4860 * (352) 873-7400

Patient Name: _____Hospice #:_____

A) <u>Short-Term Inpatient Level of Care</u> includes intensive medical, nursing and psychosocial care for pain control crisis and/or other symptom management. Inpatient Level of Care charges are covered by the Medicare Hospice Benefit, Medicaid and some insurance companies.

1. <u>While on Inpatient Level of Care</u>, Room & Board charges (single occupancy room, meals, TV and local phone calls) **<u>are</u>** covered by Medicare, Medicaid and some insurance companies.
2. Patients and/or representatives are invited to participate in care planning meetings at least weekly. Once pain control and/or other symptoms are managed, the patient's care status must be changed to Routine Level of Care. <u>If continued residence at a Hospice House becomes inappropriate according to Medicare guidelines, assistance with relocation will be provided for the patient.</u>

B) <u>Routine Level of Care</u> includes medical, nursing and psychosocial hospice care services. Routine Level of Care charges (except Room and Board) are covered by Medicare, Medicaid and some insurance companies.

1. <u>While on Routine Level of Care</u>, Room & Board charges (single occupancy room, meals, TV and local phone calls) are **<u>not</u>** covered by Medicare, Medicaid or most insurance companies.
2. A patient's care needs may fluctuate between qualifying for Short-Term Inpatient Level of Care and Routine Level of Care (per Medicare/Medicaid guidelines) during a period of time at a Hospice House. If placed on Routine Level of Care at a Hospice House room and board charges will be $180.00/per day unless a reduced rate has been established.
3. No one will be denied care in a Hospice House because of established inability to pay. If patient and/or representative(s) declare that the full Room and Board charge would cause hardship, Hospice of Marion County will set fee based on ability to pay. This amount will be determined by a Financial Counselor or Social Worker upon calculation of patient financial responsibility. To request a reduced rate, the patient and/or personal representative agrees to provide complete information regarding assets, monthly income/expenditures, previous year's income tax return and most recent month's checking and savings bank statements.

C) <u>Billing Information:</u>

Invoices will be sent to the third party payer if applicable (Medicare, Medicaid or health insurance) or to the patient and/or personal representative's address. The appropriate address is:

Name_____

Address_____City_____State_____Zip Code_____

In the event of unpaid bills from an admission to a Hospice House, Hospice of Marion County has the right to file against an estate for payment.

I, the patient or authorized personal representative, request admission to a Hospice of Marion County Hospice House. This acknowledges that I have been given the opportunity to ask questions concerning the Hospice House, the care provided, related charges and relocation policies.

_____ ____/____/____
Patient Signature Date

Patient is unable to sign because: _____

I agree to guarantee payment from the patient's finances and to comply with the terms of this Agreement.

_____ _____ ____/____/__
Patient Representative Signature Relationship Date

_____ _____ ____/____/__
Patient Representative Signature Relationship Date

_____ ___/_____/_____
Hospice of Marion County, Inc. Representative Signature Date