CONSENT FOR ADMISSION & CARE/HOSPICE BENEFIT ELECTION

Hospice #_____

P. O. Box 4860 * Ocala, FL 34478-4860 * (352) 873-7400

I,_____ hereby consent to admission and care by ***Hospice of Marion County, Inc., Inc*.** (HMC) I acknowledge and consent to the following:
I understand HMC's goal is palliative care and not to cure my life limiting illness. HMC does not discriminate regardless of diagnosis, race, national origin, age, gender, religious affiliation, creed, disability, sexual orientation, or the ability to pay for service rendered.

HOSPICE INTERDISCIPLINARY TEAM: Hospice services are provided by an interdisciplinary team which includes: my physician, a patient care coordinator, nurses, social workers, chaplains, volunteers, home health aides, bereavement staff, and the Hospice Medical Directors. These services are provided both on a scheduled basis and as needed 24 hours a day, 7 days a week. I have been informed of my right to choose my attending physician, and I hereby request my attending physician to be:

☐ Community Physician Dr._____

☐ HMC Chief Medical Officer Dr. Mery Lossada, or other HMC Medical Director
An HMC Medical Director will assume responsibility for my medical needs if my attending physician is unavailable.

PLAN OF CARE: The parties acknowledge that HMC has been chosen to provide hospice services to my family and me, along with the hospice team. A plan of care will be developed based on our needs, which will be reviewed regularly. I can review my plan of care and will participate in decisions related to my care. I understand the focus of my care will be to maintain me in my own home. I understand if I am to receive full benefits of hospice care it is important for me to make my needs and concerns known to the hospice staff. I will actively participate in plans for my care.

TREATMENTS AND PROCEDURES: I consent to all treatments and procedures to include a physical assessment that are on my plan of care as related to my life limiting illness.

RELEASE OF INFORMATION: I authorize HMC to release any necessary information including medical records that are applicable, including mental health, substance abuse and/or Human Immunodeficiency Virus – AIDS. These records will be released as required to other health care providers to assure continuity of care, reimbursement, quality assurance, utilization review, and as required by law, regulatory agencies and accrediting bodies.

PRESCRIPTION DRUGS: HMC uses Palliative Care Pharmacy, a division of HMC to provide the medication related to my life limiting illness as defined in my individualized plan of care. I give consent for my medication to be ordered from the Palliative Care Pharmacy. I understand that due to DEA and Law Enforcement concerns, as well as recurring manufacturing shortages, HMC maintains a limited selection of controlled substances, which will be provided per physician order as required by my plan of care. Further, I understand that generic and therapeutic substitution(s) of my current medications may be required. I understand that all hospice provided medications no longer in use will be disposed of properly by law or regulatory requirements. I give consent for HMC to exchange information with my community pharmacy related to my medications and hospice diagnosis. I understand that if I have Medicare Part D drug coverage, my pharmacy must bill all of my medications to HMC, who will work with my physician and pharmacy to determine whether my medications will be covered under the hospice benefit or by my Medicare Part D plan. If a medication is determined by the hospice physician to be related to the terminal illness but not medically necessary for pain and/or symptom management, hospice will not pay for the medication. This medication also will not be covered by my Medicare Part D plan. I understand that if I want to continue taking the medication that I will need to pay for it out of pocket unless I have coverage from another insurer. If I request a medication that is not on the hospice formulary and I refuse to try a medication that HMC believes will be as effective and is on the hospice formulary, I understand that my Medicare Part D plan will not pay for this medication, and I will have to pay for it out of pocket.

ADVANCE DIRECTIVES: I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself and my preference for life sustaining treatment. I may express my wishes in a document called an Advance Directive so my wishes may be known when I am unable to speak for myself. I have made an Advance Directive ☐ Yes ☐ No

Copy of Advance Directive requested: ☐ POA for Health Care ☐ HCS ☐ Living Will ☐ DNR
Copy of Advance Directive received: ☐ POA for Health Care ☐ HCS ☐ Living Will ☐ DNR

I have been informed that under Florida law having a Living Will is **not** sufficient to avoid the use of life support methods **if 911 is called or an ambulance transports**.

Patient:_____Hospice #_____

FINANCIAL RESPONSIBILITY AND REIMBURSEMENT: For those eligible patients, Medicare and Medicaid pays for **all** care and services related to the terminal illness as established by the hospice interdisciplinary Plan of Care. HMC may bill me for those services/supplies not paid for by Medicare, Medicaid, or insurance. Services not covered by Medicare, Medicaid, or insurance will be confirmed in writing by HMC. I will be responsible for the costs of any treatment or services/supplies provided, treatments for conditions not related to my life limiting illness and for any treatments for my life limiting illness which are NOT part of the hospice plan of care or not PRE-AUTHORIZED by HMC. I agree to a financial statement and to complete all needed forms.

MY REIMBURSEMENT SOURCE IS EXPECTED TO BE:

☐ **Hospice Medicare** Benefit #:_____ **Effective Date:_____/_____/_____**

Medicare card reviewed: ☐ Yes ☐ No

MEDICARE BENEFIT ELECTION: I choose to elect the Hospice Medicare benefit to receive hospice care from HMC. I understand HMC's goal is palliative care and not to cure my life limiting illness. By choosing Hospice Medicare, I am giving up payment for other Medicare service benefits. Only HMC will be able to receive Medicare payment for care or services provided to me for my terminal illness or any other condition related to my terminal illness. Exceptions to this are:

a. Medicare will make payment for physician services if my attending physician is not a hospice employee or is not receiving any payments from hospice.
b. Medicare will make payments for services provided to me by another hospice when services are arranged through Hospice of Marion County, Inc., where allowed by Medicare regulations.
c. Medicare will make payment for hospice care according to benefit periods. These benefit periods are as follows: First Benefit Period - 90 Days**,** Second Benefit Period - 90 Days, Unlimited number of subsequent 60 Day periods

I can choose not to continue my hospice care at any time. To discontinue care, I must complete a revocation statement. I can obtain this statement from any HMC employee.

If I revoke my Hospice Medicare Benefit in the middle of a benefit period, I give up the remaining days in the benefit period. For example, if I revoke my Hospice Medicare Benefit after the first 10 days, I give up the remaining 80 days in the first benefit period. If I revoke the Medicare Benefit during a subsequent 60 day period, I will forfeit the remaining days in that period. A new 60 day period may be elected at a later date.

While on Hospice Medicare Benefits, I can choose to receive hospice care from another hospice program at any time during the Medicare Benefit periods. Only one change per benefit period is allowed. More than one change will start a new benefit period. To change programs, I must first confirm that the hospice I wish to be admitted to can admit me and on what date. I must inform HMC of my wishes so arrangements for transfer can be made. I then must document the date I wish to discontinue care from HMC, the name of the Hospice from which I wish to receive care, and the date that care will start.

Medicare Part D: ☐ Yes ☐ No

Part D Plan Name:_____

Phone #:_____ Fax #:_____

Customer Service #:_____ Member ID #:_____

Group #:_____ BIN #:_____

☐ **Hospice Medicaid** Benefit #:_____ **Medicaid** card reviewed ☐ Yes ☐ No
☐ AHCA Florida Medicaid form completed ☐ Medicaid Platinum Release form completed

☐ **Private Insurance:** Insurance card reviewed ☐ Yes ☐ No

☐ I select _____ as my primary payor for my hospice services

Name of Insurance Company: _____Policy #_____

Address:_____ Phone #:(_____)_____

Patient:_____Hospice #_____

I understand I will be billed monthly for any charges not paid by my insurance and payment is due when billed unless other arrangements are made. I authorize payment of benefits directly to HMC and assign any such benefits to HMC. I will be responsible for payment if coverage is denied for any reason.

☐ **Veteran's Administration Insurance** ☐ I select Veteran's Administration as my primary payor for my hospice services

☐ **Private Pay** (Patient has no Insurance)

Since I have no health insurance coverage, I or my designated representative, will be responsible for fully cooperating with HMC to apply for any available funding sources, such as Medicaid, in order to fulfill my financial obligations.

I agree to pay for services provided by HMC, the balance in full each month as billed or I or my representative will contact the finance department for payment arrangements.

I understand that acceptance into the HMC's program will not be based on my ability or inability to pay for services.

The method of reimbursement for care provided by HMC has been thoroughly explained to me and I have been given the opportunity to ask questions. If I have any further questions I can call the finance department at 352-854-5226.

CAREGIVERS: I ask my family and/or significant other(s) to respect my choice of hospice care, and to fulfill the role of primary caregiver for me, if applicable.

My designated caregiver is:_____ Relationship:_____

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI): I hereby authorize Hospice of Marion County, Inc., to release verbal medical information to my designated caregiver and to my family and friends as follows:

Name:_____Relationship: (Family Physician)_____Phone #:_____

Name: _____ Relationship: _____Phone #:_____

Name: _____ Relationship: _____Phone#:_____

I understand that this authorization will remain in effect during this admission or until I revoke it in writing, to an authorized employee of HMC. HMC does not and has not conditioned treatment, payment, admission or eligibility of benefits upon signing this document. I understand that health information disclosed pursuant hereto is subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act. Also, I hereby release HMC, and its employees from any and all liability that may arise from the release of information as I have directed.

Hospice of Marion County, Inc. supports schools with nursing programs by allowing students to participate in patient care. The students gain valuable knowledge of hospice care and the hospice mission. All students are supervised by a Hospice of Marion County, Inc. staff member. You will be asked if you wish to have a student to provide care.

☐ I give permission for student participation in my care.
☐ I **do not** give permission for student participation in my care.

I acknowledge receipt of the HMC's Patient/Caregiver Resource Guide that includes the Patients Rights and Responsibilities, Reasons for Discharge, The DNRO Disclosure, and the Management and Disposal of Controlled Drugs in the Home Policy and Procedure. I have also received a copy of the Notice of Privacy Practices. For more information about the Medicare Hospice Benefits, visit www.medicare.gov/publications.

Photo ID Reviewed ☐ Yes ☐ No

X_____ _____ _____/_____/_____

(Signature of Patient or Legal Representative) Relationship (Date of Signature)

Patient unable to sign because:_____

_____ _____/_____/_____

(Witness Signature) (Date of Signature)

If verbal consent is obtained at time of admission, written consent must follow within 5 days:

Informed consent explained by telephone to:_____

Relationship to patient:_____

_____/_____ ____/____/____ ____:_____

Hospice Staff Signature Hospice Staff Signature Date Time