Health Information Record #: ______________________

Patient Name: ______________________

PATIENT/FAMILY ADMISSION AGREEMENT/INFORMED CONSENT/BENEFIT ELECTION

1. I understand that I am giving informed consent and agree to receive Hospice care which is palliative and not curative, focused on alleviating pain and other symptoms. The Hospice Team will provide care for my physical, psychosocial and spiritual needs related to conditions of a life threatening illness and according to patient/family needs. I understand that emergency procedures such as Cardiopulmonary Resuscitation (CPR) will not be provided by Hospice personnel, contracted services, or volunteers, however, as a hospice patient I may access treatment through alternative means (For Example, EMS).

2. I understand that professional medical services are provided by an interdisciplinary team consisting of physicians, registered nurses, social service coordinators, chaplains, and other professionals. These services will be available as scheduled and as needed (by phone and assessment visits) 24 hours a day, 7 days a week to respond to patient and family needs as quickly as possible. Complementary therapies (massage, healing touch and expression) are also available and provided according to the patient's plan of care; and volunteer support may be accessed when available.

3. I understand that hospice services are primarily provided through home care and that SHORT TERM inpatient care may be available to manage and stabilize conditions for continued care in the home or nursing facility, as determined by my attending physician or hospice Medical Director. The hospice inpatient unit and the hospital are not licensed for, or able to provide, long-term hospitalization or custodial care.

4. I understand that the Hospice team is not intended to take the place of either the family or the primary physician but that its role is to support, educate and assist the family in caring for the patient. The Hospice team will provide pain and symptom control services and consultation as requested by the primary physician, and will coordinate available resources. I understand and accept our (patient/family) responsibility as the primary caregiver for the patient's care on a 24-hour basis. I agree to make arrangements for additional part time or full time caregiver assistance in the home when needed and to be financially responsible for such assistance. I understand that when residing in a nursing home setting, the nursing home staff serves as the caregiver in the patient's primary residence.

5. NURSING HOME ROOM AND BOARD: I understand that room and board in a nursing facility is the responsibility of the patient and/or family. Should I apply for Medicaid to cover room and board in a nursing facility I accept responsibility for and agree to participate in the application process. ___ I reside in a skilled nursing facility. ___ I am privately responsible for room and board (or) ___ Medicaid is responsible for room and board.

6. I understand the need to use and disclose health information to provide care and services and I consent to the release of necessary information including appropriate medical records to or from any in-bed facility, hospital, home health agency, private physician, contracted service, accrediting body, licensing agent, or other community agency providing needed services or resources.

7. I understand that if at any time it is determined that one or more of the following reasons for discharge are met, the Hospice staff will assist us in discharge planning. *Reasons for Discharge*: Patient no longer meets eligibility criteria; Patient has moved out of Hospice geographically defined service area; Patient/family desire discharge; Patient enters into a non-contracted facility and a contract cannot be obtained; Discharge for cause according to Avow Hospice policy.

8. I understand that all fees for hospice care including physician services, nursing, personal care, social services, counseling, medications, equipment, supplies, and other hospice core services will be billed to our third party insurance payor (Medicare, Medicaid, or private insurance) or directly to us if we have no third party reimbursement source.

9. ADVANCE DIRECTIVES: I understand my right to declare advance directives including a health care surrogate designation, living will, or durable power of attorney. I acknowledge receipt of a description and explanation of Advance Directives and provide the following information:

Health Care Surrogate Designation	☐Yes	☐No	Durable Power of Attorney	☐Yes	☐No
Living Will (or information copied)	☐Yes	☐No	Proxy Notification	☐Yes	☐No

10. MEDICAID BENEFIT ELECTION: I have received an explanation of The Florida Medicaid Hospice Care Services program with the opportunity to discuss the benefits, requirements and limitations of this program and terms of this election statement. I understand that I will be entitled to elect Medicaid hospice care coverage as long as I am Medicaid eligible and am certified by the hospice physician as terminally ill. I understand that by signing this election statement, I am waiving all rights to Medicaid services for the duration of the election of hospice care for the following services (i) hospice care provided by a hospice other than the hospice designated by me (unless provided under arrangements made by the designated hospice) and (ii) any Medicaid services that are related to the treatment of the condition or a related condition for which hospice care was elected or that are equivalent to hospice care with the following exception: services provided by my attending physician (if that physician is not employed by the designated hospice or receiving compensation from hospice for those services).

11. MEDICARE BENEFIT ELECTION: I have received an explanation of the Hospice Medicare Benefit and election periods (two initial 90 day periods followed by an unlimited number of 60 day periods) with the opportunity to discuss the benefits, requirements and limitations of this election statement. I understand that certain Medicare services are waived when I elect the Hospice Medicare benefit, and this has been fully explained to

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Patient Name: ______________________________

PATIENT/FAMILY ADMISSION AGREEMENT/INFORMED CONSENT/BENEFIT ELECTION

me. I understand that I am entitled to elect Medicare or Medicaid hospice care coverage as long as I am Medicaid or Medicare eligible and certified by the hospice physician as terminally ill. I understand that I may revoke the hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is effective and submitting the statement to the hospice prior to the effective date, and that at that time, my rights to other Medicaid or Medicare services will resume, provided I continue to be eligible. ______Medicare (or) ______ Medicaid Hospice Benefit

12. DESIGNATION OF REPRESENTATIVE: I hereby authorize Avow Hospice, Inc. to represent me (patient named above) in conversations with the Medicare and/or Medicaid programs, regarding eligibility for benefits or as a representative regarding any consideration.

13. PRIVATE INSURANCE: Hospice benefits vary according to an individual's policy. My hospice benefits have been explained to me, and I understand that a financial assessment will be completed should my insurance not cover hospice services or if benefits are limited, and that charges not covered by my insurance are my responsibility. I authorize payments on my behalf to be paid directly to Avow Hospice for the allowable medical expenses covered under my insurance policy. If my policy does not allow direct payments, I will direct my insurance company to make a check out as follows: Avow Hospice, Inc., 1095 Whippoorwill Lane, Naples, FL 34105. I authorize Avow Hospice to endorse and deposit checks into its account, as payment for hospice services rendered.

Primary Insurance Co. Name ______________________________ Phone: ______________

Address: ______________________________

Policy #: ______________________ Group #: ________ Name of Insured:

Secondary Insurance Co. Name ______________________________ Phone: ______________

Address: ______________________________

Policy #: ______________________ Group #: ________ Name of Insured:

14. MEDICARE SECONDARY PAYOR QUESTIONAIRE:

a. Are you currently working full or part time? ☐Yes ☐No Date of retirement: __________
b. Are you married, and is your spouse currently working full or par time? ☐Yes ☐No
c. Are you covered under a group health plan based on your employment, spouse employment or family member's employment? ☐Yes ☐ No
d. Was this illness due to a work related accident/condition? ☐Yes ☐No
e. Are you entitled to lung benefits? ☐Yes ☐No
f. Are you entitled to Medicare benefits for End Stage Renal Disease? ☐Yes ☐No

15. I understand that all services or treatments will be provided according to the Hospice plan of care, which is individualized for each patient. All medical procedures, diagnostic services (laboratory tests, x-rays, CT scans, etc.) hospital stays, emergency room visits, and any other medical service or procedure related to the terminal diagnosis must be pre-authorized by Hospice in order to be covered under this benefit. Payments for medical services not pre-authorized by Hospice are the responsibility of the patient.

16. I would like my Primary Physician ______________________________.

INFORMATION RECEIPT: I acknowledge the receipt of information on Hospice Services, Disaster Preparedness, Patients Rights and Responsibilities, Advanced Directives, Notice of Privacy Practices, Medicare and Medicaid hospice benefits and how to access Avow Hospice 24 hours a day 7 days a week. I have been given the opportunity to ask questions and discuss the information and all questions have been answered to my satisfaction.

I have received a full explanation and disclosure of the care and services provided by Avow Hospice Inc. and I am voluntarily making an informed health care decision to request admission to the Hospice Program effective ________________.

Medicare#: ______________ Medicaid#: ______________ SSN: ______________ DOB: __________

______________________________ __________
Patient's Signature Date

______________________________ __________
Family Representative's Signature Date

______________________________ __________
Avow Hospice Representative's Signature Date

If patient unable to sign, then state reason: ______________________________