Community Hospice

ADMISSION SERVICE AGREEMENT

I elect to receive hospice services provided by Community Hospice, Inc. and request that authorized benefits begin on August 12th, 2014.

- I/We understand that the Hospice program is palliative, not curative, in its goals. The program emphasizes the relief of symptoms such as pain and physical discomfort and addresses the spiritual needs and the emotional stress which may accompany a life-threatening illness.
- I/We understand that Hospice services are not intended to take the place of care by family members or others who are important to the patient, but rather to support them in the care of the patient.
- By choosing Hospice benefits, only Community Hospice, Inc. will be able to receive payment for care or services provided to me related to my terminal illness. Services provided by my attending physician (provided he is not the hospice Medical Director) will be covered by Medicare even if the services are related to my terminal condition. Services not related to this illness will be covered by my regular Medicare/Medi-Cal/private insurance coverage.
- If I seek treatment/hospitalization, which has not been pre-authorized by Community Hospice, I understand I may be financially responsible for those services received.
- I/we understand that services provided to me by the Hospice interdisciplinary team will be in accordance with my plan of care and may include the following:

1. Intermittent visits by the team members providing medical, nursing, counseling, psychosocial, spiritual, dietary and home health aide services.
2. Intermittent visits and/or consultation by auxiliary team members providing physical, occupational and speech therapies as approved by the interdisciplinary team.
3. Management of my physical symptoms related specifically to my terminal illness.
4. Instruction for myself and my caregivers for managing my care.
5. Counseling and emotional support for my family/caregivers.
6. Hospice-trained volunteers to augment the professional services.
7. Durable medical equipment and supplies approved for my care by the hospice interdisciplinary team.
8. Prescriptions and biologicals as approved for pain and symptom control by the hospice interdisciplinary team.
9. A full year of bereavement support for those close to me.
10. Depending on my needs for comfort and palliative care and when deemed necessary by the interdisciplinary team, I understand services may be provided at different levels including:
    a. Routine, intermittent visits in my place of residence.

Patient/Client Name – Last, First, Middle Initial:	Patient ID Number:
Parvin, Mary Jean	23322

White – Clinical Record Yellow – Patient/Client Representative

b. Continuous Care: provided for a brief period in time of crisis when acute management of medical symptoms does not require an inpatient stay.

c. Inpatient Respite Care (Respite) for a period of up to 5 days to relieve the caregivers who are caring for me.

d. General Inpatient Care (GIP) for a brief period of time in a contracted inpatient facility for pain control or acute/chronic symptom management which cannot be managed in my residence.

TA (Int.) General Inpatient Care and Inpatient Respite Care are provided in either a contracted Skilled Nursing Facility or in the Alexander Cohen Hospice House (ACHH). There are room and board fees for people who stay at either facility beyond the GIP or Respite days. Community Hospice is not responsible for fees at a nursing facility; the fees at ACHH are $ 220 per day. By initialing this paragraph you agree to pay these fees and understand that you and/or your legal decision maker will be billed should you fall under this criterion.

I understand that hospice services will be continued as long as my terminal prognosis remains unchanged. If my physician or the hospice Medical Director determines that my condition is no longer terminal, I will no longer be eligible for the hospice benefit. If this occurs, hospice will inform me prior to any change in my benefit election.

I understand that I can choose to change hospices once per benefit period.

I also understand that I may revoke my election of hospice care at any time during a benefit period. To revoke services, I understand I must file a revocation statement with Community Hospice, Inc. I understand that if I cancel my benefit, I will then forfeit any days remaining in the benefit period. I understand that if I leave the service area of Community Hospice, the hospice will be unable to coordinate my care and I will be discharged. At a later date, I may elect to receive hospice coverage for any of the remaining election periods I am eligible to receive.

Release of Information

TA (Int.) I have received a copy of the Notice of Privacy Practices and was given the opportunity to ask questions and voice concerns. I understand that the agency may use or disclose protected health information about me to carry out treatment, payment or healthcare operations. I authorize and give my permission to Community Hospice to release and/or receive any of my past and/or current medical information which is necessary for the coordination and continuation of my care. Further, this authorization and release applies to the furnishing of any and all information required to establish my claim for benefits with my insurance company or any government agency from which I claim benefits in payment of my bills from the agency. In addition I understand basic contact information regarding myself and my loved ones may be included in Community Hospice's data base to receive fundraising mailings. I may opt out of receiving fundraising materials at any time.

Authorization for Payment

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medi-Cal or other responsible payer be made on my behalf to Community Hospice. I understand that I am responsible for all amounts not paid by my commercial insurance. I hereby elect to participate in hospice under the following program checked:

☑ Medicare ☐ Medi-Cal ☐ Commercial Insurance ☐ No Insurance

Patient/Client Name – Last, First, Middle Initial:	Patient ID Number:
Parvin, Mary Jean	83327

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If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full for hospice related services and I have no financial liability, unless I have been notified in writing that service(s) will not be covered by Medicare and wish to receive the care or service. If I have other insurance, I will be responsible for the co-payment and any charges that my insurance will not cover.

If I have Medicare:

☐ Yes	☒ No	I have black lung benefits
☐ Yes	☒ No	Hospice services will be paid through government research program
☐ Yes	☒ No	Veteran's Administration has authorized care
☐ Yes	☒ No	The illness/injury is due to a work-related accident
☐ Yes	☒ No	The illness/injury is due to a non-work-related accident
☐ Yes	☒ No	I receive Medicare for ESRD
☐ Yes	☒ No	I am currently employed
☐ Yes	☒ No	My spouse is currently employed

If I checked YES to any of the boxes, I have completed the Medicare Secondary Payer Screening form.

Advance Directive for Health Care

I have received information about and been encouraged to complete an Advance Directive for Healthcare should I so desire. I do ☑ do not ☐ have an Advanced Directive.

Rights and Responsibilities

TA (Int.) I understand my rights and responsibilities as they have been presented to me both verbally and in writing.

TA (Int.) I understand that the Community Hospice's Medical Directors are physicians licensed by the Medical Board of California. Per the Medical Board: NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California. (800) 633-2322. www.mbc.ca.gov.

Signature/Dates:

X _____ 8-12-14 Tiffany Anderson
Patient/Client Representative *Date* *Printed name and relationship to patient*

X _____ 8-12-14
Community Hospice Representative *Date*

Patient/Client Name – Last, First, Middle Initial:	Patient ID Number:
Parvin, Mary Jean	23320

White – Clinical Record Yellow – Patient/Client Representative

Community Hospice℠

Community Hospice Inc.
4368 Spyres Way
Modesto, CA 95356

Patient Name: Mary Jean Parvin **Patient ID:** 23322 **Date:** 8.12.14

Mary Jean Parvin is under hospice care for a terminal illness
Patient's name

Subsequently, Mary Jean Parvin is a DO NOT RESUSCITATE (DNR).
Patient's name

Patient's or patient's representative signature — Date: 8-12-14

Garfield Pickell, M.D., Medical Director — Date: 8.12.14

PHYS 104 (06/14/11) Rev 11/1/13