HOSPICE AND PALLIATIVE CARE OF GREATER WAYNE COUNTY

INFORMED CONSENT FORM FOR HOSPICE CARE IN THE NURSING HOME

We, the patient and caregiver, agree to admission to the Hospice & Palliative Care of Greater Wayne County, Ohio (HPC) program and understand and agree to the following conditions. We request that HPC assume professional management of patient care.

Introduction: 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 emotional stress which may accompany a life-limiting illness.

Caregiver: We understand that Hospice services are not intended to take the place of care by nursing home staff or others who are important to the patient, but rather to support them in the care of the patient. Nursing home staff and the family will participate in decisions about the care provided to the patient in the long term care setting.

Nursing Home Care: We understand that care will be provided by nursing home staff in collaboration with the Hospice & Palliative Care of Greater Wayne County professional staff and volunteers. Scheduled visits are made by Hospice staff to the patient in the long term care setting. Visits will be arranged with the family as needed to provide information on the patient's condition and care, and to allow for the family's wishes to be incorporated in the patient plan of care.

Consultation and visits by Hospice staff nurses for urgent matters and pain and symptom control are available 24 hours a day, 7 days a week. In a crisis, Hospice may provide staff to provide care to the patient in the long term care setting to enable the patient to remain in the nursing home.

Inpatient Care: We understand that if it is determined necessary by Hospice and the patient's attending physician, the patient can receive short term care in a contracted inpatient facility when pain or other symptoms fail to respond to management in the nursing home. Other reasons may be determined on an individual basis. We understand that if, after admission to the inpatient setting, the Hospice team decides there is no longer a need for Hospice inpatient care, the patient will be discharged to the nursing home. The Hospice staff will provide assistance in making discharge plans.

Choice of Care: We understand that we will have a choice about the care provided to us. We may review the plan of care that guides Hospice services and, if we desire, may refuse a particular treatment or service offered.

We further understand that some medical services or procedures, such as advanced cardiac life support or respirators, are not provided by Hospice. The subject of resuscitation should be discussed with the patient's physician. Other services, such as intravenous therapy, are provided only if they are determined by the Hospice Interdisciplinary Team to be necessary for the patient's comfort.

Follow-Up Care for Families: We understand that the "caregiver" and others who are part of the patient's family or who are important to the patient may choose to participate in the Hospice bereavement program. Services designed for family members and others include individual counseling, support groups, phone contacts, mailings, and memorial services.

Records: We authorize Hospice & Palliative Care of Greater Wayne County, Ohio to obtain copies of medical and billing records and to keep records which may include necessary information about the patient's medical condition, family and finances during the time which we are under the care of the Hospice program.

We permit the release of necessary information and medical records to or from any appropriate agency, medical person, physician, regulatory and/or accrediting body, or consultant as required to assure coordination and continuity of care and as necessary for reimbursement. Except as required for patient care, reimbursement, or quality improvement, such records will not be released to persons outside Hospice without our written consent

Definition of Family & Unit of Care: We understand that the Hospice focus is on the care of the patient/family unit as defined by the patient. We will attempt to identify immediate family & the extended family upon admission to Hospice, thus allowing Hospice to offer Bereavement Services to any family member who desires those services.

Financial Responsibility: We have read the explanation regarding the benefits, provisions and scope of services to be offered to us. We understand that efforts will be made to recover cost of care through private insurance, Medicaid, or Medicare. However, we understand that the patient will not be denied admission to the program if we are not able to pay.

Withdrawal/Discharge: We accept the conditions of Hospice & Palliative Care of Greater Wayne County as described, understanding that we may choose not to remain in the program and that Hospice may discharge us from the program if Hospice care is no longer appropriate. This means there will be no further liability to us or Hospice & Palliative Care of Greater Wayne County. We understand, however, that we may request to be readmitted at a later date.

Rights/Responsibilities and Privacy Notice: We have received and reviewed the patient/family rights and responsibilities as outlined by Hospice & Palliative Care of Greater Wayne County. We have received a copy of Hospice & Palliative Care of Greater Wayne County's Privacy Notice.

Preferred Drug List: We have been informed that Hospice & Palliative Care of Greater Wayne County uses a Preferred Drug List.

We have been able to discuss the above conditions with a member of the Hospice staff and have had our questions answered to our satisfaction.

Hospice services to begin on ________________________________

____ ____________________
Signature of Patient or Legal Guardian Date

____
Name of Patient or Legal Guardian (printed)

____ ____________________
Signature of Next of Kin/Guardian Date

____ ____________________
Name of Next of Kin/Guardian (printed) Relationship to Patient

____ ____________________
Signature of Hospice Representative Date

____ ____________________
Name of Hospice Representative (printed) Title

____ ____________________
Signature of Nursing Home Representative Title

____ ____________________
Designated Nursing Home Date

TYPE OF HOSPICE BENEFIT: Medicare_____ Medicaid_____ Per Diem _____ Insurance_____
DATE OF BENEFIT ELECTION____________________