INFORMED CONSENT AND TREATMENT AUTHORIZATION

This agreement is entered into by and between A1KARE HOSPICE AND PALLIATIVE CARE INC. (hereinafter called Agency) and _____ (hereinafter called Patient.) This agreement is entered into pursuant to a desire by Patient to obtain hospice services. I request admission to A1KARE HOSPICE AND PALLIATIVE CARE INC. and understand and agree to the following conditions:

I understand that the Hospice program is palliative, not curative, in the goals and treatments. 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 understand I am encouraged to participate in the development and implementation of the approved plan of care and 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. With the help of Hospice, the person designated the "caregiver" will provide around-the-clock care to the patient in their place of residence. If twenty-four-hour care is not available, the caregiver will arrange for another to provide it. The caregiver will also participate in decisions about the care provided to the patient. The Hospice Interdisciplinary Team supplements rather than replace care provided by the family or Care Center Staff I accept the conditions of A1KARE HOSPICE AND PALLIATIVE CARE INC. as described, understanding that I may choose not to remain in the program and that Hospice may discharge me from the program if hospice care is no longer appropriate. This means there will be not further liability to me or to A1KARE HOSPICE AND PALLIATIVE CARE INC. I understand however, that I may request to be readmitted at a later date. I have been able to discuss the above conditions with a member of the Hospice staff and have had my questions answered to my satisfaction.

Treatment Authorization. The undersigned Patient or Patient's legally authorized representative hereby consents to any and all examinations and treatments prescribed by Patient's physician (or hospice physician) rendered by the Agency's licensed nurses, physical therapists, occupational therapists, speech therapists, registered dietitians, social workers, spiritual counselors, home health aides and volunteers.

FINANCIAL AGREEMENT

In consideration of the mutual promises and obligations related to treatment rendered to Patient by Agency, it is agreed as follows:

1.**Payment Responsibility**: It is understood that for Hospice patients, the agency assumes financial responsibility for medications and /or durable medical equipment and medical supplies related to the terminal illness. The Patient and/or Patient's agent assumes financial responsibility for all other charges not authorized by the hospice. The agency in accordance with this agreement shall assist Patient in obtaining financial assistance from third party payers such a Medicare and private insurers.

2.**Pharmacy Services**. I acknowledge that I have the right to direct a pharmacist to dispense a prescription using the brand my physician prescribed instead of a generic drug product. I also understand that generic drug products generally cost less than brand name products, but the price differences vary from prescription to prescription I hereby consent and agree that, if allowable under state law, any pharmacist who dispenses any of my prescription drugs may select a drug product that is generically equivalent to the brand prescribed by my physician, unless I submit to Hospice a written request for a brand name product.

3.**Termination.** Except for Medicare eligible hospice Patients, the Agency upon due notice of no less than thirty days, may terminate services for lack of payment for its services. In addition, the Agency may terminate services, when in its sole medical judgment determines there is no longer any reasonable expectation that it can meet the Patient/family's needs.

MEDICARE/MEDICAID HOSPICE BENEFIT ELECTION

As a Medicare Part A or Medicaid beneficiary, I hereby elect A1KARE HOSPICE AND PALLIATIVE CARE INC. as my sole provider of hospice care effective (date) _____.

I understand the hospice program to be palliative, not curative in its goals and treatment, which the program emphasizes the alleviation of physical symptoms including pain, and the identification and meeting of emotional and spiritual needs that the patient and family may experience related to the terminal illness.

I understand that while this election is in force, Medicare/Medicaid will make payments for care related to this illness on to the physician designated below and A1KARE HOSPICE AND PALLIATIVE CARE INC., and that services related to this illness provided by hospitals, home health agencies, nursing homes, and any other company or agency will not be reimbursed by Medicare/Medicaid unless specifically ordered and authorized by A1KARE HOSPICE AND PALLIATIVE CARE INC. I understand the services not related to this illness will continue to be covered by Medicare/Medicaid along with hospice benefits.

I understand that once in each election period I may elect to receive services through a hospice program other than A1KARE HOSPICE AND PALLIATIVE CARE INC. Such change shall not be considered a revocation of hospice services. The physician I have chosen to serve as my attending physician is:

Name:	
Address:	
Phone:	**Fax:**

I understand that:

a) By signing this election form requesting hospice care under the Medicare Hospice Benefit, I am entitled to unlimited days of hospice care in the sequence periods consisting of 1) 90-day period, 2) 90-day period, 3) An infinite number of 60-day periods.
b) By electing hospice care under the Medicare Hospice Benefit, I waive all other Medicare Part A services, except, 1) my right to treatment or therapy for any condition other than my terminal illness under Medicare Part A, and 2) I do not waive the right to continue seeing my attending physician and I will be responsible for any bills from my attending physician under Medicare Part B, when appropriate.
c) By electing hospice care under the Medicare Hospice Benefit, I can choose to receive hospice care from another hospice program at any time during the benefit periods. 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 the A1KARE HOSPICE AND PALLIATIVE CARE INC. of my wishes so arrangements for transfer can be made. I then must document the date I wish to discontinue care from the A1KARE HOSPICE AND PALLIATIVE CARE INC., the name of the hospice from which I wish to receive care, and the date that care will start. No benefit will be lost by properly converting to another hospice program.
d) By electing hospice care under the Medicare Hospice Benefit, I can choose not to continue hospice care from another hospice program at any time. To discontinue care, I must complete a revocation statement. I can obtain this statement from the visiting personnel from A1KARE HOSPICE AND PALLIATIVE CARE INC.. If I revoke my Medicare Hospice Benefit in the middle of a benefit period, I give up the remaining days in the benefit period. For example, if I revoke my Medicare Hospice Benefit after the first 10-days, I give up the remaining 80-days in the first benefit period. I would then have the second 90-day period and the subsequent infinite number of 60-day periods.

I understand that hospice care provides:

a) Medical care from my primary physician, nursing care and all other hospice services from A1KARE HOSPICE AND PALLIATIVE CARE INC. nurses and staff.
b) Care by the hospice physician, professional nurses and others as is appropriate will be provide as often as necessary to permit control of pain, discomfort, anxiety, and other disturbing symptoms of illness. I understand hospice care is not intended to be curative, rather it is to provide comfort and intended to alleviate, to the extent possible, symptoms connected with my illness.
c) Coverage for nursing care, medical social services, physician services, counseling services, bereavement, volunteers, dietary consulting services, medical appliances and supplies (including drugs and biologicals for palliation and the management of terminal disease symptoms), and physical, occupational and speech therapies as needed.
d) The hospice will, within the limits of its resources, provide emotional, social and spiritual support to me, my family and others closely involved in my life.
e) All hospice services will be provided only with the express authority of the patient/family, the A1KARE HOSPICE AND PALLIATIVE CARE INC., and the attending physician.
f) All treatment and therapy decisions will be made with the consent of the patient/family, attending, physician, the A1KARE HOSPICE AND PALLIATIVE CARE INC. Medical Director and the Interdisciplinary Team.
g) There will be ongoing conferences regarding my plan of care in terms of my physical, emotional, social and spiritual needs, and I may attend if I so choose.

I understand that inpatient hospice care:

a) Will be provided by the hospice for pain control, symptom management, and management of psychosocial problems related to my terminal illness. I understand that this care will be provided at a facility contracted with the A1KARE HOSPICE AND PALLIATIVE CARE INC.
b) I understand that some hospice services may require procedures performed in a hospital outpatient setting, and that the A1KARE HOSPICE AND PALLIATIVE CARE INC. will arrange for these services as needed and on an out-on-pass basis.

I understand that respite care:

a) Will be arranged by the A1KARE HOSPICE AND PALLIATIVE CARE INC., under the Skilled Nursing Facility certification, for up to five days at a time, occurring once over 60-days, if I require these services.

I have been given the opportunity to ask questions about my care by the hospice and all questions have been answered to my satisfaction. I accept the conditions of the hospice as described with the understanding that I may revoke my election for Hospice care at any time. I understand that if, after admission to the A1KARE HOSPICE AND PALLIATIVE CARE INC., my physician(s) and I no longer consider hospice services appropriate or sufficient, or if I wish to pursue life-prolonging therapies, I must revoke my election of hospice care without further penalty to any party. I understand that such action on my part will be regarded by the A1KARE HOSPICE AND PALLIATIVE CARE INC. as a constructive revocation of the Medicare Hospice Benefit in the absence of any signed statement by me. I understand that the hospice will not be financially or medically responsible for any therapies or costs incurred as a result of my life-prolonging actions. As the patient, Primary Care Giver and/or Legal Responsible Party, we have researched other health care alternatives and have deemed that they are not an option for the patient at this time.

As a result, I choose to elect the Medicare Hospice Benefit through the services of the A1KARE HOSPICE AND PALLIATIVE CARE INC..

BENEFICIARY AND FAMILY CENTERED CARE-QUALITY IMPROVEMENT ORGANIZATION (BFCC-QIO):

I acknowledge that I have been provided information regarding my right to and the provision of Immediate Advocacy through the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if

I disagree with any of the hospice's determinations. I have been provided with the contact information for the BFCC-QIO that serves my area: Livanta 1−877−588−1123; 1−855−887−6668 (TTY).

RIGHT TO REQUEST PATIENT NOTIFICATION OF HOSPICE NON-COVERED ITEMS, SERVICES AND DRUGS:

I understand that I have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items, Services and Drugs" addendum that lists the items, services and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions that would not be covered by the hospice. A1KARE HOSPICE AND PALLIATIVE CARE INC. must furnish this Notification to me within five (5) days, if I request this Notification on the start of care date. A1KARE HOSPICE AND PALLIATIVE CARE INC. must furnish this Notification to me within 72 hours or three (3) days if request this Notification during the course of hospice care.

I elect to receive the "Patient Notification of Hospice Non-Covered Items, Services and Drugs"
Initials:_____ Date:_____

I decline to receive the "Patient Notification of Hospice Non-Covered Items, Services and Drugs"
Initials:_____ Date:_____

HOSPICE SERVICES

Routine Home Care. I understand that hospice services are delivered primarily in the home (which may include a nursing home) provided by a team of hospice professionals, staff and volunteers. These services are available both on a scheduled basis and as needed. I understand that these services may include, as set forth in the hospice plan of care: nursing, physician care, social work, spiritual, nutrition and bereavement counseling, home health aides/homemakers, medical supplies, physical therapy, occupational and speech-language therapy, and medications prescribed for relief of pain or discomfort.

Inpatient Care/Inpatient Respite Care I understand that inpatient hospice care and inpatient respite care are provided in an inpatient bed when it is deemed necessary by the hospice interdisciplinary team. I understand that hospice inpatient care is designed for short-term stays with the goal of stabilizing the patient and family emotionally and physically so the patient can return to home. I understand that inpatient respite care is designed to provide brief periods of respite for the family or primary caregiver while the patient receives hospice care in an inpatient bed.

Continuous Care. I understand that continuous care (a minimum of 8 hours of care in a 24-hour period) may be provided in a patient's home when it is deemed necessary by the hospice interdisciplinary team. I understand that continuous care is designed for short-term periods to manage acute medical symptoms with the goal of stabilizing the patient.

I understand that under the Medicare Hospice Benefit, I am entitled to hospice care, which consists of two 90-day periods and subsequent 60-day periods of unlimited duration. For Medicaid the benefits are two 90-day periods, a period of 30 days and one subsequent benefit period limited to seven months. The Hospice Interdisciplinary Team evaluates recertification for continuation of hospice care at the end of each benefit period.
I understand that I am responsible for the cost of care for my terminal illness if I seek care beyond what is considered medically necessary by the hospice interdisciplinary group and documented on my plan of care.
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 to be effective, and submitting the statement to A1KARE HOSPICE AND

PALLIATIVE CARE INC. prior to that date. This revocation constitutes a waiver of the right to hospice care during the remainder of the current election period.

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

As a A1KARE HOSPICE AND PALLIATIVE CARE INC. patient, you have the right to:

1. Be informed of your rights and responsibilities in a language and manner, which you understand.
2. To exercise your rights as a patient of the hospice.
3. Be fully informed, as evidenced by your written acknowledgement or by that of your appointed representative, of these rights and of all rules and regulations governing patient conduct, prior to or at time of admission.
4. To have your property and person treated with respect.
5. Make informed decisions regarding proposed and ongoing care and services.
6. Choose whether or not to participate in research, investigational or experimental studies, or clinical trials.
7. Have your communication needs met.
8. Have grievances regarding treatment or care that is or fails to be furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and to not be subjected to discrimination or reprisal for exercising his/her rights
9. Confidentiality of information, privacy and security.
10. Be involved in the care planning process.
11. Be fully informed by a physician of your medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in your Medical treatment.
12. Be informed and receive written information concerning our policies on advance directives, Including a description of applicable State law.
13. Choose your attending physician.
14. Have an appropriate assessment and Management of your pain and other symptoms.
15. Be fully informed, prior to or at time of admission, of services available through the hospice program, and related charges, including services not covered under Titles XVIII or XIX of the Social Security Act.
16. Refuse treatment to the extent permitted by law and to be informed of the medical consequences of Such refusal.
17. Be advised of what hospice services are to be Covered under the hospice benefit.
18. Receive information about the scope of services that the hospice will provide and specific limitations on those services
19. Be assured confidential treatment of personal and clinical records and to approve or refuse their release to any individual outside the hospice, except in the case of transfer to another health facility, or as required by law or third-party Payment contract.
20. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation Of your property.

PATIENT RESPONSIBILITIES

As a A1KARE HOSPICE AND PALLIATIVE CARE INC. patient, you have the responsibility to:

1. Remain under a doctor's care while receiving hospice services.
2. Inform the hospice of advance directives or any changes in advance directives, and provide the hospice with a copy.
3. Cooperate with your primary doctor, hospice staff and caregivers by providing information, following instructions and asking questions.
4. Advise the hospice of any problems or dissatisfaction you have with the care provided.
5. Notify the hospice of address or telephone number changes or when you are unable to keep appointments.
6. Provide a safe home environment in which care can be given. If the patient's or staff's welfare or safety is threatened, service may be terminated.
7. Obtain medications, supplies and equipment ordered by your physician if they cannot be obtained or supplied by the hospice
8. Treat hospice personnel with respect and consideration.
9. Sign the required consents and releases for insurance billing, and provide insurance and financial records as requested.
10. Accept the consequences for any refusal of Treatment or choice of non-compliance.
11. Advise the agency of any problem or Dissatisfaction with our care, without being subject to discrimination or reprisal. The Hospice will investigate all grievances; document the existence of the complaint and findings. Findings will be communicated to the patient/family.

Procedures for Making Complaints:
If you have any complaints regarding the services you have received from A1KARE HOSPICE AND PALLIATIVE CARE INC. the Department of Health Services operates a 24-hour, toll-free hotline that you may contact at any time:

In Los Angeles County: 1-800-228-1019
The Department of Health Services office hours are M-F, 8 am – 5 pm, except holidays. You may write to them at the following address:

Department of Health Services
5555 Ferguson Drive, Suite 320
City of Commerce, CA 90022

A1KARE HOSPICE AND PALLIATIVE CARE INC. is an affirmative, action/equal opportunity employer and does not discriminate on the basis of race, color, national origin,

Patient's Name:
Date:

INFORMED CONSENT AND TREATMENT AUTHORIZATION

7/9

ADVANCE DIRECTIVES

I have been provided the following information regarding advance directives.

- ❑ Informed of my rights to formulate an Advance Directive.
- ❑ I am not required to have an Advance Directive in order to receive medical treatment by any healthcare provider but understand that cardiopulmonary resuscitation (CPR) will not be performed by hospice staff.
- ❑ The terms of any Advance Directive that I have executed will be followed by any healthcare provider and my caregivers to the extent permitted by law.

❑ **The patient has an Advance Directive:** Name and Address of Agent:

- ❑ Power of Attorney for Health Care
- ❑ Living Will

Copy Received: ❑ Yes ❑ No

❑ **The patient does not have an Advance Directive**

RELEASE OF PATIENT RECORDS

I understand that A1KARE HOSPICE AND PALLIATIVE CARE INC. may need to obtain medical records and related information from hospitals, nursing homes, physicians, pharmacies, home health agencies, insurance companies, health care benefit plans, or others in order to assure continuity of care and proper reimbursement. I authorize the above persons and entities to release to the hospice agency and its representative medical records and related information necessary to be helpful to the provision of hospice care. I also authorize A1KARE HOSPICE AND PALLIATIVE CARE INC. and its representatives to release medical records and related information to others for the purposes of my health care, administration and management of my health care (including utilization review), or processing and obtaining payment for services and supplies rendered to me. I understand and agree that these authorizations specifically include my permission and consent to release any information regarding a diagnosis of AIDS or results of Human Immunodeficiency Virus (HIV) tests to the extent permitted by law. A photocopy of this authorization shall be as valid as the original.

All services are ordered by a Physician and will be provided under the supervision of a Registered Nurse or Qualified Therapist as mandated and defined in the Federal guidelines.

Anticipated services to be provided:

☐ SN _____

☐ MSW _____

☐ Hospice Aide _____

☐ Chaplain/Counselor _____

☐ Volunteer _____

☐ Therapy _____

I hereby authorize services to be provided by the Hospice to begin on _____(start of care date).

INFORMED CONSENT AND TREATMENT AUTHORIZATION

CLIENT AND/OR CAREGIVER ROLE IN THE PLAN OF CARE

I understand and accept the responsibility of participating and cooperating in my plan of care. I understand that we have the right to be informed in advance about the care to be furnished, the plan of care, expected outcomes, barriers to treatment, and of any changes in the care to be furnished. The Hospice IDT will advise and consult with me, and utilize my input when adjustments to the plan of care are made. I also understand that I have the right to refuse hospice care and services at any time. I understand that any barriers to treatment such as functional limitations or safety concerns will be identified in the formation of the plan of care. We accept the conditions of hospice as described, understanding that we may choose to discontinue the hospice program at any time, or that hospice may discharge us from the program if hospice care is no longer appropriate or for non-compliance with the IDT plan of care. I acknowledge that I have been made aware of the opportunity to attend the Interdisciplinary Team conference to discuss my plan of care and expected outcomes. I understand that the durable medical equipment necessary for pain and symptom control will be provided through contracted medical equipment companies as ordered by the physician in conjunction with the IDT. Hospice is supportive in nature and is not designed to take the place of the family or caregiver(s), and as such, I understand that charges for private and/or live-in caregivers, housekeeping, etc. are not covered by, or provided by Hospice. Should such services become necessary, and/or are requested, I understand I am responsible for payment.

MEDICARE SECONDARY PAYER QUESTIONNAIRE ☐ NOT APPLICABLE

1. Are you currently working full/part time? ☐Yes ☐No Is your spouse working full/part time? ☐Yes ☐No
2. Are you entitled to Black Lung medical benefits? ☐Yes ☐No
3. Is this service for treatment of a work-related injury/illness? ☐Yes ☐No; if YES, please provide the name and address of worker's compensation agency, insurance company, and your employer: _____
   _____
4. Is this service for treatment of an illness/injury, which resulted from an automobile or other accident? ☐Yes ☐No; if YES, please provide the name/address and policy number of the auto or non-auto liability or no-fault insurer:_____
5. Have you received a kidney transplant? ☐Yes ☐No; are you on dialysis? ☐Yes ☐No
6. Have you received maintenance dialysis treatments? ☐Yes ☐No
7. Do you have a fee service card from the Department of Veteran's Affairs? ☐Yes ☐No

Acknowledging and understanding the above, I elect the ☐Medicare Hospice Benefit ☐Medi-Cal Hospice Benefit

PATIENT IDENTIFICATION

Use two (2) of the patient identifiers upon admission and compare with the referral

☐ Ask the patient his/her name
☐ Obtain telephone number
☐ Date of Birth
☐ Social Security Number / Medicare Number
☐ Address
☐ Phone Number

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

Hospice services and the plan of care have been read and explained to me. I have been given ample opportunity to ask questions, and all of my questions have been answered to my satisfaction. I understand all the options available to me and after careful consideration and discussion regarding hospice care, I freely choose A1KARE HOSPICE AND PALLIATIVE CARE INC. to provide my hospice care. I acknowledge receipt of the following materials and information:

- ☐ Informed Consent and Treatment Authorization
- ☐ Medicare/Medicaid Hospice Benefit Election
- ☐ Client financial responsibility/insurance verification
- ☐ written material explaining Advance Directives, Durable Power of Attorney for Healthcare
- ☐ California Out of Hospital Do Not Resuscitate Orders (POLST)
- ☐ Information regarding the Grievance/Complaint procedure for the hospice
- ☐ California Department of Public Health (DPH) phone number for any concerns
- ☐ CDPH Complaints Line Information for any safety concerns.
- ☐ Patient/Family Bill of Rights and Responsibilities
- ☐ Information regarding company's policy for Abuse/Neglect/Exploitation
- ☐ Hospice's Notice of Privacy Practices
- ☐ Information on disposal of medications
- ☐ Information on disposal of sharps
- ☐ Information on hand hygiene, cough etiquette, oxygen home safety, flu program and fall prevention

Patient's Signature:		**Date:**
If Patient is unable to sign, state reason:		
Name & Signature of legally authorized representative (if applicable):		**Relationship:**
Employee: (Last, First)	Signature:	Discipline:
Patient Name: (Last, First)		MR #: