ADVANCE DIRECTIVES

Patient's Legal Name: ______________________ (Last) (First) (M.I.) Social Security #: __________

Address: ______________________ Street City State Zip Age: _____ Sex: _____ Phone: ( ) __________

PREFERRED INTENSITY OF CARE:

Hospitalization	☐ Yes ☐ No	Diagnostic Procedures	☐ Yes ☐ No	Antibiotics by Mouth	☐ Yes ☐ No
IV Fluids	☐ Yes ☐ No	Nasogastric Tube	☐ Yes ☐ No	Antibiotics by Feeding Tube	☐ Yes ☐ No
Lab Work	☐ Yes ☐ No	Gastrostomy Tube	☐ Yes ☐ No	Antibiotics by IV	☐ Yes ☐ No

DO NOT RESUSCITATE (DNR) FORM

PATIENT WITH DECISION-MAKING CAPACITY:

☐ If my heart stops beating or if I stop breathing, I hereby direct paramedics or other pre-hospital medical personnel who may be called to provide emergency care to me NOT to use cardiopulmonary resuscitation measures to restart or restore my heart or breathing functions. I have discussed this matter with my physician and I fully understand the implications of my decision, which I freely and voluntarily make. I understand I can change my mind and can revoke this directive at any time. I give permission for this directive to be given to pre-hospital care providers, doctors, nurses, and other health care personnel as necessary. I understand this directive will not prevent me from obtaining other necessary emergency medical care from pre-hospital care providers or other medical care directed by a physician.

☐ I want any/ all medical personnel to use resuscitation measures to restart or restore my heart or breathing functions.

______________ Patient's Signature ______________ Patient's Printed Name ___/___/___ Date

______________ Witness' Signature ______________ Witness' Printed Name ___/___/___ Date

IF THE PATIENT DOES NOT HAVE DECISION-MAKING CAPACITY, PATIENT'S LAWFUL SURROGATE MUST COMPLETE THE FOLLOWING:

PATIENT LAWFUL SURROGATE DECISION MAKER:

☐ As the above named patient's lawful surrogate for making health care decisions, including the withholding of life support when appropriate, I hereby direct paramedics, or other pre-hospital medical personnel who may be called to provide emergency care to the patient, NOT to use cardiopulmonary resuscitation or other resuscitative measures to restart or restore the patient's heart or breathing functions. I have discussed this matter with the patient's physician and I fully understand the implications of my decision, which I freely and voluntarily make. My decision is based upon either my understanding of the patient's previously expressed preferences, or what perceive to be the patient's interests or both. I understand I can change my mind and can revoke this directive at any time. On behalf of the patient, I give permission for this directive to be given to pre-hospital care providers, doctors, nurses, and other health personnel as necessary. I understand this directive will not prevent the patient from obtaining other necessary emergency medical care from pre-hospital care providers or other needed medical care directed by a physician.

☐ I want any/all medical personnel to use resuscitation measures to restart or restore the patient's heart or breathing functions.

______________ Surrogate's Signature ______________ Surrogate's Printed Name ___/___/___ Date

______________ Witness' Signature ______________ Witness' Printed Name ___/___/___ Date

Surrogate's Address: ______________________ Surrogate's Phone # ( ) __________

COMPLETION OF PHYSICIAN STATEMENT BELOW IS MANDATORY FOR HOSPICE CARE PERSONNEL TO FOLLOW THIS DNR DIRECTIVE:

PATIENT'S PHYSICIAN: *(Please Sign, retain pink copy for your record, and return signed original, ASAP)*

I hereby affirm that this directive is the expressed wish of the patient or the patient's lawful surrogate, is medically appropriate, and is documented in the patient's permanent medical record. If this directive has been executed by the patient's lawful surrogate, I have confirmed that the surrogate is legally authorized to so act on the patient's behalf. If this directive has been executed by the patient, I have confirmed that the patient was legally competent at the time to do so. This patient is: ☐ to receive ☐ not to receive

Cardiopulmonary resuscitation or other resuscitative measures from paramedics or other pre-hospital care providers.

______________ Physician's Signature ___/___/___ Date Phone #: ( ) __________

Print Name of Physician: ______________________ Cal. License #: __________

Address: ______________________

WHITE – Chart PINK – Patient YELLOW - Physician

HOSPICE CARE OF THE VALLEY, INC.

INFORMED CONSENT AND TREATMENT AUTHORIZATION

This agreement is entered into by and between HOSPICE CARE OF THE VALLEY, 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 admissions to HOSPICE CARE OF THE VALLEY, INC. and understand and agree to the following conditions:

I understand that the Hospice program is palliative, not curative, in its 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 that 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 patin. 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 of Care Center Staff.

I accept the conditions of HOSPICE CARE OF THE VALLEY, INC. as described, understanding that we 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 no further liability to me or to HOSPICE CARE OF THE VALLEY, 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 the 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 treatment of the terminal illness. The Patient and/or Patient's agent assumes financial responsibility for all other authorized charges. The agency in accordance with this agreement shall assists the 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 prescriptions drugs may select a drug product that is generally equivalent to the brand prescribed by my physician, unless I submit to Hospice a written request for a brand 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, the Agency determines there is no longer any reasonable expectation that it can meet the Patient/Family's needs.

PATIENT: ______________________________
(Last) (First)

MEDICARE/MEDI-CAL HOSPICE BENEFIT ELECTION

As a Medicare Part A or Medi-Cal beneficiary, I hereby elect **HOSPICE CARE OF THE VALLEY, INC.** as my sole provider of hospice care election (date)__________________________.

I understand the hospice program to be palliative, not curative, in its goals and treatment, which 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/Medi-Cal will make payments for care related to this illness on to my attending physician and to **HOSPICE CARE OF THE VALLEY, 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/Medi-Cal unless specifically ordered and authorized by **HOSPICE CARE OF THE VALLEY, INC.**. I understand the services not related to this illness will continue to be covered by Medicare/Medi-Cal along with hospice benefits.

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 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/Medi-Cal Hospice Benefit, I am entitled to hospice care, which consists of two 90-day periods and subsequent 60-day periods of unlimited duration. 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 **HOSPICE CARE OF THE VALLEY, INC.** prior to that date. This revocation constitutes a waiver of the right to hospice care during the remainder of the current election period.

I understand that once in each election period I may elect to receive services through a hospice program other than **HOSPICE CARE OF THE VALLEY, INC.**. Such change shall not be considered a revocation of hospice services.

PATIENT: ____

(Last) (First)

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

As a HOSPICE CARE OF THE VALLEY, INC. patient, you have the right to:

1. Be informed of your rights in a manner which you understand.
2. Be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.
3. Receive quality end-of-life care.
4. Be informed of the provisions of the law pertaining to advanced directives, including but not limited to living wills, power of attorney for health care, withdrawal or withholding of treatment and/or life support.
5. Voice concerns and not be discriminated against for doing so.
6. Receive effective pain management and symptom control for the hospice conditions related to the terminal illness.
7. Be involved in developing your hospice plan of caré.
8. Refuse care or treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
9. Choose your own attending physician.
10. 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.
11. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property.
12. Receive information about the services covered under the hospice benefit, and by what discipline, e.g., registered nurse, counselor, chaplain, etc.
13. Receive information about the scope of services that the hospice will provide and specific limitations on those services.
14. 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.
15. 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.
16. Make informed decisions regarding proposed and ongoing care and services.
17. Keep and use personal clothing and possessions.
18. Choose whether or not to participate in research, investigational or experimental studies, or clinical trials.
19. Be advised in advance of any change in treatment, care, or services.
20. Be informed by the licensee of the provisions of the law regarding complaints and procedures for registering complaints confidentially including but not limited to, the address and telephone number of the local District office of the Department of Health Services.
21. Be assured the personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.

If you have any questions about your rights, please call the Hospice toll-free number at 1-800-923-9638.

Patient Responsibilities

As a HOSPICE CARE OF THE VALLEY, INC. patient, you have the responsibility to:

1. Remain under a doctor's care while receiving agency services.
2. Provide the agency with a complete and accurate health history to the best of your ability.
3. Participate in the plan of care.
4. Ask questions.
5. Follow instructions, rules and regulations.
6. Accept the consequences for any refusal of treatment or choice of noncompliance.
7. Provide a safe home environment in which your care can be given.
8. Show respect and consideration.
9. Cooperate with your doctor, agency staff and other caregivers.
10. Treat agency personnel with respect and consideration.
11. Advise the agency of any problems or dissatisfaction with our care, without being subject to discrimination or reprisal.
12. Provide the agency all requested insurance and financial records and meet financial commitments.
13. Sign the required consents and release for insurance billing.
14. Notify the agency when unable to keep appointments.
15. Provide a copy of an advance directive, if one exists.
16. Notify the agency, with a minimum of 24 hours if possible, of any changes of residence.

Procedures for Making Complaints

If you have any complaints regarding the services you have received from HOSPICE CARE OF THE VALLEY, INC., the Department of Health Services operates a 24-hour, toll-free hotline that you may contact at any time:

1-800-554-0348

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
100 Paseo de San Antonio Suite 235
San Jose, CA 95113

HOSPICE CARE OF THE VALLEY, INC. is an affirmative action/equal opportunity employer and does not discriminate on the basis of race, color, national origin, religion, sex, handicap or age.

I have received a copy of the notice of patient rights and responsibilities.

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

PRINTED NAME OF PATIENT OR REPRESENTATIVE

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.
- ☐ The terms of any Advance Direcive 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:

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

Name and Address of Agent:

____

____

Copy received: ☐ Yes ☐ No

☐ The patient does not have an Advance Directive.

RELEASE OF PATIENT RECORDS

I understand that HOSPICE CARE OF THE VALLEY, 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 HOSPICE CARE OF THE VALLEY, INC. and its representatives medical records and related information necessary to be helpful to the provision of hospice care. I also authorize HOSPICE CARE OF THE VALLEY, 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 extend permitted by law. A photocopy of this authorization shall be as valid as the original.

RECEIPT OF INFORMATION

Hospice services have been explained to me; I have been given the opportunity to ask any questions I have concerning the hospice program of care, and my questions have been answered to my satisfaction. We have been provided the following materials:

- A copy of Patient's Rights
- Written materials explaining a patient's legal rights to accept or refuse medical treatments and to prepare an advance directive for health care.
- HIPAA (Notice of Privacy Practices)

ACKNOWLEDGEMENT

I acknowledge and agree to the terms and conditions described in the following documents:

☐ Informed Consent and Treatment Authorization ☐ Financial Agreement
☐ Medicare/Medi-Cal Hospice Benefit Election ☐ Advance Directives

______________________________________ ____________
SIGNATURE OF PATIENT DATE

IF PATIENT UNABLE TO SIGN, STATE REASON:____________________________________

X______________________________________ ____________
SIGNATURE OF REPRESENTATIVE DATE

X____
NAME AND ADDRESS OF REPRESENTATIVE (Print)

The foregoing was read, discussed, and signed in my presence

____
SIGNATURE OF HOSPICE CARE OF THE VALLEY, INC. REPRESENTATIVE DATE

PATIENT:____
(Last) (First)