All Care
All Care Health Solutions
Hospice & Palliative Care
815 S Bridgeway Place, Suite 122
Eagle, ID 83616
P-208.473.2717 / F 208.473.2451

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Hospice Election of Benefits

I _____ choose to elect the Medicare hospice benefit and receive Hospice services from ALL CARE HOSPICE & PALLIATIVE CARE to begin on _____.
(Effective Date of Election)

Note: The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.

Right to choose an attending physician

I understand that I have a right to choose my attending physician to oversee my care. My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician

☐ I acknowledge that my choice for an attending physician is:

Physician Full name: DR. JASON LUDWIG, D.O. NPI: 1144258534

Office Address: 4740 N PENNGROVE WAY, #100. MERIDIAN, ID 83646

Hospice Philosophy and Coverage of Hospice Care

By electing hospice care under the Medicare hospice benefit, I acknowledge that:

- I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.
- I was provided information on which items, services, and drugs the hospice will cover and furnish upon my election to receive hospice care.
- I was provided with information about potential cost-sharing for certain hospice services, if applicable.
- I understand that by electing hospice care under the Medicare hospice benefit, I waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.
- I understand that items, services, and drugs unrelated to my terminal illness and related conditions are exceptional and unusual and, in general, the hospice will be providing virtually all of my care while I am under a hospice election. The items, services, and drugs determined to be unrelated to my terminal illness and related conditions continue to be eligible for coverage by Medicare under separate benefits.

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Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs

- As a Medicare beneficiary who elects to receive hospice care, you have the right to request at any time, in writing, the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"** addendum that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice.
- The hospice must furnish this notification within 5 days, if you request this form on the start of care date, and within 72 hours (or 3 days) if you request this form during the course of hospice care.

Beneficiary and Family Centered Care Quality Improvement Organization Contact Information

As a Medicare hospice beneficiary, you have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice's determinations. The BFCC-QIO that services your area is:

Idaho: Kepro 888-317-0891

☐ I elect to receive the "**Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**

(**Hospice**: Please provide the beneficiary with the addendum. Must be signed and dated accompanying the election statement.)

☐ I decline to receive the "**Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**

_____ _____

Signature of Beneficiary/Representative **(Date Signed)**

☐ Beneficiary is unable to sign -Reason: _____

_____ _____

Signature of All Care Representative **(Date Signed)**

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Patient Notification of Hospice Non-Covered Items, Services, and Drugs

☐ Elected to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

☐ Declined to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

Date of Request: _____ **Date Furnished**: _____

(Hospice must furnish this addendum within 5 days if requested at the time of hospice election and within 72 hours if requested during the course of hospice care.

Diagnoses Related to Terminal Illness and Related Conditions (hospice is responsible to cover all items, services, and drugs):

1.	**4.**
2.	**5.**
3.	**6.**

Diagnosis Unrelated to Terminal Illness and Related Conditions:

1.	**4.**
2.	**5.**
3.	**6.**

Non-covered items, services, and drugs determined by hospice as not related to my terminal illness and related conditions:

Items/Services/Drugs	Reason for Non-coverage

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Note: The hospice makes the decision as to whether or not conditions, items, services, and drugs are related for each beneficiary. This addendum should be shared with other health care providers from which you seek item, services, or drugs, unrelated to your terminal illness and related conditions to assist in making treatment decisions.

Right to Immediate Advocacy

As a Medicare beneficiary you have the right to appeal the decision of the hospice agency on items not being covered because the hospice has determined they are unrelated to the individual's terminal illness and related conditions. You have the right to contact the Medicare Beneficiary and Family Centered-Quality Improvement Organization (BFCC-QIO) for immediate assistance. Visit this website to find the BFCC-QIO for your area. https://quiprogram.org/contact-zones or call 1-800-MEIDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Acknowledgement of non-covered items, services, and drugs not related to my terminal illness and related conditions

The purpose of this addendum is to notify beneficiary (or representative), in writing, of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the individual's terminal illness and related conditions. I acknowledge that I have been given a full explanation and have an understanding of the list of items, services and drugs not related to my terminal illness and related conditions not being covered by hospice. Signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessarily agreement with the hospice's determinations.

_____ _____

Signature of Beneficiary/Representative **Date**

_____ _____

Signature of All Care Representative **Date**

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Authorization for Release of Medical Information

Patient: _____

Date of Birth: _____

To: _____

You are hereby authorized and requested to furnish to All Care Hospice & Palliative Care, or their representative, all of my medical and drug records including:

- ▶ History and Physical Exam
- ▶ Progress Notes
- ▶ Clinical Summary
- ▶ Physician's Notes
- ▶ Consultation Reports
- ▶ Laboratory Reports
- ▶ Operative Reports
- ▶ Nurse's Notes
- ▶ Pathology Reports
- ▶ Outpatient Information
- ▶ X-Ray Reports
- ▶ Other (Specify):

I also hereby give consent to All Care Hospice & Palliative Care to make copies of said records for the purpose of coordinating and providing my medical care.

This authorization will remain in effect a maximum of six months from the date of signature and may be canceled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.

The following email address can be used to inform, update or coordinate care with myself, family, or care providers.

Email address: _____

_____ _____

Patient/Representative Signature **Date**

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

911/Emergency Services Notice to Protect You

It is an honor to care for you, or your loved one during this difficult time. We would like to take a moment to explain the Medicare/Medicaid hospice benefit and what it covers in terms of emergency/ urgent care services.

Once a person chooses to receive hospice care, they enable the hospice benefit election. Part of that benefit is that a patient chooses not to receive curative treatment for their terminal diagnosis. A patient can still call 911 or go to the emergency room for injuries/illnesses that are not related to their terminal diagnosis. However, the hospice agency must be aware of all treatments and services the patient is going to receive prior to receiving care. Hospice can provide most services and treatments, so contact hospice prior to calling 911.

If you or your loved one wish to enable 911 or emergency services, the hospice agency must first obtain a revocation notice from you.

By signing below, you acknowledge that you must sign a revocation notice prior to obtaining any other medical interventions such as emergency services or calling 911. This will enable you to use those services and they will get billed to your insurance instead of you. In the event that you don't sign the revocation form before seeking treatment, the hospital and/or emergency services can bill you for the services instead of your insurance.

Your signature on the affirmations page acknowledges you have received and fully understand All Care Hospice & Palliative Care's explanation of the Medicare/Medicaid Hospice Benefit as it applies to emergency and urgent care services.

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Consent for Primary Caregiver

I, _____ agree to accept the role of primary caregiver(s)

caregiver(s) for _____ who is requesting admission into All Care Hospice & Palliative Care program of care. The commitment and responsibilities of this role and of hospice care/services are described below:

1. I understand the goal of hospice is not to cure the terminal illness but to provide symptom relief and supportive care in this final phase of life.
2. I understand the hospice interdisciplinary team will provide education, training, and support in the management of the patient's physical, emotional, psychosocial, and spiritual needs.
3. I understand the hospice staff will provide emotional, psychosocial, and spiritual support to help me cope with my caregiver responsibilities, the eventual patient's death, and my bereavement.
4. I understand that in my role as a primary caregiver, I will be responsible for meeting or arranging for the patient's 24 hours a day care needs. I will arrange for care in my absence.
5. I understand the hospice medical record will contain information about me. Every effort will be made to keep this information confidential. I authorize this information to be released to the attending physician and other appropriate healthcare providers for the patient's care. I also authorize the release of this information, as needed, to process insurance claims.
6. I understand hospice services are primarily provided on a prearranged, appointment basis, but crisis or consultation assistance with hospice is available 24 hours a day, 7 days a week. I will consult hospice in case of any emergency.
7. I understand to receive full benefits of hospice care it is important for me and the patient to make our needs and concerns known to the hospice interdisciplinary team and to participate in the planning for care.
8. I understand I may choose to change my mind about this method of care and withdraw from this primary caregiver agreement. However, I agree not to do so without giving advance notice to the patient and hospice, so another primary caregiver can be arranged for.
9. I have received the Patient/Family Orientation for Hospice Care Packet. At this time, I believe I understand the responsibility of being primary caregiver, the nature of the patient's illness, and the goal of hospice care. My questions about the hospice program have been answered to my satisfaction by the hospice staff.

Your signature on this page acknowledges you have received and fully understand All Care Hospice & Palliative Care's Consent for Primary Caregiver as well as the role and responsibilities of the primary caregiver.

Printed Caregiver Name(s): _____

Signature: _____ **Date:** _____

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

To :

All Care Hospice & Palliative Care is participating in a national survey to provide the United States Department of Health and Human Services with information about the quality of health care delivered to people in their homes. You may be selected to take part in this important telephone interview. We have partnered with **Pinnacle Quality Insight** to contact you **via telephone** to complete this interview. Phone calls from Pinnacle Quality Insight will appear on your caller ID as being from a toll-free area code.

The number that will appear on your caller ID is 1-888-444-9961

This will help you know when Pinnacle might be calling, so that you will feel safe to answer. Please keep this in mind so that you do not miss this survey opportunity.

The interviewer will ask for your opinions about the hospice care your loved one received. We hope that you will take a few minutes to go through this important call. The survey is designed to measure caregiver's perspectives on hospice care for public reporting. The data collected from the survey will be provided to consumers to help them make informed choices when selecting a hospice. It will also be used to help improve the quality of care provided by hospices. *Your participation is important.*

It is important that your answers reflect your own opinions about the Hospice care your loved one received, so please do **not** ask anyone from this Hospice Agency for help completing the survey.

All information you give in this survey will be held in confidence and is protected by the Privacy Act. Your name will not be attached to the publicized results.

If you have any questions about the survey, please contact Pinnacle Quality Insight at 1-888-444-9961.

Thank you in advance for your participation.

Sincerely,

Angela Hilleshiem
All Care Hospice & Palliative Care
Administrator

GIVE US A 10!

HOSPICE CUSTOMER SATISFACTION SURVEY

Communication with family

Family caregivers reported how often the hospice team:

- Kept them informed about when they would arrive to care for their family member
- Explained things in a way that was easy to understand
- Listened carefully to them when they talked about problems with their family member's hospice care
- Kept them informed about the family member's condition
- Listened carefully to them
- Gave them confusing or contradictory information about their family member's condition or care

---

Getting timely help

Family caregivers reported how often:

- They got help as soon as they needed it, when they asked the hospice team for help
- They got the help they needed from the hospice team during evenings, weekends, or holidays

---

Treating patient with respect

Family caregivers reported how often:

- The hospice team treated their family member with dignity and respect
- They felt the hospice team really cared about their family member

---

Emotional and spiritual support

Family caregivers reported about how much:

- Emotional support they got from the hospice team while their family member was in hospice care
- Emotional support they got from the hospice team in the weeks after their family member died
- Support they got for their religious or spiritual beliefs

Help for pain and symptoms	**Family caregivers reported whether their family member got as much help with pain as needed, and how often their family member got needed help for:** · Pain · Trouble breathing · Trouble with constipation · Feelings of anxiety or sadness
Training family to care for patient	**Family caregivers reported whether the hospice team gave them the training they needed about:** · Side effects to watch for from pain medicine · If and when to give more pain medicine · How to help if their family member had trouble breathing · How to help of their family member became restless or agitated
Rating of this hospice	**Family caregivers rated this agency on a scale of 0 (worst possible) to 10 (best possible)**
Willing to recommend this hospice	**Family caregivers reported how likely they would be to recommend this agency to other friends or family**

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Today's Date: _____

Insurance and Billing

Check all insurance sources the patient currently has:
☐ Medicare ☐ Medicaid ☐ Private Insurance

Information listed below should be copied directly from the patients Medicare card. Name of Beneficiary: _____ Medicare Claim #: _____

To be completed by admission discipline:

YES	NO	
☐	☐	Is the patient now or ever been a participant in the Hospice program?
☐	☐	Was illness/injury due to a work related accident covered by Workers Comp or Black Lung?
☐	☐	Was illness/injury due to a Non-Work related accident?
☐	☐	Is the patient on kidney dialysis for End Stage Renal Disease?
☐	☐	Is the patient covered under a Group Health Plan by their employer or spouse's employer?
☐	☐	Is the patient currently working full or part-time?
☐	☐	Is the patient a disabled Medicare Beneficiary under the age of 65?
☐	☐	Is the patient's spouse employed and under the age of 70?

Patient's Medicaid ID Number: _____ ☐ Number unknown follow up needed
☐ Patient has applied for Medicaid and is pending

Contact All Care Hospice & Palliative Care billing office prior to admitting HMO patient

Medicaid HMO: _____
Name of Insurance: _____ **Customer Service Phone #:** _____
Insured's Name: _____ **Relationship to Patient:** _____
Insured's DOB: _____ **Insured's Social Security Number:** _____
Insured's Employer: _____ **Employer's phone:** _____

Skilled Nursing Facility Only ☑ N/A

Effective Date: _____ ☐ Admission ☐ Change **Facility:** _____

Facility billing office informed of hospice admission/change. Notified:

Room and Board will be paid by:

☐ Patient/family will be responsible (facility to bill patient)
☐ Patient is on skilled days under a diagnosis other than the hospice admission diagnosis. (Contact hospice prior to admit)
☐ All Care Hospice & Palliative Care will be responsible while the patient is on in-patient level of care
☐ Medicaid (facility to bill hospice)

Level of Hospice Care:

☐ Routine
☐ Inpatient
☐ Respite
☐ Continuous Care

Your signature on the affirmations page acknowledges you have received, answered correctly, and fully understand All Care Hospice & Palliative Care's Hospice Insurance Benefit Form.

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Hospice Services Disclosure Form

Required Services Covered by the Medicare Hospice Benefit

All of the following services are required and covered *if they are needed to palliate the symptoms of a terminal diagnosis* and are included in the patient's Plan of Care.

- Medicines, medical supplies, and durable medical equipment (hospital bed, walker, etc.)
- Laboratory services
- X-ray and radiation therapy
- Emergency services
- Ambulance and transport services
- Short-term inpatient stays in a hospice facility, hospital, or skilled care facility for management of acute symptoms
- Short-term continuous nursing care in the home for crisis care of acute symptoms that can be managed at home with extra support from the hospice team.
- Five-day inpatient respite periods when caretakers require a break from care giving responsibilities
- Bereavement support and counseling services
- Use of an interdisciplinary team
  - Medical supervision and physician services
  - Individual case management and coordination of care by a registered nurse
  - Intermittent nursing visits
  - Social work services
  - Pastoral counseling and spiritual support provided or coordinated by a hospice chaplain
  - Home health aide and homemaker services
  - Volunteer services
  - Dietary counseling and physical, occupational, speech, and respiratory therapy services as appropriate

Medicare Hospice Levels of Care

☐ **Routine Home Care** is provided in a patient's residence or a nursing facility if they reside there.

☐ **Continuous Care** is used to provide intensive care for short periods of time to manage a crisis situation. At least 8 hours of direct one on-one care must be required during a 24-hour period, and at least half of that care must be provided by a licensed nurse.

☐ **Inpatient Care:** For the control of acute pain or symptoms that cannot be adequately managed in the home, short-term care is provided in a hospital or skilled nursing facility.

☐ **Respite Care** is provided in a hospital or skilled nursing home to allow the patient's primary care giver a rest. Up to 5 days of respite care are allowed at a time.

Special Services

I understand that if I need hospitalization or special services not provided by hospice, I or my legal representative must make arrangements for these services. The hospice shall in no way be responsible for failure to provide the same and is hereby released from any liability arising from the fact that I am not provided with such additional care.

I have read and understood the services provided by All Care Hospice & Palliative Care and the four levels of care as outlined above. I have also received a copy of this form.

Your signature on the affirmations page acknowledges you have received and fully understand All Care Hospice & Palliative Care's Hospice Services Disclosure Form.

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Medicare Benefit Recipients: The patient understands that application for payment under Title XVIII of the Social Security Act may be made and that information must be provided by the patient in order to receive such payment. The patient hereby certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. The patient hereby requests payment of authorized Medicare benefits are to be made on the patient's behalf.

Initials

_____ **1.** All Care Hospice & Palliative Care will receive payment for my care, relating to my terminal illness. Medicare will continue to make payment to my attending physician for services if my physician is neither a hospice employee nor receiving payments from All Care Hospice & Palliative Care. If my physician is a hospice employee, All Care Hospice & Palliative Care will bill Medicare for visits to my physician. I understand that I have the right to seek treatment or therapy for any condition **unrelated** to my terminal illness in the normal manner. Any such care is **not** reimbursed by All Care Hospice & Palliative Care.

_____ **2.** I accept Medicare benefits related to my terminal illness while enrolled in the Medicare Hospice program. I understand that I must have prior approval from hospice before ordering or receiving treatments, supplies, equipment, or any other service related to my terminal illness. I understand that if I fail to get pre-authorization from All Care Hospice & Palliative Care for any services, treatments, supplies, equipment, etc., related to my illness, I may be financially responsible for charges incurred.

_____ **3.** The Medicare hospice program is divided into benefit periods consisting of two 90-day periods and unlimited 60-day periods. I must use the benefits periods in the above order. I may discontinue hospice care at any time by completing a revocation statement. If I revoke during a benefit period, I lose the remaining days in that benefit period. I have the option of changing to another hospice once per benefit period.

_____ **4.** I acknowledge that I have been given a copy of the Patient's Rights and Responsibilities and Notice of Hospice Privacy Practices.

_____ **5.** As a Medicare recipient, I understand the above and authorize hospice Medicare services from All Care Hospice & Palliative Care by signing below.

Certification: The undersigned hereby certifies that he or she has read the foregoing, received a copy thereof, and is the patient or is the duly authorized patient's agent/representative authorized by the patient to execute the above and accept its terms.

I consent for hospice care to begin on: _____ Benefit Period Elected: ☐ 1 ☐ 2 ☐ 3 ☐ 4

I designate Dr. JASON LUDWIG DO, NPI: BL6950136 _____ as my attending physician.

Your signature on the affirmations page acknowledges you have received and fully understand All Care Hospice & Palliative Care's Hospice Benefit Authorization.

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Date of Birth: _____

Today's Date: _____

Medicare Secondary Payer Worksheet

Section A

1. **Are you receiving Black Lung (BL) Benefits?**
   - ☐ Yes. Date benefits began: _____
   - ☑ No. Go to 2.

   BL is Primary Only for Claims Related to BL.
2. **Are the services to be paid by a government program such as a research grant?**
   - ☐ Yes. Government program will be primary.
   - ☑ No. Go to 3.
3. **Has the Department of Veterans Affairs (DVA) authorized to pay for care at this facility?**
   - ☐ Yes. DVA is primary.
   - ☑ No. Go to 4.
4. **Was the illness/injury due to a work related accident or condition?**
   - ☐ Yes. Date of injury/illness: _____

   Complete Payer Info. Workers Comp. is primary payer only for claims related to the injury/illness that is work related.
   - ☑ No. Go to Section B.

Section B

1. **Was the illness/injury due to non-work related accident?**
   - ☐ Yes. Date of accident: _____
   - ☑ No. Go to Section C.
2. **What type of accident caused the illness/injury?**
   - ☐ Automobile
   - ☐ Non-Automobile

   Complete Payer Info. No Fault-Insurer is Primary Payer. Only for those claims related to the accident. Go to Section C.
   - ☐ Other: _____
3. **Was another party responsible for this accident?**
   - ☐ Yes. ***Complete payer info.*** Liability Insurer is primary only for those claims related to the accident.
   - ☐ No. Go Section C.

Section C

1. **Are you entitled to Medicare based on:**
   - ☑ Age. Go to Section D.
   - ☐ ESRD. Go to Section F.
   - ☐ Disability. Go to Section E.

Section D - Age

1. **Are you currently employed?**
   - ☐ Yes. ***Complete Payer Info.***
   - ☐ No. Never employed.
   - ☑ No. Date of Retirement: _____
2. **Is your spouse currently employed?**
   - ☐ Yes. ***Complete Payer Info.***
   - ☐ No. Never employed.
   - ☑ No. Date of Retirement: _____

   If the patient answered "No" to both questions 1 and 2, Medicare is primary. Do not proceed any further.
3. **Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?**
   - ☐ Yes.
   - ☐ No. Stop

   Medicare is primary unless the patient answered "Yes" to the questions in Sections A or B.
4. **Does the employer that sponsors your GHP employ 20 or more employees?**
   - ☐ Yes. Stop. GHP is primary. ***Complete payer info.***
   - ☐ No. Stop

   Medicare is primary unless the patient answered "Yes" to the questions in Sections A or B.

Section E - Disability

1. **Are you currently employed?**
   - ☐ Yes. ***Complete Payer Info.***
   - ☐ No. Never employed.
   - ☐ No. Date of Retirement: _____

Section E - Disability (cont.)

2. **Is your spouse currently employed?**
   - ☐ Yes. ***Complete Payer Info.***
   - ☐ No. Never employed.
   - ☐ No. Date of Retirement: _____

   If the patient answered "No" to both questions 1 and 2, Medicare is primary. Do not proceed any further.
3. **Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?**
   - ☐ Yes.
   - ☐ No. Stop, Medicare is primary.
4. **Are you covered under the GHP of a family member other than your spouse?**
   - ☐ Yes. ***Complete payer info.***
   - ☐ No.
5. **Does the employer that sponsors the GHP employ 100 or more employees?**
   - ☐ Yes. Stop, GHP is primary. ***Complete payer info.***
   - ☐ No. Stop, Medicare is primary.

Section F - ESRD

1. **Do you have GHP coverage?**
   - ☐ Yes. ***Complete Payer Info.***
   - ☐ No. Stop, Medicare is primary.
2. **Have you received a kidney transplant?**
   - ☐ Yes. Date of Transplant: _____
   - ☐ No.
3. **Have you received maintenance dialysis treatments?**
   - ☐ Yes. Date Began: _____

     If you participated in a self-dialysis training program, provide date training started: _____
   - ☐ No.
4. **Are you within the 30-month coordination period that starts _____? (The coordination period-CP - starts the first day of the month an individual is eligible for Medicare, even if not yet enrolled. If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the coordination period starts with the first day of the month of dialysis or kidney transplant.)**
   - ☐ Yes.
   - ☐ No. Stop, Medicare is primary.
5. **Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?**
   - ☐ Yes.
   - ☐ No.
6. **Was your entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?**
   - ☐ Yes. Stop, GHP is primary through 30M CP.
   - ☐ No. Initial entitlement based on age or disability.
7. **Does the working age or disability MSP provision apply? (Is the GHP primarily based on age or disability entitlement)**
   - ☐ Yes. GHP is primary through 30M CP.
   - ☐ No. Medicare is primary.

Primary Payer Information

Employer (Patient): _____
Address: _____
Employer (Spouse): _____
Address: _____
Insurer/GHP: _____
Address: _____
Policy ID Number: _____
Group ID Number: _____
Membership Number: _____
Name of Policy Holder: _____
Relationship to Patient: _____

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Payment Responsibility: The patient and/or the patient's authorized agent have full responsibility for the payment of all fees and charges in accordance with All Care Hospice & Palliative Care's fee schedule. It is understood that for hospice patients, All Care Hospice & Palliative Care 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 unauthorized charges. All Care Hospice & Palliative Care, in accordance with this agreement, shall assist the patient in obtaining financial assistance from third-party payers, such as Medicare, Medicaid and private insurers.

Rates: Should a patient choose to receive care from All Care Hospice & Palliative Care without having Medicare, Medicaid, other private insurance, or third party payer source, the following rates will apply:

Routine Home Care: $166/Day **Inpatient Care:** $704/Day
Continuous Care: $48/Hour **Respite Care:** $171/Day
If your ability to pay changes after you are on hospice, you will not be removed from hospice care due to inability to pay.

Agency Choice: Medicare/Medicaid hospice care is a Medicare or Medicaid benefit. As such, patients can choose what hospice agency provides their hospice care. By signing below, I confirm that I am aware that I have a choice over which agency provides my hospice care and I have chosen All Care Hospice & Palliative Care of my own free will. If at any time I wish to discontinue care with All Care Hospice & Palliative Care, I or my legal representative must contact All Care Hospice & Palliative Care at (208) 473-2717 to cancel.

Advance Directives: I have been made aware of my right to make health care decisions for myself. I am also aware that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself. I have a:

☐ **Living Will** ☐ **Durable Power of Attorney for Health Care**
☐ **POST Form** ☐ **N/A**

Consent to Film/Record: I hereby consent for the agency to record or film my care, treatment, and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition, or for insurance providers to document my condition for payment purposes.

Frequencies: You are receiving the following care at the following daily/weekly/monthly frequencies. If there is a change in any of these services or frequencies, they will be communicated to you:

Skilled Nursing: 1-2 Times Per Week; 1-2 Additional As Needed
Aide: _____
Social Worker: EVAL
Spiritual Care: EVAL
Volunteer: EVAL

Non-Discrimination: All Care Hospice & Palliative Care does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, publication in its programs, services, activities, or in employment. For further information about this policy, contact the All Care Hospice & Palliative Care Administrator at **(208) 473-2717.**

Administrator: Angela Hilleshiem, RN
Director of Nursing: Allison Ashford, RN
Assistant Administrator: Lance, Robinson, RN

All Care
All Care Health Solutions
Hospice & Palliative Care
815 S Bridgeway Place, Suite 122
Eagle, ID 83616
P-208.473.2717 / F 208.473.2451

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Family/Friend Contact List

Patient: _____ **Date of Birth:** _____

Contact: _____ **Phone:** _____ **Relationship:** _____

EmailAddress: _____

Address: _____

Contact: _____ **Phone:** _____ **Relationship:** _____

EmailAddress: _____

Address: _____

Contact: _____ **Phone:** _____ **Relationship:** _____

EmailAddress: _____

Address: _____

Contact: _____ **Phone:** _____ **Relationship:** _____

EmailAddress: _____

Address: _____

Contact: _____ **Phone:** _____ **Relationship:** _____

EmailAddress: _____

Address: _____

All Care
All Care Health Solutions
Hospice & Palliative Care
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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Are you on life support equipment? ☐ Yes ☐ No

Do you require special transportation or equipment to leave the ☐ Yes ☐ No

If yes: what is needed: ☐ Wheelchair ☐ Van ☐ Ambulance ☐ Hoyer Lift ☐ Other:
Please mark all that apply to your patient.

Medical Suppliers:

☐ Norco 208-344-0299 ☐ Procare 208-322-5055 ☐ Bennett 208-327-8888 ☐ Adderson 208-895-0033 ☐ Medeco 208-429-1138 ☐ Other:_____

Utilities:

☐ Idaho Power 800-488-6151

☐ Utah Electric 801-998-2527

☐ Intermountain Gas 208-377-6840

Police/Fire/EMS-911

Physician Name: JASON LUDWIG **Phone:** (208)938-3663
Pharmacy Name: MOUNTAIN CARE PHARMACY **Phone:** (208)287-4667
Neighbor Name: **Phone:**

American Red Cross
208-947-4357

Emergency Management Offices: Contact emergency officials in the event of an emergency requiring assistance such as:

☐ Ada County 208-577-3000

☐ Canyon County 208-454-7271

☐ Payette County 208-642-6000

Listen to local radio stations (WXK68 162.5 Ada/Canyon WXK88 162.4 Payette) for emergency broadcast announcements.

Creating a disaster plan and practicing it are your responsibility, keep it simple but be sure it will meet your needs.

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Oxygen Use Waiver

To : _____ Date : _____

As our patient, we want to make sure that you get the education, tools, and training you need to remain safely in your home. If you use oxygen, the following conditions can put you at risk. Please ask questions or state your concerns should you have any at any time.

- ☐ Being a smoker and having oxygen in your home
- ☐ Smoking while using oxygen
- ☐ Others around you smoke while you are using oxygen
- ☐ The presence of candles, fireplace, wood burning stove, oven, and/or barbeque
- ☐ N/A

This is a very serious concern as your personal well-being and safety are of the utmost importance to us. The purpose of this letter is to stress how important it is to follow All Care Hospice & Palliative Care's well-defined safety precautions.

The All Care Hospice & Palliative Care Patient/Family Orientation for Hospice Care binder refers to fire safety and oxygen use precautions. Oxygen greatly enhances combustion and is therefore a primary safety concern while you are on oxygen. Please see Section 6: Safety in the Patient/Family Orientation for Hospice Care binder for further information. Fire *Safety/Burn Precautions* starts on page 24 and continues through page 25. Specific Oxygen Safety is on page 28.

Your signature on the affirmations page acknowledges you have received and fully understand All Care Hospice & Palliative Care's Oxygen Safety and Fire Precaution Recommendations. Your signature also indicates you will follow the recommendations as set forth in the Patient/Family Orientation Binder for Hospice Care. Failure to do so may lead to serious injury, up to and including death. The patient assumes responsibility for any injury incurred by failure to follow this policy.

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

TB SCREENING UPON ADMISSION

1. Have you had a cough for two or more weeks duration?	☐ Yes	☐ No
2. Has your cough been productive of sputum	☐ Yes	☐ No
Is it blood stained?	☐ Yes	☐ No
3. Have you had:		
Fever	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Unintentional weight loss	☐ Yes	☐ No
Lethargy	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
4. Do you or your family have TB now, or a history of TB?	☐ Yes	☐ No

Comments:

*Any patient who is considered high risk AND has exibited a cough and at least one other symptom will be identified as a potential TB patient, refer to exposure control plan.

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Statement Affirmations

Initials

_____ 1. I have read the Name of Beneficiary of Health Insurance form and its contents, and furthermore acknowledge that if I have a Medicare HMO or Advantage Plan, I am responsible for any co-pays and/or co-insurance costs.

_____ 2. I have read the Consent for Care, Patient Rights and Responsibilities, to include, the State Home Health Hotline phone number, Release of Information, Liability for Payment, Consent to Photograph, Statement of Patient Privacy Rights/Notice About Privacy, Privacy Act Statement – Health Care Records, Notice of Privacy Practices, Your Rights as a Patient to Make Medical Treatment Decisions, Advance Directives, and the Complaint and Grievance Process.

_____ 3. I have read Advance Directive for Health Care, Patient Bill of Rights and HIPAA Information.

_____ 4. I have read Authorization to Release Information for Payment and Reimbursement Purposes.

_____ 5. I have read Authorization for Release of Medical Information.

_____ 6. I have read Medicare Secondary Payer Worksheet.

_____ 7. I have read the Pinnacle Quality Insight survey notice and its contents.

_____ 8. I have received the Quality Improvement Organization (QIO) contact information (Kepro: 888-317-0891)

_____ 9. I have read and understand the Oxygen Use Waiver.

_____ 10. I have read and understand the explanation of the Medicare/Medicaid hospice benefit as it applies to emergency/urgent care services.

_____ 11. I have read and understand the Consent for Primary Caregiver.

_____ 12. I have read and understand the Hospice Insurance Benefit form.

_____ 13. I have read and understand the Hospice Services Disclosure form.

_____ 14. I have read and understand the Hospice Benefit Authorization.

_____ 15. I have read the Emergency Preparedness Plan and its contents.

_____ 16. I have read TB Screening upon Admission

☐ **Category 1 - Within 24 hours:** Patients who cannot safely forgo care and require health care intervention regardless of other conditions. Patients in this category may include: highly unstable patients with a high probability of inpatient admission if home care is not provided; IV therapy patients; highly skilled wound care patients with no family/caregiver or other outside support.

☐ **Category 2 - Within 24-48 hours:** Patients with recent exacerbation of disease process; patients requiring moderate level of skilled care that should be provided that day; patients with essential untrained families/caregivers not prepared to provide needed care.

☐ **Category 3 - Within 48-72 hours:** Patients who can safely forgo care or a scheduled visit without a high probability of harm or deleterious effects; this category may include homemaker patients, routine supervisory visits, evaluation visits, patients with frequencies of one or two times a week if health status permits, or if a competent family/caregiver is present.

BY SIGNING BELOW YOU AGREE TO THE ABOVE STATEMENTS OF AFFIRMATION

_____ _____

Patient or Representative Signature **Date**

_____ _____

Relationship to Patient (If unable to sign) **Reason Patient Unable to Sign**

_____ _____

Signature of All Care Representative **Date**

Print Form

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Idaho Physician Orders For Scope of Treatment (POST)

*THIS FORM MUST BE SIGNED BY A **PHYSICIAN** IN **SECTION E** TO BE VALID*

If any section is NOT COMPLETE, provide the most treatment included in that section

EMS: If questions arise, contact on-line Medical Control

Patient's Last Name:

Patient's First Name:

Date of Birth:

☐ Male ☐ Female

Section A

Select only one box

Cardiopulmonary Resuscitation: Patient does not have a pulse and/or is not breathing:

☐ **Resuscitate (Full Code)**

☐ **Do Not Resuscitate (No Code): Allow Natural Death; Patient does not want any heroic or life-saving measures.**

If patient is not in cardiopulmonary arrest, please follow the orders found in **B,** and **C**.

Section B

Medical Interventions: Patient has a pulse and/or is breathing:

☐ **Comfort Measures:** Please treat patient with dignity and respect. Reasonable measures are to be made to offer food and fluids by mouth and attention must be paid to hygiene. Medication, positioning, wound care, and other measures shall be used to relieve pain and discomfort. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **These measures are to be used where patient lives, do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

☐ **Limited Additional Interventions:** In addition to the care described above, you may include cardiac monitoring and oral/IV medications. Transfer to hospital if indicated but do not use intubation or advanced airway interventions. **Do not admit to Intensive Care.**

☐ **Aggressive Interventions:** In addition to the care described above, you may include endotracheal intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. **Receiving hospital may admit to Intensive Care if indicated.**

☐ **Other Instructions:**

Section C

Artificial Fluids and Nutrition:

☐ Feeding tube ☐ No Feeding tube

☐ IV fluid ☐ No IV fluid

☐ Other Instructions:

Antibiotics and Blood Products:

☐ Antibiotics ☐ No Antibiotics

☐ Blood Products ☐ No Blood Products

☐ Other Instructions:

Section D

Advance Directives: The following documents also exist:

☐ Living Will ☐ DPA ☐ DPAHC ☐

Section E

Patient/Surrogate Signature: _____

Print Patient/Surrogate Name | Relationship | Date

Physician Signature: _____

Print Physician's Name | Idaho License Number | Date

Discussed with: ☐ Patient ☐ Spouse ☐ DPA ☐ DPAHC ☐ Other

The basis for these orders is: ☐ Patient's request ☐ Patient's known preference ☐

FORM SHALL ACCOMPANY PATIENT WHENEVER TRANSFERRED OR DISCHARGED

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