

## Delaware Hospice Election of Hospice Benefit - Informed Consent Form

Patient Name: \_\_\_\_\_

<b><i>For Office Use Only</i></b>		Med. Record# _____	Admission Date: _____		
<input type="checkbox"/> Medicare DHI Effective Date _____	<input type="checkbox"/> Medicaid DHI Effective Date _____	<input type="checkbox"/> Medicaid Pending	<input type="checkbox"/> TRICARE/Champus DHI Effective Date _____	<input type="checkbox"/> Other Insurance DHI Effective Date _____	<input type="checkbox"/> No Insurance DHI Effective Date _____

1. I understand that the care provided by Delaware Hospice is palliative in nature and is aimed at management of my symptoms and to help me attain a level of maximum comfort during my illness. My right to management of pain and symptom control will be respected, supported and addressed appropriately.
2. I understand that my care will be provided by and/or under the direction of a hospice team composed of a physician, nurse, social worker, chaplain and other disciplines that may be deemed necessary. I may also request a volunteer to assist me.
3. I understand that my physician will collaborate with the hospice team to provide my care. He/she will also consult with the Delaware Hospice medical director, as necessary, for management of the symptoms associated with my illness, such as discomfort, nutrition, etc.
4. I understand that Delaware Hospice services are designed to be delivered primarily in my residence and are available 24 hours a day, 7 days a week. However, if inpatient care is required for pain control, symptom management or respite purposes, Delaware Hospice will provide continuity of care through admission to a contracted inpatient facility.
5. The reimbursement for Delaware Hospice's care has been explained to me. I understand that admission to Delaware Hospice is not based upon my ability to pay, and Delaware Hospice will not discontinue or diminish care because of lack of insurance coverage for medically necessary hospice care.
6. I understand I may be billed for co-payments and/or deductibles required by my medical insurance. I will also be responsible for payment of any service(s) I seek beyond those authorized in the hospice plan of care. Delaware Hospice will pay for consultant physician bills that are related to the terminal illness, home health aide/homemaker services approved by Delaware Hospice and medications related to terminal illnesses.
7. I understand that Medicare/Medicaid/Champus will make payment for unlimited hospice days. These days are broken into the following periods:
 

First Benefit Period - 90 days	Third Benefit Period - 60 days
Second Benefit Period - 90 days	Fourth Benefit Period - every 60 days thereafter

 I waive the right to Medicare payments for the following services.
  1. Hospice care provided by a hospice other than Delaware Hospice (unless provided under arrangements made by Delaware Hospice).
  2. Any Medicare services that are related to the treatment of the terminal condition for which Delaware Hospice was elected and is responsible.
8. I understand that I can revoke this benefit at any time and resume those insurance benefits which are waived during the period I am a Delaware Hospice patient. I understand that with revocation I will lose days remaining in the benefit period in which I revoke.
9. I understand I may use Medicare/Medicaid/Champus in the usual manner to pay for:
  - a. Attending physician charges if he/she is not a Delaware Hospice employee and/or
  - b. Treatment of condition(s) unrelated to the terminal illness for which I am receiving hospice care.

10. Delaware Hospice may require the following to insure my safety, comfort and appropriate medical care:

- a. Acceptance of personal medical alert system to summon help in an emergency.
- b. Lock box to enable Delaware Hospice personnel to obtain entry into my home.
- c. Participation in planning for my care if and when I reach the point that I must have someone with me at all times. This may include hiring of additional help or admission to a nursing facility if other arrangements cannot be made.
- d. Acceptance of recommendations by the Delaware Hospice staff and my physician as to when additional help or placement is needed.
- e. Disclosure of my financial status, as needed, only to determine my ability to hire additional help not furnished by Delaware Hospice.

When Delaware Hospice personnel determine that I am unsafe to be alone, my alternative plan for care will be:

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11. I authorize Delaware Hospice personnel to perform all necessary care and services outlined in the Plan of Care signed by my physician and filed in my Delaware Hospice clinical record.

12. I certify that the information given by me or my representative in applying for payment under Title XVIII and/or Title XIX and/or private insurance is correct. I request that payment of authorized benefits be made on my behalf to Delaware Hospice.

13. I understand that if during the continued evaluation of the appropriateness of care, I no longer meet the criteria for continued hospice care, I will be discharged. I will be notified as soon as possible of the planned discharge from Delaware Hospice.

14. I understand Delaware Hospice provides an educational experience for students who are in advanced training programs. I  do  do not consent to intern participation in my care.

15. All prescription medications should be disposed of when they no longer needed by the patient. Federal law prohibits the transfer of a controlled drug to any person other than the patient for whom it was prescribed. Delaware Code 475 (A) of Title 16 prohibits the possession of a non-controlled drug which requires a prescription if it had not been prescribed for that person. Listed below are some suggestions for disposing of leftover prescription drugs:

- a. Destroy the medication in your home.
- b. Call your pharmacist and ask him/her to handle the disposal of the medication.

16. PATIENTS RIGHT TO DETERMINE HEALTH CARE. Delaware Hospice believes that the patient is the person most suited to make decisions about his/her health care, including the right to accept or refuse medical treatment.

You have the right to sign a written Advance Health Care Directive regarding your treatment. This "directive" may give advance instruction about your medical treatment to your physician and Delaware Hospice staff should you become unable to express your wishes. If you have a written directive, it will become part of your medical record.

In writing, you would be directing your care in the following area: artificial respiration, artificial nutrition and hydration (nourishment provided by a feeding tube); cardiopulmonary resuscitation (CPR); antibiotics; basic life support; advance cardiac life support.

You will be given competent and conscientious care whether or not you have a written Advance Health Care Directive.

You have the right to file a complaint regarding Advance Health Care Directive requirements with the Division of Service for the Ageing at 1-302-577-4791 (New Castle County) or 1-302-422-1386 (Kent/Sussex County) or 1-717-783-7247 (Pennsylvania).

You will receive a copy of the brochure "Advance Health Care Directive".

17. My signature on this form acknowledges that I have received a copy of Delaware Hospice's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Delaware Hospice and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

**I have read the above information.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Patient's Name (please print)

Signed by  Patient  Legal Representative

\_\_\_\_\_  
Reason patient is unable to sign

\_\_\_\_\_  
Legal Representative

\_\_\_\_\_  
Relationship to patient

POA or guardianship forms requested

\_\_\_\_\_  
Delaware Hospice Witness

\_\_\_\_\_  
Date and Time Signature

Please fax consent form to: (302) 479-2597, or mail to:

Delaware Hospice  
Attn: Referral Center  
3515 Silverside Road  
Wilmington, DE 19810