INSPIRATION
A STEP FORWARD COMPANY

Patient Name:_____

Patient and Family Admission Questions:

Funeral Home: For final arrangements the patient wishes to use _____ funeral home.

Death Certificate information:

Has the patient ever used tobacco products: Yes ☐ ☐ No

If yes, what type of tobacco: Smoking Tobacco ☐ ☐ Chewing Tobacco

If yes, are they a current or former smoker? Current ☐ ☐ Former

How long has the patient been using/used tobacco? _____

If the patient is a former tobacco user, how long ago did they quit? _____

Veteran Status:
Is the patient or their spouse a veteran? Yes ☐ No ☐ Spouse ☐

Which branch of the military did they serve? _____

In which era did they serve? _____

Are they enrolled at the VA? Yes ☐ No ☐

Religious Affiliation:
I am religiously affiliated with: _____

History of Drug Use: Yes ☐ No ☐

If yes, what: _____

How long: _____

History of Alcohol Use: Yes ☐ No ☐

If yes, how long: _____

Hobbies or interests? _____

_____

Anything else you would like us to know about the patient or their loved ones?

_____

_____

Patient Name: _____

Informed Consent, Attending Designation, and Hospice Election Statement

Election:

Hospice Election I, _____ (Patient Name) choose to elect the Medicare hospice benefit and receive Hospice services from **Inspiration Hospice.**

My hospice election will begin on_____ **(Start of Care Date)**.

Note: The start of care date, also known as the effective date of the election, 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.

I am electing to use the following insurance:

_X_ Medicare Hospice Benefit

_____ Medicaid Hospice Benefit

_____ Private Insurance

Office Use Only:

Benefit Period: 1

Medicare/Medicaid Hospice Benefit Election: I understand that The Hospice Medicare Benefit Program booklet will be provided with my admit paperwork.

I hereby elect to receive the Medicare Hospice Benefit from Inspiration. Inspiration will provide services, medications, and durable medical equipment related to my terminal diagnosis. I understand that once the Medicare/Medicaid Hospice Benefit starts, Original Medicare/Medicaid will cover the cost for hospice if it is related to my terminal illness.

Attending Designation: I acknowledge that hospice services are limited to palliative care and that I am not being offered a "cure" for my illness. I understand that should I choose to pursue aggressive treatment for my illness; I may be eligible to receive care from another provider of services. The hospice team will work closely with me and my attending physician to design and implement a palliative plan of care.

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:

(Please provide any information that will uniquely identify your attending physician choice.)

Physician Full name: _____

My signature on this form acknowledges that the identified attending physician is my choice. I understand that Medicare/Medicaid will pay for hospice services provided by my attending physician if the physician is not an employee of, nor receiving compensation for those services from Inspiration.

OFFICE USE ONLY - Attending has been verified: Yes No

Patient Name: _____

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.

I understand that by electing to receive the Medicare/Medicaid Hospice Benefit that Inspiration will not provide/cover the following:

- Hospice care provided by any other hospice other than Inspiration (unless this is provided under arrangements made by Inspiration.)
- Room and board.
- Outpatient/Inpatient hospital care, including: emergency room visits and ambulance transportation. (Unless it is arranged by your hospice team for general inpatient stays.)
    - General Inpatient Stays: Short-term inpatient palliative care is provided directly by the hospice in a hospital and/or skilled nursing facilities with which Inspiration has contracted. To assure continuation of my hospice benefit and the continuity of my plan of care, I only choose to receive short-term inpatient care at an Inspiration contracted facility, or I can choose to revoke the Medicare/Medicaid Hospice Benefit. If general inpatient care is deemed necessary by the hospice staff, Inspiration will set up these services.

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.

I understand that Inspiration Hospice is financially responsible only for the service included on my hospice plan of care. If I do not agree with the recommended hospice plan of care or wish to seek treatment, I understand that I may choose to revoke the Medicare Hospice Benefit at any time.

Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO): 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 (or your representative) disagree with the decision of the hospice agency on

items not covered because the hospice has determined they are unrelated to your terminal illness and related conditions.

Please visit this website to find the BFCC-QIO for your area: https://qioprogram.org/locate-your-qio or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048

Private Insurance Authorization: I hereby authorize any insurer or other organization from whom I am entitled to receive payment for hospice services, to make payment for such services directly to Inspiration.

Financial Responsibility: I have read the explanation regarding benefits, provisions, and the scope of services. I understand that efforts will be made to recover cost of care through Medicare, Medicaid, or private insurance. However, I understand that I will not be denied admission to hospice if I am unable to pay.

Preferred Drug List: I have been informed that Inspiration uses a Preferred Drug List. I also understand that Inspiration will provide medication related to my prognosis, per the formulary. I also understand that hospice does not cover all medications. I understand that I can choose to pay for medications not covered by Inspiration.

Understanding of Hospice: I understand that Inspiration is a palliative care program and not curative in its goals. The program emphasizes the relief of symptoms such as pain and physical discomfort. Inspiration will also provide means to address the spiritual and emotional stress which may accompany a terminal illness through chaplains and social workers. I also understand that every attempt will be made to preserve my personal dignity with the help of the nursing staff.

Definition of Family and Unit of Care: I understand that Inspiration focuses on both my care and the care of my loved one, as defined by me.

The Caregiver and 24-Hour Care: I understand that Inspiration is not intended to take the place of care provided by a family member, a loved one, private duty caregiver, or facility staff but be an added support to the care already in place. I understand that Inspiration Hospice does not provide 24-hour care. If 24-hour care is needed, I understand that it is up to myself or my designated caregiver to arrange for this type of care. I understand that Inspiration will continue to follow my care in whatever setting the I may move to, if my location is within Inspiration Hospices geographic coverage area. I understand that if my home is in a facility, care will be provided by facility staff in collaboration with Inspiration staff.

I have asked that_____(designated caregiver) make arrangements for my 24-hour care needs, once I can no longer make this choice. **NOTE:** If I currently have a Health Care Power of Attorney, my agent should be listed as the designated caregiver. If the designated caregiver listed on this form is different from my Health Care Power of Attorney Agent, **my Health Care Power of Attorney Agent has the ultimate authority over my medical decisions <u>once I can no longer speak for myself.</u>**

Health Care Power of Attorney: I have provided Inspiration with a copy of the Utah Advance Health Care Directive. **If I do not have a Health Care Power of Attorney, I understand that my assigned social worker can help me complete this form.** I understand that I have the right not to choose an agent. I also understand that I can revoke my agent at any time.

Plan of Care: I understand that both I and my designated care giver will participate in decisions about the care provided by the hospice care. I also understand that my designated care giver will receive training and support when it is needed to manage my ongoing care. I understand that my plan of care will be reviewed every 15 days by the

hospice team. I understand that I can review my plan of care if requested in writing. I also understand that I can refuse a particular treatment or service offered at any time.

Patient Choice of Care: I understand that I have the choice about how, where, and who provides my care. I also understand that I have the right to name my Financial Power of Attorney, Health Care Power of Attorney, and make my resuscitation wishes known. I understand that if I do not currently have these documents; an Inspiration professional can assist me with completing them.

Election Periods: I understand by electing to use the hospice benefit, I am entitled to hospice care for two (2) election periods of ninety (90) days each. Thereafter, I will receive unlimited sixty (60) day periods, based on Medicare Hospice eligibility requirements.

Discharge: I understand that if my condition stabilizes or improves, I may be discharged from Inspiration. I understand that I must meet Medicare eligibility requirements to stay on service. I understand that prior to discharge the hospice team will assist my family and I with discharge planning. I also understand that if my condition changes, I can request to be readmitted at a later date.

Revocation: I understand that I may revoke this Consent/Election and withdraw from hospice treatment at any time by signing a Revocation Statement, which will be given to me upon my request. If I revoke this election, I understand that I will forfeit any remaining days in the election period but will be eligible for benefits previously waived by my electing to use hospice. I may opt to re-elect my hospice benefit at a later date, if eligible.

Informed Consent: My signature on this form certifies that I have been provided with a through explanation of services provided by Inspiration Hospice and that I consent to receive care. I have received, reviewed, and been educated on the following:

- Welcome Letter/Hours of Operation
- Admission Information/Eligibility Requirements for Hospice
- Why Inspiration Hospice is Unique
- Service Provided
- Home Use and Disposal of Controlled Substance Policy
- Patient Rights and Responsibilities
- Nondiscrimination Policy and Grievance/Complaint Process
- The Medicare Hospice Benefit
- Signs and Symptoms of Approaching Death Instruction Sheet
- Infection Control
- When to Call
- Family Disaster Plan Education
- Home Safety Guidelines
- Emergency Preparedness/Risk/Disaster Evaluation
- Authorization to Release Medical Information
- Durable Medical Equipment Form
- Patient Authorization to Disclose Protected Health Information/Notice of Privacy
- Aide Plan of Care
- End of Life Planning:
  - Advance Health Directive
  - Durable Power of Attorney (POA)
- Provider Order for Life Sustaining Treatment (POLST)
- Informed Consent, Attending, Election

Consent to Regulatory Surveyor Visits: I consent to receive visits from healthcare professionals and hospice accrediting or regulatory surveyors that are authorized by Inspiration to observe my care. I also consent to be interviewed by these individuals.

Consent to Disclose My Location: I give Inspiration permission to disclose my location and medical condition to their personnel to further my care.

Patient Name: _____

Bereavement Care for My Loved Ones: I understand that after my passing, my loved ones will be offered bereavement from an Inspiration Hospice professional. Bereavement services include counseling, support groups, phone contacts, mailings, and memorial services.

Photo Release: I understand that mine or my loved one's image may be used for medical purposes. I understand that every safeguard is in place to protect these images and my privacy. I also understand that my image will not be used for promotional purposes without my written consent.

Release for Memorials: I give Inspiration permission to use my photograph or a digital image and my name at future memorials and to alter the same without restriction. I further agree that my name or identity may be revealed in descriptive text or commentary in connection with the memorial. I understand and agree that any of the memorial literature using my likeness including negatives, prints and digital reproductions thereof will become property of Inspiration and will not be returned. I hereby hold harmless, release, and forever discharge Inspiration, its agents, and employees, from any and all claims, demands, and liabilities whatsoever in connection with this authorization. I, or my surrogate, am at least 18 years of age, and am competent to contract in my own name. I have read this release before signing it, and fully understand the contents, impact and meaning of the release.

_____ **Opt-Out of Memorials:** By initialing this section, I am opting out of having my name and image used at Inspiration's future memorials.

Complaints: If I have complaints or problems, I can call the administrator at 801.281.1314 without fear of any retaliation, loss of services and/or benefits. If I do not feel my problem is resolved, I may register a complaint with the Utah Department of Health Facility Licensing, Certification, and Resident Assessment by calling their hotline at 1.800.999.7339.

Records: I authorize Inspiration to obtain copies of medical and billing records and keep such records, which may include necessary information about my medical condition and my finances during my time on hospice. I understand that Inspiration Hospice will use these records for the purpose of providing treatment, obtaining payment for care, and conducting health care operations. I also understand that Inspiration has established policies to safeguard against unnecessary disclosure of my private health and financial information.

Consent to Treat: I certify that I have read and understand this statement in its entirety. I have also read and understand the additional information provided to me by Inspiration. I hereby authorize hospice services to be provided to me by Inspiration.

I have been able to discuss the above conditions with a member of Inspiration staff and have had all my questions answered to my satisfaction.

_____ _____

Signature of Patient or Representative **Date**

_____ _____

Printed Name of Patient or Representatives **Authority of Representative**

_____

If Patient Refuses/Is Unable to sign, Please Describe

_____ _____

Signature of Witness **Date**

INSPIRATION
A STEP FORWARD COMPANY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____ MR#: _____

Address: _____
Streets, City, State, Zip

I authorize the release of the following medical records to Inspiration Hospice from the below mentioned entities to be used for consultation, treatment, and billing purposes **(Check ALL That Apply)**:

☐ History and Physical	☐ Lab Results	☐ Discharge Summaries
☐ Progress Notes	☐ Psychology Evaluation	☐ Nursing Notes
☐ Physician Orders	☐ Social Work Assessment/Notes	☐ X-Ray Reports
☐ Aide Care Plans/Notes	☐ Other Communicable Diseases	☐ OT/PT Assessments/Notes
☐ HIV Test Results	☐ Consultation	☐ Alcohol/Drug History
☐ AIDS/ARC Diagnosis/Treatments	☐ Other: _____	☐ **Complete Medical Record**

*If records pertain to mental health, substance abuse, AIDS/HIV, or spouse/child abuse, additional requirements may need to be met prior to release.

Exceptions to information released:_____

From: ☐ Any Hospital/Outpatient Clinic that provided care to me during the previous 12 months (Please List):

_____

☐ Any Doctor/Medical Office who has provided care in the previous 12 months (Please List):

_____

☐ Any Nursing Home/Assisted Living Center that I resided in during the previous 12 months (Please List):

_____

☐ The Referring Health Care Agency:

_____

*The agencies listed above are released from all legal liability that may arise from the release of the information requested.

This authorization will remain effective for one year (1 year) unless an earlier date or event specified: _____

INSPIRATION
A STEP FORWARD COMPANY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

You have the right to revoke this Authorization at any time, provided that you do so in writing directed to your health care provider's Privacy Contact, and except to the extent that he/she has already used or disclosed the information in reliance on this Authorization.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that you have already used or disclosed the information in reliance on the Consent.

A photocopy or facsimile of this authorization shall have the same force and effect as the original.

*Should I refuse to sign this authorization, my ability to obtain care, payment, or enrollment in said health program will not be affected. I understand that I may revoke this authorization, in writing, at any time. Written revocation will be delivered to Inspiration-A Step Forward Hospice.

*By signing this form, I authorize the release of records with the knowledge that Inspiration-A Step Forward Hospice may obtain information regarding any mental health, substance abuse, HIV/AIDS, or spousal/child abuse.

_____ _____

Signature of Patient/Guardian/Personal Representative Date

_____

Printed Name

If signed by a Personal Representative, please state the relationship: _____

RE-DISCLOSURE BY THE RECIPIENT IS PROHIBITED. USE OF THIS INFORMATION FOR ANY PURPOSE OTHER THAN AS STATED ON THIS AUTHORIZATION IS PROHBITED.

INSPIRATION
HOME HEALTH & HOSPICE
A STEP FORWARD COMPANY

Revised 2/19

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION & ACKNOWLEDGEMENT OF PRIVACY NOTICE.

Patient Name: (Please Print)		DOB:	MRN:
Patient email:		Phone #:	SSN#:
Patient Address			
	City:	State:	Zip:

Information to be Disclosed: I authorize Inspiration-A Step Forward to **DISCLOSE** my patient information & location to:

*The Mortuary of Your Choice	*Clergy Listed on your Spiritual Assessment	*Nursing Facilities	*Pharmacies/Laborites
*Insurance Companies	*Hospitals/EMS	*Medical Equipment Vendors	*Social Service Agencies
*Your Referring Physician	*VA Services	*Transportation Companies	*State Appointed POA

***Any Other Necessary Medical Agency**

I authorize the following person(s) to RECEIVE my patient information (IF YOU ARE NOT THE PATIENT PLEASE INCLUDE YOUR INFORMATION FIRST):

Point of Contact's Name:	Relationship:	
Phone:	Email:	
Address:	Notice of Admission: ✔	Ongoing information about my care: ✔

Name:	Relationship:	
Phone:	Email:	
Address:	Notice of Admission: ☐	Ongoing information about my care: ☐

Name:	Relationship:	
Phone:	Email:	
Address:	Notice of Admission: ☐	Ongoing information about my care: ☐

*I understand at the time of my death, the people listed above will be contacted by Inspiration-A Step Forward's Bereavement Team.

*I understand that I may revoke this authorization in writing at any time.

*I have received a copy of the Inspiration-A Step Forward's Notice of Privacy Practice which includes: identifying me as a patient at Inspiration-A Step Forward Hospice.

*I have received a copy of the Inspiration-A Step Forward's Patient Right's and Responsibilites

*Information relating to my care that may be shared is limited to: medication information, a summary of diagnosis and prognosis, and a list of services and personnel available for assistance.

***I understand that if I am the Medical Power of Attorney, I am required by Inspiration-A Step Forward to provide written documentation stating the patient's wishes.**

I hereby authorize the use and/or disclosure of my personal information as indicated in the checked boxes above.

Signature of Patient or Representative:	Date:
Printed Name of Patient or Representative:	Authority:
If Patient Refuses/Is Unable to sign. Describe:	

Witness Signature:	Printed Name of Witness:	Date: