Face Sheet

Patient Name:	**MR#:**	**Admit Date:**

PATIENT INFORMATION	**REFERRAL INFORMATION**
Care Type: ☐ Routine ☐ Continuous. Care ☐ Respite ☐ GIP	**Referral Date & Time:**
Location: ☐ Home ☐ SNF/LTC Facility ☐ Hospital ☐ GRP Home/ALF	**Evaluation Date & Time:**
Facility Name: **Room#:**	**Referred by:**
Address:	**Where did they hear about Pillars Hospice Care:**
City: **Zip:**	
Phone: **Fax:**	
DOB: **Age:** **Sex:**	**PHARMACY INFORMATION**
Marital Status: **Spouse Name:**	**Allergies:**
Height: **Weight:** lbs	**Local Pharmacy:**
DNR: ☐ Y ☐ N **Living Will:** ☐ Y ☐ N **POA:** ☐ Y ☐ N	**Phone#:**
Religious Preference:	**PAYOR INFORMATION**
Local Church: **Other Clergy:**	**Social Security#:**
Ethnicity:	**Medicare #:**
Language: **Interpreter:** ☐ Y ☐ N	
PRIMARY CAREGIVER INFORMATION	**AHCCCS#:**
Name:	**Insurance Co:**
Relationship: **Lives w/ patient:** ☐ Yes ☐ No	**Policy Holder:**
Address:	**Policy #:**
City: **Zip:**	**Additional Insurance:**
Home Phone #:	**Non-Funded** ☐
Cell Phone #	
E-Mail:	
POA Name:	**TEAM INFORMATION**
Address:	**Nurse CM:**
City: **Zip:**	**Nurse:**
Home Phone #:	**CNA:**
Cell Phone #:	**Chaplain:**
E-Mail:	**SW:**
DIAGNOSIS HISTORY	**Volunteer:**
Hospice Diagnosis:	**PHYSICIAN INFORMATION**
Metastasis: ☐ No ☐ Yes **Where:**	**Primary Physician:**
Comorbidities:	**Phone #:** **Fax #:**
	Address:
Diagnosis/Prognosis Awareness: **Patient** ☐ **Yes** ☐ **No** **Family** ☐ **Yes** ☐ **No**	**Phone #:** **Fax #:**
MORTUARY INFORMATION	**Consulting Physician:**
Mortuary/Donor:	**Phone #:** **Fax #:**
Phone #:	**Consulting Physician:**
MILITARY INFORMATION	**Phone #:** **Fax #:**
Branch: **Era:**	
Spouse of Veteran: ☐ **VA Benefits** ☐	**Hospital Preference:** **Avoid** ☐

Bereavement Contacts

Patient Name: _____ **MR#:** _____

Name:	**Name:**
Address:	**Address:**
City: **Zip:**	**City:** **Zip:**
Home #: **Cell #:**	**Home #:** **Cell #:**
Relation:	**Relation:**
E-Mail:	**E-Mail:**
Name:	**Name:**
Address:	**Address:**
City: **Zip:**	**City:** **Zip:**
Home #: **Cell #:**	**Home #:** **Cell #:**
Relation:	**Relation:**
E-Mail:	**E-Mail:**
Name:	**Name:**
Address:	**Address:**
City: **Zip:**	**City:** **Zip:**
Home #: **Cell #:**	**Home #:** **Cell #:**
Relation:	**Relation:**
E-Mail:	**E-Mail:**

PILLARS HOSPICE CARE, LLC

INFORMED CONSENT AND TREATMENT AUTHORIZATION

Election of Hospice Benefit Election

This agreement is entered into by and between Pillars Hospice Care, LLC
And

_____.
Name of Patient

I request admission to Pillars Hospice Care, LLC and understand and agree to the following conditions:

- I understand that Hospice is a comprehensive program of professional and volunteer services established to provide supportive and palliative care to patients with a life limiting illness. I understand that hospice care is not designed to cure disease, but rather to provide the relief of symptoms such as pain and physical discomfort and other symptoms related to my terminal illness and related conditions. This care addresses the spiritual needs and the emotional stress which may accompany a life-threatening illness and provide comfort dealing with my terminal illness.
- I understand that the nature of treatment as it relates to the terminal illness is palliative care rather than curative treatment. Palliative care means patient and family centered care that optimizes the quality of life by anticipating, preventing, and treating suffering
- I understand and accept the responsibility of participating and cooperating in the development and implementation of the approved plan of care. All care and services will be in conjunction with input from me, my physicians, and the hospice interdisciplinary team.
- I understand that Hospice services are not intended to take the place of care by family members or others who are important to me, but rather to support them in my care.
- I understand that the hospice program is primarily routine care provided in my home by professionals on an intermittent basis, available 24 hours a day, 7 days a week.
- I understand The Hospice Interdisciplinary Team supplements rather than replaces care provided by the family or Facility Staff.
- I understand that services related to my terminal condition may include: the services of nurses, physicians, medical social work, counselors (including dietary and pastoral care), physical therapy, occupational therapy, speech language pathology, certified nursing assistant/homemaker, volunteers, provision of medical supplies (including drug and biologicals) and durable medical equipment.

INFORMED CONSENT:

The undersigned Patient or Patient's legally authorized representative hereby consent to any and all examination, treatments, prescriptions and use of psychotropic medications as prescribed by the Patient's physician (and/or hospice physician). This care will be rendered by the hospice Interdisciplinary team which consists of Pillars Hospice Care, LLC's employees or contracted staff of licensed nurses, physical therapists, occupational therapists, speech therapists, registered dieticians, medical social workers, spiritual counselors, certified nursing assistants and volunteers. Contracted services are coordinated, supervised, and evaluated by Pillars Hospice Care, LLC. All services will be provided in a safe and effective manner by qualified staff. All services and care provided will be documented in accordance with this agreement and the patient's Plan of Care.

PRIMARY CAREGIVER NOTIFICATION

The Primary Caregiver assures the responsibility of care for the patient. Hospice is there, at the same time, to assist and educate the primary Caregiver in provision of that care. With the support and guidance of Hospice, the person designated as the "caregiver" will provide around the clock care to me in my 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 me.

_____agrees to accept the role of Primary Caregiver for the above-named person.
Name of Primary Caregiver

Responsibilities of the Primary Caregiver include:

- Committed to helping that person remain at home, if that be in accord with their wishes, during this illness.
- Providing care for him/her to the best of their ability.
- Participate in the development and ongoing revision as needed, of the patient/family plan of care.

Responsibilities of Pillars Hospice Care, LLC include:

- Patient care visits in accord with the plan of care
- Provision of detailed instructions and information as needed to assist in providing care
- Provision of spiritual and emotional support
- Assistance to patient/caregiver in coping with the progression of illness and eventual death
- Provision of support after the death for 13 months

BENEFIT PERIODS and DURATION OF ELECTION

I understand that under the Medicare Hospice Benefit, I am entitled to hospice care, which consists of two 90-day periods followed by an unlimited number of 60-day periods during the remainder of my lifetime as long as I continue to meet hospice eligibility. However, I may voluntarily terminate (revoke) my hospice election period at any time. I understand that once Pillars Hospice Care, LLC chooses to admit me, it may not automatically or routinely discharge me at its discretion, even if the care promises to be costly or inconvenient. I understand that the election of the hospice benefit is my choice rather than the hospice's choice, and Pillars Hospice Care, LLC cannot revoke my election. I also understand that Pillars Hospice Care, LLC should neither request nor demand that I revoke my election. The duration of my election of hospice care will continue through the initial and subsequent election periods without a break in care as long as I remain in the care of hospice; do not revoke the election; and am not discharged from hospice.

Certification/Recertification of Hospice eligibility:

I understand the Interdisciplinary Team evaluates recertification for continuation of hospice care at the end of each benefit period. I understand that I will be required to be seen by a physician for a Face to Face visit after my second 90-day period and prior to each subsequent 60-day period.

Waiver of benefits:

I understand and acknowledge that:

- I was provided with 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 above 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.

Revocation and re-election

I understand that I or my representative may revoke the election of hospice care at any time during an election period and return to standard Medicare coverage by signing a statement to that effect, specifying the date when the revocation is to be effective, and submitting the statement to Pillars Hospice Care, LLC prior to that date. This revocation constitutes a waiver of the right to hospice care during the remainder of the current election period.

If an election has been revoked, I or my representative may at any time file an election, for re-admission to hospice. If I or my representative re-elect the hospice benefit, a new benefit period begins and I am eligible for any other election period that is still available.

Transfer

I understand that once in each election period I may elect to receive services through a hospice program other than Pillars Hospice Care, LLC. Such change shall not be considered a revocation of hospice service but as a transfer of Hospice care.

Termination/Discharge

I understand that Pillars Hospice Care, LLC may terminate services/discharge for cause, when in its sole medical judgment determines there is no longer any reasonable expectation that it can meet the Patient/family's needs if my or my family's behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to me or the ability of the hospice to operate effectively is seriously impaired. I understand I may be discharged from hospice care if I move out of the service area.

Notice of Medicare Non-Coverage in Hospice (NOMNC)

I understand that should the interdisciplinary team of Pillars Hospice Care LLC determine that I am no longer eligible for continued Hospice services, Pillars Hospice Care, LLC must provide the Notice of Medicare Provider Non-Coverage (Generic Notice) to me no later than two days before the effective date of the end of the coverage that their Medicare coverage will be ending. I understand that if I do not agree that coverage should end, I may request an expedited review of the termination decision by the Quality Improvement Organization (QIO) in Arizona.

LEVELS OF HOSPICE CARE:

Routine Home Care

I understand that hospice services are delivered in my place of residence provided by a team of hospice professionals, staff, and volunteers. I understand that these services may include, as set forth in the hospice plan of care: skilled nursing visits, physician care/visits, social work visits, spiritual support, nutrition and bereavement counseling, Certified Nursing Assistant/homemaker visits, volunteer assistance, physical therapy, occupational and speech-language therapy. I understand that Nursing services, physician services and drugs and biologicals for the relief and palliation of the terminal illness and related conditions must be available to me on 24-hour basis 7 days a week. I understand hospice will provide medical supplies and appliances and durable medical equipment related to the terminal illness and related conditions, and as identified in the hospice plan of care and as prescribed for relief of pain or discomfort.

Inpatient Care

I understand that inpatient hospice care is provided in a Medicare certified facility when it is deemed necessary by the hospice interdisciplinary team. I understand that hospice inpatient care is designed for short-term stays for symptom management and pain control with the goal of stabilizing me and the family emotionally and physically so I can return to home.

Respite Care

I understand that Respite care is provided in a Medicare certified facility when it is deemed necessary by the hospice interdisciplinary team and is designed to provide brief periods of respite for the family or primary caregiver while I receive hospice care.

Continuous Care

I understand that continuous care (a minimum of 8 hours of care in a 24-hour period) may be provided in my 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 me. I understand this care will be predominantly covered by a nurse and a Certified Nursing Assistant.

DESIGNATION OF ATTENDING PHYSICIAN

I have the 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:

_____
(Name of Physician/Nurse Practitioner)

_____
(Address, City, State, Zip Code)

_____
(Phone Number)

I understand that if I wish to change the above designated attending physician or if my designated attending chooses not to continue responsibility for my care, I or my representative must file a signed and dated statement with Pillars Hospice Care, LLC that indicates my choice for change of attending physician.

I understand that while this election is in force, Medicare or AHCCCS will make payments for care related to this illness to the physician designated above and to Pillars Hospice Care, LLC, and that services related to this illness provided by hospitals, home health agencies, nursing homes, and any other company or Hospice will not be reimbursed by Medicare or AHCCCS unless specifically ordered and authorized by Pillars Hospice Care, LLC. I understand the services not related to this illness will continue to be covered by Medicare/AHCCCS along with hospice benefits.

The Hospice Medical Director that is responsible for oversight and coordination of the management of my care is:

_____
(Name of Medical Director)

_____
(Address, City, State, Zip Code)

_____
(Phone Number)

FINANCIAL AGREEMENT

Payment Responsibility:

I understand that Pillars Hospice Care, LLC assumes financial responsibility for medications related to the terminal illness and related conditions and durable medical equipment and medical supplies related to the terminal illness. 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; that I and/or my representative assume financial responsibility for all other charges. I understand that Pillars Hospice Care, LLC in accordance with this agreement shall assist Patient in obtaining financial assistance from third party payers such a Medicare and private insurers.

Pharmacy Services:

I understand that Pillars Hospice Care, LLC will continue to provide all of the medications that are reasonable and necessary for the palliation and management of my terminal illness and related conditions including analgesics, anti-nauseants, laxatives and antianxiety drugs. The medications ordered by my attending physician or hospice medical director related to the terminal illness and related conditions will be provided from a community pharmacy contracted by Pillars Hospice Care, LLC. Any medications deemed unrelated to the terminal illness will be submitted to Part D for processing and payment by the patient. Any medication deemed related to the terminal illness but no longer necessary or unrelated to the terminal illness and no longer necessary will be either discontinued or paid for by the patient.

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

I understand that as a patient of Pillars Hospice Care, LLC, I have the right to:

1. Exercise my rights as a hospice patient.
2. Have myself and my property treated with respect.
3. Be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.
4. Be assured of appropriate and compassionate care regardless of race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or ability to pay for services rendered.
5. Be informed of your rights in a manner, which you understand.
6. Make informed decisions regarding proposed and ongoing care and services.
7. Choose whether or not to participate in research, investigational or experimental studies, or clinical trials.
8. Be communicated with in the language the patient or family feels most comfortable.
9. To voice complaints and grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice without being subjected to discrimination or reprisal for exercising my rights.
10. Confidentiality of information, privacy, and security
11. 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.
12. Be involved in the care planning process.
13. 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
14. Formulate advance directives.
15. Choose my own attending physician.
16. Have an appropriate assessment and receive effective pain management and symptom control from the hospice for conditions related to the terminal illness
17. Keep and use personal clothing and possessions.
18. An environment that preserves dignity and contributes to a positive self-image, unlimited contact with visitors and others.
19. Be fully informed, prior to or at time of admission, of services available through Pillars Hospice Care, LLC, and related charges, including services not covered under Titles XVIII or XIX of the Social Security Act.
20. Refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
21. Be advised of what hospice services are to be rendered and by what discipline, i.e., registered nurse, counselor, chaplain, etc.
22. Be advised in advance of any change in treatment, care, or services.
23. Be assured of confidential treatment of personal and clinical records, visitation, financial affairs, hygiene, and receipt of hospice services.
24. Be assured of the approval or refusal of clinical records 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 as specified in the Privacy rule of Health Insurance Portability and Accountability Ace of 1996.
25. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse or exploitation including injured of unknown source, and misappropriation of my personal property.
26. 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 Dept. of Health Services.
27. Be informed of the provisions of the law pertaining to advanced directives, including but not limited to living wills, power or attorney for health care, withdrawal or withholding of treatment and/or life support.
28. Be assured the personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.
29. Receive information addressing any beneficial relationship between Pillars Hospice Care, LLC and referring entities.

Patient Responsibility

As a patient of Pillars Hospice Care, LLC, I have the *responsibility* to:

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

Pillars Hospice Care, LLC Responsibility

I understand that as a patient of Pillars Hospice Care, LLC, Hospice has the *responsibility* to:

1. Protect and promote the exercise of these rights.
2. Conduct and document a patient specific comprehensive assessment
3. Provide care and services to meet the physical, psychosocial, emotional, and spiritual needs of the patient and family.
4. Coordinate Transportation services.
5. Ensure that all alleged violations of patient rights involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice are reported immediately to the hospice administrator; investigated and immediate action taken to prevent further violations.
6. If allegations are verified, take appropriate corrective actions according to State law and report to State survey and certification agency within 5 days of becoming aware of the violation.

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

As a Mediare beneficiary who elects to receive hospic 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 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**.**

PROCEDURES FOR MAKING COMPLAINTS

You have the right to advise Pillars Hospice Care, LLC of any problem, complaint or dissatisfaction with our care or any services you have received without being subject to discrimination or reprisal. Make your complaint known to the Social Worker or Administration. Every effort will be made to resolve the problem. Pillars Hospice Care, LLC will investigate all grievances, document the existence of the complaint and findings. Findings will be communicated to the patient and family within 5 days of receipt of the complaint.

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 Pillars Hospice Care, LLC is:

LiVanta BFCC-QIO Program
9090 Junction Drive, Suite 10
Annapolis Junction, MD 20701
Toll Free: 1-877-588-1123
Appeals: 1-855-694-2929
All other reviews: 1-844-420-6672

CONTACT INFORMATION FOR MAKING COMPLAINTS

The Department of Health Services, and CHAP operate 24-hour, toll-free hotlines that you may contact at any time:

Department of Health Services
150 North 18th Avenue, Suite 450
Phoenix, Arizona 85007-3242
In Maricopa/Gila County: 602-364-3030 (Prompt menu # 5 to file a complaint)
Hearing Impaired Line:1-800-221-9968 (Record message on answering machine)

The Community Health Accreditation Program (CHAP)
1275 K Street NW Suite 800
Washington, DC 20005
Phone: 1-800-656-9656

Pillars Hospice Care, LLC does not discriminate against any person on the basis of race, color, sexual orientation, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment.
For further information about this policy, contact:
Kimberly Argenti RN 504 Coordinator
602-788-1138
or
State of Arizona Department of Health Services Hospice Complaint Line: 602-364-3030
Hearing Impaired Line: 1-800-367-9839

CONTACT INFORMATION FOR HOSPICE:

Pillars Hospice Care, LLC is available 24 hours a day 7 days a week by phone:
602-788-1138

Our office is located at:
10221 N. 32nd Street
Suite H
Phoenix, Arizona 85028-3849
Our Fax is: 602-788-1136

HOSPICE BENEFIT ELECTION

The effective date of Hospice Election and Start of Care is _____.

(Note: The start of care date, 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.)

As a **Medicare Part A** beneficiary, I hereby elect Pillars Hospice Care, LLC as my sole provider of hospice care. I understand that Pillars Hospice Care, LLC will receive payment for my care from Medicare.

Name as it appears on card	Medicare Number	Social Security Number	Date of Birth

As an **AHCCCS** beneficiary, I hereby elect Pillars Hospice Care, LLC as my sole provider of hospice care. I understand that Pillars Hospice Care, LLC will receive payment for my care from Medicaid.

Name as it appears on card	Medicaid Number	Social Security Number	Date of Birth

As a **Private Insurance** beneficiary, I hereby elect Pillars Hospice Care, LLC as my sole provider of hospice care. I understand that Pillars Hospice Care, LLC will receive payment for my care from Insurance Provider.

Name of Insurance Provider	Member Name as it appears on card	Member Social Security Number	Member Date of Birth
Group Number	Member ID	Health Plan Number	

CONSENT TO PHOTOGRAPH

As a patient of Pillars Hospice Care, LLC, I hereby authorize a staff member to take my photograph for the purposes listed below:

☐ Photographs of appropriate parts of my body (specifically for the treatment of wounds) in order to provide supporting documentation of my medical condition. I understand that these photographs will become the property of Pillars Hospice Care, LLC and be placed in and remain part of my medical record.

☐ Photographs of me for identification purposes. I understand that these photographs will become the property of Pillars Hospice Care, LLC and be placed in and remain part of my medical record.

☐ I do not authorize a Pillars Hospice Care, LLC staff member to take my photograph for the reasons listed above.

ADVANCE DIRECTIVES

I have been provided the following information regarding advance directives:

- I have been informed of my right 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 Directive that I have executed will be followed by any healthcare provider and my caregivers to the extent permitted by law.

☐ I have	☐ I have not	Executed an Advanced Directive (DNR)	☐ Copy Received
☐ I have	☐ I have not	Executed a Durable Power of Attorney for Health Care	☐ Copy Received
☐ I have	☐ I have not	Executed a Living Will (End of Life Care)	☐ Copy Received

RECEIPT OF INFORMATION

I was given an explanation and have full understanding of the purpose of hospice care including the nature of hospice car 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 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. I have been provided the following materials:

- A copy of Patient's Rights and Responsibilities
- Written materials explaining a patient's legal rights to accept or refuse medical treatments (Living Will- End of Life Care)
- Written materials to assist in the selection and preparation of a Durable Health Care Power of Attorney
- Written material to document your Medical Care Directives (DNR)
- Written material explaining the Medicare Hospice Benefit
- Written Educational materials explaining Infection Control and Handwashing; Covid-19 Precautions and information, Home Safety; Medication Management and Destruction of Controlled Substances, Disaster Preparedness and Emergency Event Management, Translator/Interpreter services, Privacy Practices and HIPPA, Urgent Issues, Pain and Pain management

ACKNOWLEDGEMENT

I acknowledge and agree to the terms and conditions as described in the above document:

☐ Informed Consent and Treatment Authorization

☐ Financial Agreement

☐ Primary Caregiver Notification

☐ Grievance and Complaint Procedure

☐ Designation of Attending Physician

☐ Advance Directives

☐ Hospice Benefits

☐ Patient Rights and Responsibilities

☐ Medicare Hospice Benefit Election

☐ Privacy Notice

☐ Photography Release

☐ Controlled Substance Disposal

☐ Emergency Preparedness and Emergency Event Management

I accept the conditions of PILLARS HOSPICE CARE, LLC as described above. I have been able to discuss the above conditions with a team member of the Hospice staff and have had my questions answered to my satisfaction. In accordance with the above agreement, I attest my signature.

_____

Signature of Patient Date

If Patient unable to sign, state reason: _____

_____

Signature of Legally Authorized Representatives /Primary Caregiver Date

_____

Signature of Hospice Representative Date

PILLARS HOSPICE CARE

RELEASE OF PATIENT RECORDS

I understand that PILLARS HOSPICE CARE, LLC 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.

Permission is granted for the release of the requested medical information listed below to PILLARS HOSPICE CARE, LLC and other records or information related to my terminal illness that may assist in my care.

☐ Current History and Physical
☐ X-ray Report
☐ EKG Report
☐ Consultation Report
☐ Discharge Summary
☐ Lab Report
☐ Surgical Report
☐ Previous Hospice Records
☐ Chemotherapy Summary
☐ Radiation Therapy Report
☐ Pathology Report
☐ Other: _____

Date of Request	Request sent to:	2nd Request:	Date Received:

_____

Signature of **Patient** Date

If Patient unable to sign, state reason: _____

_____

Signature of **Legally Authorized Representative/Primary Caregiver** Date

_____

Name of Legally Authorized Representatives /Primary Caregiver

_____

Address of Legal Representative /Primary Caregiver

_____

Signature of Hospice Representative Date

Patient: _____ DOB: _____ SS#: _____ MR# _____
(Last), (First)

Pillars Hospice & Palliative Care, LLC

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

Patient Name: _____ Patient MRN: _____

Purpose of Issuing this Notification

The purpose of this addendum is to notify the requesting Medicare beneficiary (or representative), in writing, of those conditions, items, services, and drugs not covered by the hospice because the hospice has determined they are unrelated to your terminal illness and related conditions. If you request this notification on the effective date of the hospice election (that is, on the start date of hospice care), the hospice must provide you this form within 5 days. If you request this form at any point after the start date of hospice care, the hospice must provide you this form within 3 days.

Diagnosis Related to Terminal Illness and Related Conditions:

1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

Diagnosis Unrelated to Terminal Illness and Related Conditions:

1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

Non-covered Items, Services, and Drugs Determined By Hospice to be Unrelated to Your Terminal Illness and Related Conditions:

Items/Services/Drugs	Reason for Non-coverage

Note: The hospice makes the decision as to whether or not conditions, items, services, and drugs are related for each patient. As the patient or representative, you should share this list and clinical explanation with other healthcare providers from which you seek items, services, or drugs, unrelated to your terminal illness and related conditions to assist in making treatment decisions. The hospice should provide its reasons for non-coverage in language that you (or your representative) understand.

Right to Immediate Advocacy

As a Medicare beneficiary, you have the right to contact the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) to request for 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.

Signing this notification (or its' updates) is only acknowledgement of receipt of this notification (or its updates) and does not constitute your agreement with the hospice's determinations.

Signature of Beneficiary: _____ Date Signed: _____

☐ Beneficiary is unable to sign

Signature of Representative: _____ Date Signed: _____

PILLARS HOSPICE CARE, LLC

PM FORM 3.15.1

Informed Consent for Psychotropic Medication Treatment

I have discussed the following information with my prescriber for each medication listed below:

- The diagnosis and target symptoms for the medication recommended;
- The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment;
- The possible risks and side effects;
- The possible alternatives;
- The possible results of not taking the recommended medication:
- The possibility that my medication dose may need to be adjusted over time, in consultation with my prescriber;
- My right to actively participate in my treatment by discussing medication concerns or questions with my prescriber; and
- My right to withdraw voluntary consent for medication at any time (unless the use of medications in my treatment is required in a Court Order or in a Special Treatment Plan).

I understand the medication information that has been provided to me. By signing below, I agree to the use of each medication.

Medication	Target Symptoms to be addressed*	How Discussed**	Patient/ Guardian Initial & Date***	Prescriber Initial & Date
		☐ In person ☐ Telephone ☐ Tele Medicine ☐ Previously	Date __________	Date ___________
		☐ In person ☐ Telephone ☐ Tele Medicine ☐ Previously	Date ___________	Date ___________
		☐ In person ☐ Telephone ☐ Tele Medicine ☐ Previously	Date ___________	Date ___________
		☐ In person ☐ Telephone ☐ Tele Medicine ☐ Previously	Date ___________	Date ___________
		☐ In person ☐ Telephone ☐ Tele Medicine ☐ Previously	Date ___________	Date ___________
		☐ In person ☐ Telephone ☐ Tele Medicine ☐ Previously	Date ___________	Date ___________
		☐ In person ☐ Telephone ☐ Tele Medicine ☐ Previously	Date ___________	Date ___________

___________________________ ___________________________ __________ _______

Patient Printed Name Patient/GuardianSignature Initials MR#

___________________________ ___________________________ _______

Prescriber Printed Name Signature Initials

*Target Symptoms refer to specific symptoms associated with a diagnosis, such as tearfulness, hallucinations, insomnia. List the target symptoms rather than the underlying diagnosis.

Previously indicates the medication had been discussed in a previous setting or by another prescriber (hospital, another clinic, etc.) and you are verifying that the person continues to consent to treatment.*Ensure informed consent form with original patient signature is located in patient's file. If consent obtained by telephone or through tele-medicine, individual may initial and date at next face-to-face visit.

DEVELOPED BY JOHN PRESTON, PSY.D., ABPP

To the best of our knowledge recommended doses and side effects listed below are accurate. However, this is meant as a general reference only, and should not serve as a guideline for prescribing of medications. Please check the manufacturer's product information sheet or the P.D.R. for any changes in dosage schedule or contraindications. (Brand names are registered trademarks.)

ANTIDEPRESSANTS

NAMES		Usual Daily Dosage			Selective Action On Neurotransmitters[2]		
Generic	Brand	Range	Sedation	ACH[1]	NE	5-HT	DA
imipramine	Tofranil	150-300 mg	mid	mid	+ +	+++	0
desipramine	Norpramin	150-300 mg	low	low	+++++	0	0
amitriptyline	Elavil	150-300 mg	high	high	++	++++	0
nortriptyline	Aventyl, Pamelor	75-125 mg	mid	mid	+++	++	0
clomipramine	Anafranil	150-250 mg	high	high	0	+++++	0
trazodone	Desyrel, Oleptro	150-400 mg	mid	none	0	++++	0
nefazodone	Generic Only	100-300 mg	mid	none	0	+++	0
fluoxetine	Prozac[4], Sarafem	20-80 mg	low	none	0	+++++	0
bupropion	Wellbutrin[4]	150-400 mg	low	none	++	0	++
sertraline	Zoloft	50-200 mg	low	none	0	+++++	+
paroxetine	Paxil	20-50 mg	low	low	+	+++++	0
venlafaxine	Effexor[4]	75-350 mg	low	none	+++	+++	+
desvenlafaxine	Pristiq	50-400 mg	low	none	+++	+++	+
fluvoxamine	Luvox	50-300 mg	low	low	0	+++++	0
mirtazapine	Remeron	15-45 mg	mid	mid	+++	+++	0
citalopram	Celexa	10-40 mg	low	none	0	+++++	0
escitalopram	Lexapro	5-20 mg	low	none	0	+++++	0
duloxetine	Cymbalta	20-80 mg	low	none	+++	+++	0
vilazodone	Viibryd	10-40 mg	low	low	0	+++++	0
atomoxetine	Strattera	60-120 mg	low	low	+++++	0	0
vortioxetine	Brintellix	10-20 mg	low	none	+	+++++	+
levomilnacipran	Fetzima	40-120 mg	low	none	+++	+++	0
MAO INHIBITORS							
phenelzine	Nardil	30-90 mg	low	none	+++	+++	+++
tranylcypromine	Parnate	20-60 mg	low	none	+++	+++	+++
selegiline	Emsam (patch)	6-12 mg	low	none	+++	+++	+++

[1]ACH: Anticholinergic Side Effects
[2]NE: Norepinephrine, 5-HT: Serotonin, DA: Dopamine (0 = no effect, + = minimal effect, +++ = moderate effect, +++++ = high effect)
[3]Uncertain, but likely effects
[4]Available in standard formulation and time release (XR, XL or CR). Prozac available in 90mg time released/weekly formulation

BIPOLAR DISORDER MEDICATIONS

NAMES		Daily	Serum[1]
Generic	Brand	Dosage Range	Level
lithium carbonate	Eskalith, Lithonate	600-2400	0.6-1.5
olanzapine/ fluoxetine	Symbyax	6/25-12/50mg[4]	2
carbamazepine	Tegretol,Equetro	600-1600	4-10+

NAMES			Daily	Serum[1]
Generic	Brand	Dosage	Range	Level
divalproex	Depakote		750-1500	50-100
lamotrigine	Lamictal		50-500	(2)
oxcarbazepine	Trileptal		1200-2400	(2)

[1]Lithium levels are expressed in mEq/l, carbamazepine and valproic acid levels express in mcg/ml.
[2]Serum monitoring may not necessary [3]Not yet established [4]Available in: 6/25, 6/50, 12/25, and 12/50mg formulations

ANTI-OBSESSIONAL

NAMES		
Generic	Brand	Dose Range[1]
clomipramine	Anafranil	150-300 mg
fluoxetine	Prozac[1]	20-80 mg
sertraline	Zoloft[1]	50-200 mg
paroxetine	Paxil[1]	20-60 mg
fluvoxamine	Luvox[1]	50-300 mg
citalopram	Celexa[1]	10-40 mg
escitalopram	Lexapro[1]	5-30 mg
vilazodone	Viibryd[1]	10-40 mg

[1]often higher doses are required to control obsessive-compulsive symptoms than the doses generally used to treat depression.

PSYCHO-STIMULANTS

NAMES		
Generic	Brand	Daily Dosage[1]
methylphenidate	Ritalin	5-50 mg
methylphenidate	Concerta[2]	18-54 mg
methylphenidate	Metadate	5-40 mg
methylphenidate	Methylin	10-60 mg
methylphenidate	Daytrana (patch)	15-30 mg
methylphenidate	Quillivant XR (liquid)[2]	10-60 mg
dexmethylphenidate	Focalin	5-40 mg
dextroamphetamine	Dexedrine	5-40 mg
lisdexamphetamine	Vyvanse	30-70 mg
d- and l-amphetamine	Adderall	5-40 mg
modafinil	Provigil, Sparlon	100-400 mg
armodafanil	Nuvigil	150-250 mg

[1]Note: Adult Doses. [2]Sustained release

ANTIPSYCHOTICS

NAMES Generic	Brand	Dosage Range[1]	Sedation	Ortho[2]	EPS[3]	ACH Effects[4]	Equivalence[5]
LOW POTENCY							
chlorpromazine	Thorazine	50-800 mg	high	high	+ +	++++	100 mg
thioridazine	Mellaril	150-800 mg	high	high	+	+++++	100 mg
clozapine	Clozaril	300-900 mg	high	high	0	+++++	50 mg
quetiapine	Seroquel	150-600 mg	mid	mid	+/0	+	50 mg
HIGH POTENCY							
perphenazine	Trilafon	8-60 mg	mid	mid	++++	++	10 mg
loxapine	Loxitane	50-250 mg	low	mid	+++	++	10 mg
trifluoperazine	Stelazine	2-40 mg	low	mid	++++	++	5 mg
fluphenazine	Prolixin[5]	3-45 mg	low	mid	+++++	++	2 mg
thiothixene	Navane	10-60 mg	low	mid	++++	++	5 mg
haloperidol	Haldol[5]	2-40 mg	low	low	+++++	+	2 mg
pimozide	Orap	1-10 mg	low	low	+++++	+	1-2 mg
risperidone	Risperdal	4-16 mg	low	mid	+	+	1-2 mg
paliperidone	Invega	3-12 mg	low	mid	+	+	1-2 mg
olanzapine	Zyprexa	5-20 mg	mid	low	+/0	+	1-2 mg
ziprasidone	Geodon	60-160 mg	low	mid	+/0	++	10 mg
iloperidone	Fanapt	12-24 mg	mid	mid	+	++	1-2 mg
asenapine	Saphris	10-20 mg	low	low	+	+	1-2 mg
lurasidone	Latuda	40-80 mg	mid	mid	+	+	10 mg
aripiprazole	Abilify	15-30mg	low	low	+	+	2 mg

[1]Usual daily oral dosage
[2]Orthostatic Hypotension Dizziness and falls
[3]Acute: Parkinson's, dystonias, akathisia. Does not reflect risk for tardive dyskinesia. All neuroleptics may cause tardive dyskinesia, except clozapine.
[4]Anticholinergic Side Effects.
[5]Dose required to achieve efficacy of 100 mg chlorpromazine.
[6]Available in time-release IM format.

ANTI-ANXIETY

NAMES Generic	Brand	Single Dose Dosage Range	Equivalence[1]
BENZODIAZEPINES			
diazepam	Valium	2-10 mg	5 mg
chlordiazepoxide	Librium	10-50 mg	25 mg
clorazepate	Tranxene	3.75-15 mg	10 mg
clonazepam	Klonopin	0.5-2.0 mg	0.25 mg
lorazepam	Ativan	0.5-2.0 mg	1 mg
alprazolam	Xanax, XR	0.25-2.0 mg	0.5 mg
OTHER ANTIANXIETY AGENTS			
buspirone	BuSpar	5-20 mg	
gabapentin	Neurontin	200-600 mg	
hydroxyzine	Atarax, Vistaril	10-50 mg	
propranolol	Inderal	10-80 mg	
atenolol	Tenormin	25-100 mg	
guanfacine	Tenex, Intuniv	0.5-3 mg	
clonidine	Catapres, Kapvay	0.1-0.3 mg	
prazosin[2]	Minipress	5-20 mg	
pregabalin	Lyrica	25-450 mg	

[1]Doses required to achieve efficacy of 5 mg of diazepam
[2]For treatment of nightmares and day time anxiety

HYPNOTICS

NAMES Generic	Brand	Single Dose Dosage Range
temazepam	Restoril	15-30 mg
triazolam	Halcion	0.25-0.5 mg
zolpidem	Ambien	5-10 mg
zolpidem	Intermezzo	1.75 mg
zaleplon	Sonata	5-10 mg
eszopiclone	Lunesta	1-3 mg
ramelteon	Rozerem	4-16 mg
diphenhydramine	Benadryl	25-100 mg
doxepin	Silenor	3-6 mg

OVER THE COUNTER

Name	Daily Dose
St. John's Wort[1, 2]	600-1800 mg
SAM-e[3]	400-1600 mg
Omega-3[4]-EPA	1-2 g
Folic acid[8]	500 mcg
N-acetylcysteine[5]	1200-2400 mg
Chamomile[6]	200-1500 mg
5-HTP[7]	300-600 mg

[1]Treats depression and anxiety
[2]May cause significant drug-drug interactions
[3]Treats depression
[4]Treats depression and bipolar disorder
[5]For trichotillomania
[6]Treats anxiety:equivalent: one cup of chamomile tea
[7]Treats depression
[8]Note: available as Deplin 1-methylfolate (presctiption) 7.5-15 mg

REFERENCES and RECOMMENDED BOOKS

Quick Reference • Free Downloads
Website: www.PsyD-fx.com

Handbook of Clinical Psychopharmacology For Therapists (2013) Preston, O'Neal and Talaga

Clinical Psychopharmacology Made Ridiculously Simple 8th Edition (2014) Preston and Johnson

Consumer's Guide to Psychiatric Drugs (2009) Preston, O'Neal, Talaga

Child and Adolescent Psychopharmacology Made Simple (2010) Preston, O'Neal, Talaga

Medicare Secondary Payer (MSP) Form

Patient Name: _____ MR#: _____

Medicare Number: _____ Date: _____

1. Do you receive Veteran's benefits? Yes ☐ No ☐

2. Are you receiving benefits under the Black Lung Program? Yes ☐ No ☐
   If yes, date benefits began _____
   If yes, are the services you will be receiving related to a non-black lung condition? Yes ☐ No ☐

3. Was this injury/illness due to a work related accident/condition? Yes* ☐ No ☐
   If yes, date of injury/illness _____

4. Was this injury/illness related to an automobile accident? Yes* ☐ No ☐
   If yes, date of accident _____

5. Was this injury/illness related to an accident in which you intend to file a liability suit or litigation is pending?
   Yes ☐ No ☐
   If yes, please provide: Attorney's name: _____
   Address: _____
   Phone number: _____

6. Are you entitled to Medicare based on: ☐ Age (65 & over) – go to question 7
   ☐ Disability – go to question 7
   ☐ End Stage Renal Disease
   Do you have group health plan (GHP) coverage? Yes ☐ No ☐
   Are you within the 30-month coordination period? Yes ☐ No ☐

7. Are you currently employed? Yes ☐ No ☐ Date of retirement _____
   a) Is your spouse currently employed? Yes ☐ No ☐ Date of retirement _____
   b) Do you have a group health plan (GHP) as primary coverage based on your own or a spouse's current(or former) employment? Yes* ☐ No ☐
   c) Does the employer that sponsors your GHP employ 20 or more employees? Yes ☐ No ☐

If you answered Yes to questions #3, #4 or #7 above, please complete the following information:

Insurance Co: _____
Address: _____
Policy/Cert #: _____
Group name & #: _____

_____ _____
Patient's Signature Date

_____ _____
Responsible Party Signature Relationship

Pillars Hospice Care, LLC
Tuberculosis Screening

Name: _____

In the past year, have you experienced any of the following symptoms with no known reasons?

	Yes	No
Persistent Cough, lasting longer than three (3) weeks		
Coughing up bloody sputum		
Fever/ chills for more than one month		
Weight loss beyond normal weight fluctuations or dieting		
Loss of appetite longer than one month		
Night sweats that leave the sheets moist		
Unexplained “tired feeling” that interferes with daily activities		
Exposure to a person with active TB		
Do you have a history of positive TB tests		

I give my permission to PILLARS HOSPICE CARE, LLC to administer the skin test for Tuberculosis. I will have the site read between 48 and 72 hours.

Signature: _____Date: _____

Manufacturer:_____ Lot #:_____ Exp. Date: _____

Administered by: _____Date Administered:_____

Dose 0.1 ml intradermal Site: Forearm ☐ Left ☐ Right

Read by: _____Date Read: _____

Result Size: _____mm ☐ Negative
☐ Positive Referred to: _____

Chest X-ray Completed: ☐ Yes ☐ No Date: _____

PILLARS HOSPICE CARE, LLC
Home Safety Evaluation

Patient Name: _____ **MR#:** _____

ENTRY AREAS	Yes	No/Plan	OTHER ROOM	Yes	No/Plan
Free of clutter / obstacle			Floors clear of clutter / obstacles		
Carpet / rugs firmly attached			Electrical cords out of path		
Irregular stairs marked			Light Switch at entry to room		
Well lit			All light bulbs working (60 watts)		
Doors sills level			Chairs firm with sturdy holds		
Door opens easily			Wheelchair accessible		
BATHROOM(S)			**STAIR**		
Night-light			Light switches top/bottom of stairs		
Shower or bath chair/bench			Stairs free of obstacles		
Elevated toilet seat w/bars			Treads have non-skid surfaces		
Safety rails in shower/toilet			Carpet/runners firmly attached		
Tub non-slip strips/suction mat			Irregular stairs marked for visibility		
Non-slip bath mat beside tub			Sturdy railing both sides of stairs		
Floor clear of water/obstacles			Can client maneuver stairs?		
Toiletries/towels within reach			**HALLWAYS**		
Hand-held shower head			Night-light		
Long handled sponge/soap			Light switches on both ends		
Wheelchair accessible			**OUTSIDE**		
BEDROOM(S)			Even Surfaces on walkways		
Light switch at entrance			Hand rails on elevated surfaces		
Lamp or light next to bed			Lights on walk space outside		
Telephone next to bed			Pathways clear of debris		
Night-light			Entrances, walking clear		
Path from bed to bathroom			Traction material available (sand)		
Bed easy to get in/out			**GENERAL**		
KITCHEN			Stairs in/out has rails on both sides		
Brightly lit work areas			Has emergency call bell in place		
Heavier Items at waist level			Low water temperatures (by touch)		
Used items at shoulder height			Phones near floor in used rooms		
FIRE SAFETY			Has Equipment? Problems:		
Smoking Materials			No pets to trip over		
O2 in Home			Flashlight accessible in all the rooms		
Smoke Detector (working)			Absence of Loose Scatter Rugs		
Fire Extinguisher (working)					

Nurse Signature: _____ **Date:** _____

FOR REVIEW ONLY

Consolo ID #

_____

Safety Drugs
Fax 602-889-9702

Phone 602-788-1138
Fax 602-788-1136

Hospice Name: **PILLARS HOSPICE CARE** Date of Request: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Patient Phone: _____

Allergies: _____

Terminal Diagnosis:_____

Comorbidities: _____

Nurse Completing form: _____ Nurses Phone number: _____

Hospice Covered Medications

Non-Covered Medications

Pharmacist Medication Regimen Review:

_____

_____

_____

Pharmacist Completing Medication Review: _____ Date: _____

Hospice Physician Signature: _____

PRIVILEGED AND CONFIDENTIAL. This facsimile transmission is intended for the individual or company to which it is addressed, and may contain information which is privileged, confidential, and prohibited from disclosure or unauthorized use under applicable law. If the recipient of this transmission is not the intended recipient, or the employee or agent responsible for delivering such materials to the intended recipient, you are hereby notified that any use, discussion, or copying of such materials is strictly prohibited by the sender. If you have received this transmission in error, please notify us immediately by telephone and return the material to the sender by mail. Thank you.

Pharmacist, fax back to Pillars Hospice Care at 602-788-1136 once Medication Regimen Review is

PILLARS HOSPICE CARE, LLC

Notification of Hospice in Change in Attending Physician

A hospice “attending physician” is described by the statutory and regulatory definitions as a medical doctor, osteopath, or nurse practitioner whom the patient identifies, at the time of hospice election, as having the most significant role in the determination and delivery of his or her medical care. CMS now requires that the beneficiary provide the hospice with a signed document when he or she chooses to change attending physicians.

This notice is to inform Pillars Hospice Care, LLC that the attending physician I have chosen to manage my care while receiving Hospice services from Pillars Hospice Care, LLC is:

Attending Physician Name: _____

Attending Physician Address: _____

Attending Physician Phone Number: _____

Attending Physician Fax Number: _____

Attending Physician NPI Number: _____

I affirm by my signature below that the change from my previously named attending physician to the above named Attending Physician has been my choice.

Effective date of change in Attending Physician is _____

Signature of Patient or Representative Date

Name of Patient or Representative

Signature of Hospice Representative Date

PILLARS HOSPICE CARE, LLC

Notice of Hospice Enrollment Change

Patient Name: _____ MR #: _____

Current Benefit Period: ☐ 1st 90 Day ☐ 2nd 90 Day ☐ 60 Day Period # _____

REVOCATION

I hereby choose to revoke my Medicare Hospice Benefit Election. I understand that, under Medicare:

1. I will forfeit the remaining days of the above Benefit Period;
2. I will resume my Medicare coverage of the benefits that were waived while on Hospice; and
3. I also understand that I can elect to access the Medicare Hospice Benefit again in the future if it is determined that I meet the criteria for hospice care.

Patient/Representative Signature: _____ Effective Date: _____

Witness Signature: _____ Date: _____

TRANSFER/CHANGE OF DESIGNATED HOSPICE PROVIDER

I hereby choose to transfer my Medicare Hospice Benefit

From: _____ **To:** _____
(Name of Hospice) (Name of Hospice)

of _____ of _____
(City/State) (City/State)

_____ _____
(10-digit Phone Number) (10-digit Phone Number)

I understand that, under Medicare, changing to another Medicare certified hospice program once in each Benefit Period does not result in the loss of any Benefit days. I hereby authorize release of medical information to the above named hospice.

Patient/Representative Signature: _____ Effective Date: _____

Witness Signature: _____ Date: _____

DISCHARGE

I understand that it has been determined by the PILLARS HOSPICE CARE, LLC Interdisciplinary Team, the Hospice Medical Director, and my Attending Physician (If applicable) that I be discharged from the PILLARS HOSPICE CARE, LLC for the following reason(s):

_____

I also understand that I can elect to access the Medicare Hospice Benefit again in the future if it is determined that I meet the criteria for hospice care.

1. I have participated in the planning for my discharge, and
2. Have received, if needed, any necessary family counseling, education, and any information on other services, and
3. Have received instructions for future care.

Patient/Representative Signature: _____ Effective Date: _____

Witness Signature: _____ Date: _____

PILLARS HOSPICE CARE

Nurses: Kimberly Argenti RN
Marilyn Berglund LPN
Deborah Keeney-Cravath RN

Social Worker: Susan Parker, MSW
Chaplain: Kristi Gorgia

Certified Nursing Assistants: Ruben Luna CNA
Emma Vogt CNA

Medical Director: Dr. Chi Duong
Hospice Physician: Dr. Vincent Cariati
Dr. Richard Moe
Nurse Practitioner: Tammy Hilliard FNP

Please do not provide any IV's, IV antibiotics, lab work, x-rays, and/ or PT/ OT/ ST therapies without prior authorization from

Pillars Hospice Care, LLC

Please do not transfer patient to an acute hospital emergency room without prior authorization from

PILLARS HOSPICE CARE, LLC

602-788-1138