ERA HOSPICE, INC. 2050 W CHAPMAN AVE STE 246 ORANGE, CA 92868

INFORMED CONSENT AND TREATMENT AUTHORIZATION

This agreement is entered into by and between **ERA Hospice, Inc.** (hereinafter called Agency) and _____ (hereinafter called Patient). This agreement is entered into pursuant to a desire by Patient to obtain Hospice services. I request admission to Hospice and understand and agree to the following conditions:

1. I understand that the Hospice program is palliative, not curative, in the goals and treatments. The program emphasizes the relief of symptoms such as pain and physical discomfort and addresses the spiritual needs and the emotional stress which may accompany a life-threatening illness.
2. I understand I am encouraged to participate in the development and implementation of the approved plan of care and that Hospice services are not intended to take the place of care by family members or others who are important to the patient, but rather to support them in the care of the patient. With the help of hospice, the person designated the "caregiver" will provide around-the-clock care to the patient in their place of residence. If twenty-four-hour care is not available, the caregiver will arrange for another to provide it. The caregiver will also participate in decisions about the care provided to the patient. The Hospice Interdisciplinary Team supplements rather than replaces care provided by the family or Care Center Staff.
3. I accept the conditions of Hospice ad described, understanding that I may choose not to remain in the program and that Hospice may discharge me from the program if hospice care is no longer appropriate. This means there will be no further liability to me or to Hospice. I understand, however, that I may request to be readmitted at a later date. I have been able to discuss the above conditions with a member of the Hospice staff and have had my questions answered to my satisfaction.

TREATMENT AUTHORIZATION: The undersigned Patient or Patient's legally authorized representative hereby consents to any and all examinations and treatments prescribed by the Patient's physician (or hospice physician) rendered by the Agency's licensed nurses, physical therapists, occupational therapists, speech therapists, registered dietitians, social workers, spiritual counselors, home health aides and volunteers.

FINANCIAL AGREEMENT:

In consideration of the mutual promises and obligations related to treatment rendered to Patient by Agency, it is agreed as follows:

1. ***Payment Responsibility:*** It is understood that for Hospice patients, the agency assumes financial responsibility for medications and/or durable medical equipment and medical supplies related to the terminated illness, agency, in accordance with this agreement for the Patient and/or Patient's agent assumes financial responsibility for all other authorized charges. The agency in accordance with this agreement shall assist the Patient in obtaining financial assistance from third-party payers such a Medicare and private insurers.
2. ***Pharmacy Services:*** I acknowledge that I have the right to direct a pharmacist to dispense a prescription using the brand my physician prescribed instead of a generic drug product. I also understand that generic drug products generally cost less than brand name products, but the price differences vary from prescription to prescription. I hereby consent and agree that, if allowable under state law, any pharmacist who dispenses any of my prescription drugs may select a drug product that is generically equivalent to the brand prescribed by my physician, unless I submit to Hospice a written request for a brand name product.
3. ***Termination***: The agency may terminate services when in its sole medical judgment determines there is no longer any reasonable expectation that it can meet the Patient/family's needs.

MEDICARE / MEDICAL HOSPICE BENEFIT ELECTION

As a Medicare Part A or Medical beneficiary, I hereby elect **ERA Hospice, Inc.** as my sole provider of hospice care Effective _____
Date (mm/dd/yy)

I understand the hospice program to be palliative, not curative in its goal and treatment, which the program emphasizes the alleviation of physical symptoms including pain, and the identification and meeting of emotional and spiritual needs that the patient and family may experience related to the terminal illness.

PATIENT:_____ MR#_____ Initial_____
(Last) (First)

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

HOSPICE SERVICES:

☐***Routine Home Care:*** I understand that hospice services are delivered primarily in the home (which may include a nursing home) provided by a team of hospice professionals, staff and volunteers. These services are available both on a scheduled basis and as needed. I understand that these services may include, as set forth in the hospice plan of care: nursing, physician care, social worker, spiritual, nutrition, bereavement counseling, home health aides, medical supplies, physical therapy, occupational therapy, speech-language therapy, and medications prescribed for relief of pain or discomfort.

☐***Inpatient Care/Inpatient Respite:*** I understand that inpatient hospice care and inpatient respite care are provided in an inpatient bed when it is deemed necessary by the hospice interdisciplinary team. I understand that hospice inpatient care is designed for short term stays with the goal of stabilizing the patient and family emotionally and physically, so the patient can return to home. I understand that inpatient respite care is designated to provide brief periods of respite for the family or primary care while the patient receives hospice care in an inpatient bed.

☐***Continuous Care:*** I understand that continuous care (1 minimum of 8 hours of care is a 24-hour period) may be provided in a patient's home when it is deemed necessary by the hospice interdisciplinary team. I understand that continuous care is designated for short-term periods to manage acute medical symptoms with the goal of stabilizing the patient.

I understand that under the Medicare/Medi-Cal Hospice Benefit, I am entitled to hospice care, which consists of two 90-day periods and subsequent 60-day periods of unlimited duration. The Hospice Interdisciplinary Team evaluates recertification for continuation of hospice care at the end of each benefit period.

I understand that I am responsible for the cost of care for my terminal illness if I seek care beyond what is considered medically necessary by the hospice interdisciplinary group and documented on my plan of care.

I understand that I may revoke the hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is to be effective and submitting the statement to Hospice prior to that date. This revocation constitutes a waiver of the right to hospice care during the remainder of the current election period.

I understand that once in each election period I may elect to receive services through a hospice program other than ERA Hospice, Inc. such change shall not be considered a revocation of hospice services.

PATIENT:_____ MR#_____ Initial_____
(Last) (First)

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INFORMED CONSENT AND TREATMENT AUTHORIZATION

I have been providing the following information regarding advance directives:

☐ Informed of my rights to formulate an Advance Directive.

☐ I am not required to have an Advance Directive in order to receive medical treatment by any health care provider.

☐ The terms of any Advance Directive that I have executed will be followed by any health care provider and my caregivers to the extent permitted by law.

The patient has an Advance Directive:

☐ Power of Attorney for Health Care

☐ Living Will

☐ The patient does not have an Advance Directive.

Name and Address of Agent:

_____

_____

_____

Copy received: ☐ Yes ☐ No

RELEASE OF PATIENT RECORDS:

I understand that **ERA Hospice, Inc.** may need to obtain medical records and related information form hospitals, nursing homes, physicians, pharmacies, home health agencies, insurance companies, health care benefit plans, or others in order to assure continuity of care and proper reimbursement. I authorize the above persons and entities to release to **ERA Hospice, Inc.,** and its representative's medical records and related information necessary to be helpful to the provision of hospice care. I also authorize **ERA Hospice, Inc.,** and its representatives to release medical records and related information to others for the purposes of my health care, administration, and management of my health care (including utilization review), or processing and obtaining payment for services and supplies rendered to me. I understand and agree that this authorization specifically includes my permission and consent to release any information regarding a diagnosis of AIDS or the results of Human Immunodeficiency Virus (HIV) tests to the extent permitted by law. A photocopy of this authorization shall be as valid as the original.

RECEIPT OF INFORMATION:

Hospice services have been explained to me in a manner and language understood by me; I have been given the opportunity to ask any questions I have concerning the hospice program of care, and my questions have been answered to my satisfaction. I have been provided with the following materials:

☐ A copy of Patient's Rights

☐ Written materials explaining a patient's legal rights to accept or refuse medical treatments and to prepare an Advance Directive for health care.

RECEIPT OF ACKNOWLEDGEMENT:

I have received, acknowledged and agreed to the terms and conditions described in the following documents:

☐ Informed Consent and Treatment Authorization
☐ Medicare/Medical Hospice Benefit Election
☐ Notice of Privacy Practices
☐ Patient/Family Hospice Information
☐ Financial Agreement
☐ Advance Directives
☐ Compliant and Grievance Program

_____ _____

SIGNATURE OF PATIENT **DATE**

IF PATIENT UNABLE TO SIGN, STATE REASON: _____

_____ _____

SIGNATURE OF LEGALLY AUTHORIZED REPRESENTATIVE (If Applicable) **DATE**

_____

NAME AND ADDRESS OF LEGAL REPRESENTATIVE (PRINT) (If Applicable)

_____

HOSPICE CARE REPRESENTATIVE

PATIENT:_____ MR#_____ Initial_____

(LAST) (FIRST)

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

I acknowledge that I have been provided with information about my financial responsibility for certain hospice services (drug copayment and inpatient respite care). I understand that I have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" addendum that lists the items, services, and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions that would not be covered by the hospice. I acknowledge that I have been provided information regarding the provision of Immediate Advocacy through the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) if I disagree with any of the hospice's determinations and I have been provided with the contact information for the BFCC-QIO that services my area: https://qioprogram.org/locate-your-qio or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

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

Initials_____ Date_____
{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"
Initials_____ Date_____

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 elated conditions to assist in making treatment decisions.*

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.*
BFCC-Q/O Name: LIVANTA / https://livantaqio.com/en and BFCC-Q/O Phone Number: 1-877-588-1123; 1-855-887-6668 (TTY).

The purpose of this addendum is to notify the 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's updates) is only acknowledgment of receipt of the addendum (or its updates) and not necessarily agreement with the hospice's determinations.

CONSENT TO PHOTOGRAPH

A patient, while under the care of ERA Hospice, Inc., depending on the overall condition of the patient, could develop some skin conditions like rashes, wounds {whether stage 1 or higher) etc. As a matter of ERA Hospice, Inc's policy, patients at the onset of these underlying condition, needs to be addressed immediately. Initially, our field nurses and/or other staff must report the situation as soon as possible, and at the same time, there might be a need to take photo/s of the skin condition for further consultation with ERA Hospice, Inc., Medical Director or a third party wound specialists. The photo could also be used during the discussion of patient's condition, status of the wounds and its progression, with the Inter Disciplinary Team {IDT) members. In such a case, as a matter of policy, ERA Hospice, Inc., will see to it that the photo/s taken shall be done strictly with the following condition/s:

1. The focus of the photo shall be on the skin condition only.
2. That there will not be, at any point in time, in any frame of the photo, will it show the face of the patient, nor any private part of the patient that is not relevant and/or necessary in addressing the said skin condition.
3. That the said photo shall be used entirely for the purpose of developing a plan of care for the patient, specifically, in addressing the skin condition, and will not be sold, published, or used in any other way, other than patient care.

Given the conditions discussed, I hereby:

☐ Give my consent to *ERA Hospice, Inc.* to take photograph/s if applicable.

☐ Refuse to give my consent to *ERA Hospice, Inc.* to take any photograph/s.

I acknowledge and understand the above, and authorize Medicare hospice coverage to be provided by

ERA Hospice Inc. to begin on _____
(Hospice Agency) **(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.

_____ _____
Signature of Patient / Patient Representative **(Date Signed)**

☐ Beneficiary is unable to sign - Reason:_____

_____ _____
Signature of Hospice Representative **(Date Signed)**

_____ _____
Witness signature **(Date Signed)**

ERA HOSPICE, INC.

2050 W CHAPMAN AVE STE 246 ORANGE, CA 92868
Tel: (714) 602-9232 Fax: (949) 620-3370

PATIENT CONSENT FOR PRIMARY CARE PHYSICIAN

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

Physician's Name: _____ **Date:** _____

☐ I wish to continue my Primary Care with my current Physician, with **ERA Hospice, Inc.,** Medical Director to intercede for only my terminal illness treatment needs and pain management.

Primary Care Physician: _____

NPI: _____ Phone: _____

☐ I would prefer **ERA Hospice, Inc.,** Medical Director to attend to my care needs.

Comments:

_____

_____

_____

_____

_____

_____ _____

Patient/Legal Guardian Signature Date:/Time

_____ _____

Hospice Representative Signature Date:/Time

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PATIENT ACKNOWLEDGEMENT

Patient's Name: _____

MR # _____ Date: _____

I have received the following information and have been given the opportunity to ask questions.

IMPORTANT INFORMATION EXPLAINED TO PATIENT/ FAMILY/ CAREGIVER	Explained	Left in Home
1. Patient's freedom of choice in selecting a hospice agency.		
2. Patient's condition/plan of care/goals and how related to his / her condition.		
3. Patient's right to participate in the plan of Care, treatment, and informed of Change.		
4. Patient/Caregiver is expected to learn and participate in care consistent with capabilities.		
5. Disease process, medication regime and diet.		
6. Written notice of Patient's Rights & Responsibilities, Consent, Assignment of Benefits, Patient grievance Procedure. Guidelines for Patient care and Emergency Care.		
7. Advance Directive. Has Patient executed an Advance Directive? YES, NO • Given written materials about right to accept or refuse medical treatment • Been informed of rights to formulate Advance Directives. • That patient is not required to execute an Advance Directives to receive medical treatment from this health care facility. • That the terms of any Advance Directives executed will be followed by the agency and caregivers to the extent permitted by laws.		
8. Visit Plan to include disciplines and frequencies.		
9. Confidentiality and Disclosure of Clinical Records.		
10. Basic Home Safety, Infection Control, Disaster Plan		
11. Patient liability for payment and right to be informed of any changes.		
12. Toll-free State Hospice Hot Line number and purpose.		
13. How to register a complaint with the agency and their right to voice grievance without fear of reprisal.		
14. Discharge Planning.		
15. Emergency Disaster Plan Priority Code: Good support system, efficient caregivers in place (Lowest Priority) Support system in place requiring frequent agency interventions (High Priority) Support systems unreliable and inconsistent and/or on 0_2, Infusion, or ventilator Therapy (Highest Priority)	Circle One Category 3 Category 2 Category 1	

Patient/Caregiver Signature: _____ Date: _____

Staff Signature/Title: _____ Date: _____

Individual Patient Emergency Preparedness Plan

Identifying Information

Patient Name:_____ SOC Date:_____
Phone Number:_____ Physician:_____
Address:_____
City:_____ State:_____ Zip:_____

Relevant Healthcare Information

Primary Dx:_____Secondary Dx:_____
Daily or more frequently Agency Services: No____ Yes____
If Yes, describe:_____
Oxygen dependent: Flow Rate_____ Hours of Use:_____ Delivery Device:_____
Life-Sustaining Infusion: No____ Yes____
If Yes, describe:_____
Other IV Therapy: No____ Yes____
If Yes, describe:_____
Patient/Caregiver Independent: No____ Yes____
Ventilator Dependent: No____ Yes____
Dialysis: No____ Yes____
If Yes, describe:_____
Tube Feeding:No____ Yes____
If Yes, describe:_____
Patient/Caregiver Independent with Self-Administered Medications: No____ Yes____
Functional Disabilities (check all that apply): ____Walker/cane ____Wheelchair ____Bedbound
____Hearing Impairment ____Visual Impairment ____Mental/Cognitive Impairment

Emergency Plan

Emergency Contact Name: _____ Phone Number: _____
If necessary, patient will evacuate to: Relative/Friend
(Name/PhoneNumber):_____
Hotel (Name / Phone Number): _____
Shelter (Location):_____
Is patient registered for special need shelter? No____ Yes___
Other (Describe):_____

Priority/Acuity Level: _____

_____
Clinician/Date

*Copy to patient and original on medical record.