ADMISSION CHECKLIST

Patient Name:________________

Marketing/Administrator/On-Call

___ Admission handbook to patient

Complete & return original to office:

___ Attending Physician Form (p.2)
___ Admission Checklist & Consent (p.3)
___ Patient Contact Form (p.4)
___ Informed Consent (p. 5-8)
___ Authorization to Disclose Health Info (p.9-10)
___ Photo Release Form *(p.11)*
___*Notes (p.12)*
___ Take Photo & email photo to Office Manager
___ Medicare Secondary Payor Worksheet (stapled)

Copy & return to office:

___ Eval/tx Order ___SNF Plan of Care
___ MDPOA ___ DNR *(complete if not in chart)*
___ Living Will ___ Insurance Card/s
___ Picture ID, if available

Copy & Leave for RN Case Manager: (hand to nurse, leave tucked into pt chart, or with family)

___ Teal Folder ___H & P
___Admission Checklist/DME order list
___ "On Call Process" handout
___ BLANK comfort pack order sets
___ Drug risk assessment form

Set up Facility Chart

___ Hospice Divider Tab & Discipline Dividers
___ FRH Contact Sheet & Phone List
___ Copy of Consent Form
___ E-Mail Admission Report to All Staff (only if on call)

Admissions Coordinator:

___ Open Chart in First Hospice
___ Nursing Rx Benefit Fax Notification Form
(fill out, fax to pharmacy, & attach fax verification to Rx benefit form)
___ SNF: Fax LTC Status Form(submit to SNF business office)
___ Fax face sheet to Weld Cty. Coroner, if needed
___ Set up new patient chart in the office
___ Place Admission report in Kerio, then email All Staff

Signature:________________________ Date:________

Signature:________________________ Date:________

Admission Nurse:

Nurse to review H&P, medlists, Labs, Progress notes as posted in Kerio current admission information folder
(copy of ** items must be put in facility chart)

First Hospice Charting (FH) and Procare

___ Medications (drug, dose, route, instructions, frequency, indication, RBV)
___ Allergies
___ Order DME and input into FH **See back of this form**
___ **All Care Settings**: Type "Admit to FR Hospice", Dx, & Level of Care in order in First Hospice
___**Initial Plan of Care
___ **Initial Nursing Assessment
___** Fall Risk Assessment
___** Braden Scale
___**CNA Plan of Care
____ NQF #0209 (First Hospice & Kerio)
____ Profile a comfort pack and bowel protocol
____ Reconcile Medications with Procare. Assign Hospice or Pt pay for EACH Medication

Non-First Hospice Admission Items

___ CTI Worksheet
___ Obtain Physician Orders as needed: in **SNF** document orders on SNF T.O.'s and make a copy, in **AL & Home** document orders in FH
___ **ALF & SNF**: Write "Admit to FR Hospice", Dx, & Level of Care on T.O. and make copy
___ **Home Patients:** Complete Drug Risk Assessment, if yes to any questions alert SW and discuss approp of placing comfort pack in home with AOC
___ If on Coumadin, notify DON
___ If on "Clinical Manager Approval Pending" drug, notify DON
___ Place nursing admission report in Kerio and send HIPAA compliant email to staff that it is ready for Review
___Return admission checklist to the office
___ Return folder and unused blanks to the office

Signature:________________________Date:________

DON Admit audit__________________ Date:________

DME Order Guide

Oxygen (use O2 ordering flow sheet for guidance)

- **Attempt to order oxygen for all pts, at some point it will usually be needed.** Okay for family to put in closet until needed. Etanks store upright in ventilated area
- **Always order a concentrator**
- **<u>Always order a backup (usually E Tanks) in event of power failure</u>**
- **SNF do not allow E-Tanks or Large Liquid Stationary. <u>Do not order</u>** (they have a room full of liquid to fill portable tanks, and they will reject a Large Liquid Tank)
- **Okay to order a humidifier for concentrators**
- **Don't forget to order appropriate oxygen tubing (nasal cannula, simple mask, etc)**

❑ Oxygen Concentrator-Regular (1 to 4.5 l/min)
❑ Oxygen Concentrator-High Flow (1 to 10 l/min)
❑ Large Liquid O2, Stationary (up to 5 l/min)
❑ Large Liquid O2, Stationary high flow (1-10 l/min)
❑ Portable O2, Refillable off Lg tank (1-5 l/min)
❑ Portable O2, Refillable off Lg tank, High flow(1-10 l/min)
❑ Hi-pressure portable O2 Tank (E Tanks)
❑ Hi-pressure portable tank other sizes: D, M per pt preference

Hospital Beds

- **<u>Rails are not allowed in SNF or ALF</u>**
- **Rails are okay (half or full) in home**
- **Order Hi-Low bed for fall risk patients**

❑ Hospital Bed: High Low (order if a fall risk)
❑ Semi electric hospital bed **<u>(no rails)</u>**
❑ Hospital Bed: Semi-Electric **w/ full or half rails**
❑ Bariatric Bed: pts must weigh over 300lbs and meet criteria per Medicare. Always discuss with DON or AOC. This and any bariatric equipment is NOT per diem. Do not use in home or ALF due to wt.

Patient Name____________________

Other Items available (on per diem)

❑ Wheelchair - Need ht/wt when ordering-18" is standard
❑ Bedside Commode (3 in 1)- Need ht/wt when ordering
❑ Shower Chair
❑ Walker, front wheel - Need ht/wt when ordering
❑ Over the Bed Table
❑ Floor mat pad (some AL's don't allow beds to be against the wall, if unsure order 2 mats)
❑ Low Air Loss Mattress P-1500 –(order this or Micro-air, unless pt prefers foam mattress)
❑ Alternating Pressure Mattress "Micro-Air"-(new mattress similar to P-2500
❑ Nebulizer (Not on per diem but nurse may order)

Addition Other Items Available

❑ APP overlay and pump
❑ Bolster Sheet – – **NOT ALLOWED IN MOST AL'S, SPECIFICALLY STRATFORD** not on per diem, okay to order without approval if indicated for patient
❑ Geri Chair – Do not order Geri chair and Hiback both
❑ Hi-Back Reclining Chair (approval for this and Geri Chair depends on length of time pt is spending out of bed, in chair
❑ Hoyer Lift – 2 people must operate per care plan
❑ Sit to Stand Lift (Sabina)
❑ Suction machine - need to order tubing and yank
❑ Aleria mattress(High scoop, limited availability air mattress, nursing homes only)
❑ Over the Bed Trapeze
❑ Pulse Dose Regulator or Oxygen conserving regulator
❑ Other - this selection on DME tab in EMR is for other items that might be needed: special pumps, etc, and should be discussed w DON or AOC
❑ All Bariatric equipment
❑ Alternate Pressure Mattress P-2500 (only for high skin risk/existing ulcers)

<u>Schryver does not carry:</u>
Optimizers for O2
Bed Canes (some SNFs may have)
Cushioned toilet seats
Blanket cradles (for foot drop)
Specialty w/c cushion (contact DON to order)

Attending Physician Information

Patient Name: ____

Patient Location: ____

- ☐ New Physician (not currently in firstHospice)
- ☐ Existing Physician

Physician Information:

(Must have the following information to enter into firstHospice)

Name: ____

Office Address: ____

City: ____________________ **State: Colorado** ____________ **Zip:** __________

Office Phone: ____

Office Fax: ____

Other Numbers and Type: _________________________________

Preferred Non-Hospice Pharmacy for Home Patients:

(Must have the following information to enter into firstHospice)

Pharmacy: ____

Pharmacy Address: ______________________________________

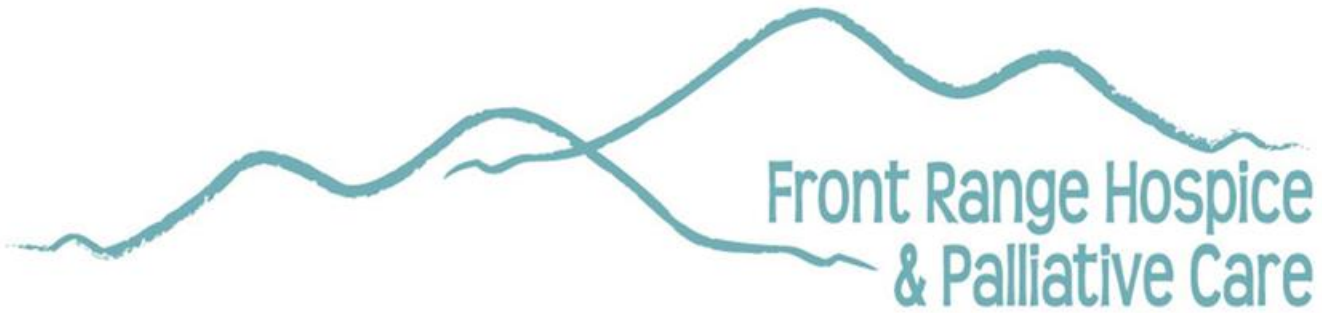
City: ____________________ **State: Colorado** ____________ **Zip:** __________

Pharmacy Phone: _______________________________________

Pharmacy Fax: ____

Other Numbers and Type: _________________________________

***Patients in ALF/SNF will utilize the pharmacy used by that facility.**



3770 Puritan Way, Suite E
Frederick, Co 80516
Phone: 303-957-3101 or 970-776-8080
Fax: 303-957-3113

ADMISSION CHECKLIST AND CONSENT

Print Name: ____

I acknowledge receipt of the following documents:

___________ Patient Informed Consent for Care

___________ Rights and Responsibilities

___________ Grievance Procedures

___________ Notice of Privacy Practice

___________ Pain Handout

___________ Disposal of Medications

I have had the opportunity to review such documents, to ask questions and to discuss their contents with a hospice representative. I understand the scope of services that Front Range Hospice provides and my rights and responsibilities. I have provided the information requested under Coordination of Care.

____

Signature of Patient or Representative Date

____

Printed Name of Patient or Representative Date

____

Signature of Front Range Hospice Representative Date

PATIENT CONTACT FORM

Patient Name: ____

Point of Contact Person for Routine Updates___________________________ _____Initial for Approval

Name: Relationship: Phone: (h)

©

Address: (w)

____Initial For Approval

Name: Relationship: Phone: (h)

(c)

Address: (w)

____Initial For Approval

Name: Relationship: Phone: (h)

(c)

Address: (w)

____Initial for Approval

Name: Relationship: Phone: (h)

(c)

Address: (w)

____Initial for Approval

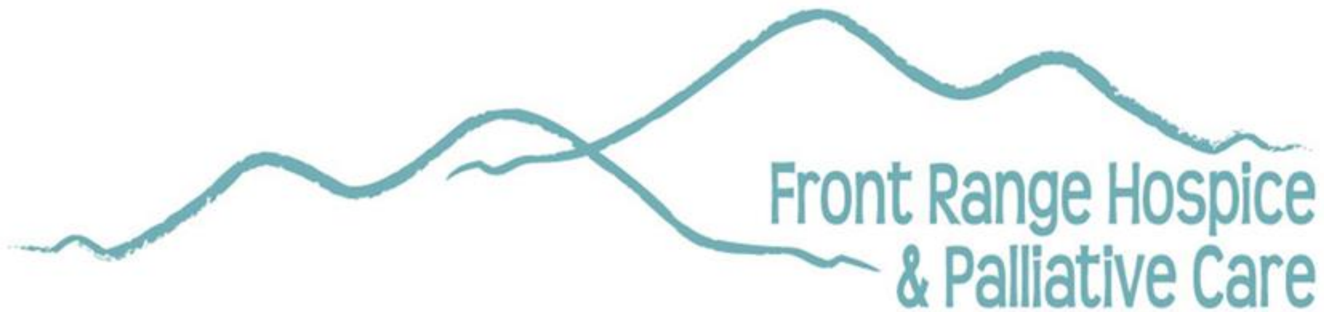
Name: Relationship: Phone: (h)

(c)

Address: (w)

____Initial for Approval

Name: Relationship: Phone: (h)



INFORMED CONSENT FOR HOSPICE CARE

I, _________________________, choose to receive care from Front Range Hospice and Palliative Care. I acknowledge and understand the following:

1) Hospice Care and Palliative Care as reimbursed by Medicare, Medicaid, and most private insurances is not curative, but focuses on quality of life by managing symptoms of my illness and providing emotional, social and spiritual support to me, my family, and others closely involved in my life.
   a) I understand that care does not generally include the use of emergency life sustaining measures or equipment.
   b) Care is delivered in the home (which may be a nursing home or assisted living facility) by a team of specially trained professionals and volunteers.
   c) Decisions regarding services and treatment will be made by me, my family, my attending physician and the hospice team. These decisions will be reflected in the Plan of Care.
   d) Care from the hospice team is intermittent and delivered by an interdisciplinary team (physician, nurse, social worker, chaplain, nurses aide and volunteers).
   e) Care will be provided through scheduled visits, but assistance is available 24 hours a day by calling 303-957-3101 or 970-776-8080.

2) As a patient receiving care from Front Range Hospice and Palliative Care, I have the following rights:
   a) To be informed of Front Range Hospice's admission criteria, the services I may expect to receive, and charges.
   b) To have care explained to my satisfaction in language I understand; my primary language is ______________________; if needed, interpretation will be done by _____________.
   c) To participate in the development of my plan of care.
   d) To expect that the information in my medical record is confidential and will not be relayed to any unauthorized person or agency outside Front Range Hospice without my consent. State laws will be followed in situations where adult or child abuse is suspected or the staff has reason to believe that I am at a high risk for suicide. The beneficiary's medical record is subject to review by KEPRO (Quality Improvement Organization) and CGS Administrators, LLC.
   e) To voice complaints and recommend changes without coercion, discrimination or unreasonable interruption of service. I will direct concerns to the CEO of Front Range Hospice or the Director of Clinical Services at 303-957-3101 or 970-776-8080. I may expect a response within two working days. If I am not satisfied with the response, I may contact the Joint Commission at Consumer complaint line at 1-800-994-6610 or the Colorado Department of Health hotline 1-800-842-8826.
   f) To refuse service or withdraw from the program at any time.

g) To make decisions concerning medical care including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. I have prepared the following Advance Directives:
   - □ Cardiopulmonary Resuscitation Directive
   - □ Living Will
   - □ Medical Durable Power of Attorney for Health Care Decisions
   - □ Five Wishes
   - □ I have no Advance Directives

3) I further understand that I have the following responsibilities:
   a) To make satisfactory arrangements for my care when the Front Range Hospice staff is not in my home or my environment is unsafe. The team is not intended to take the place of family, but rather, to support family and friends in caring for me. The person mainly responsible for my care is ______________________. If I have no 24-hour caregiver available, I agree to make, in advance, appropriate arrangements for such time as my care requires 24-hour attention.
   b) To participate as fully as possible in planning my care so that the care plan developed by the Hospice team incorporates my physical, emotional, social, and spiritual needs as well as those of my family.
   c) To provide the hospice team with accurate information to be used in providing my care.
   d) To have blood drawn and tested, when applicable, if any employee is exposed to my blood or body fluids.
   e) To be tested for tuberculosis when applicable.

4) The responsibilities of Front Range Hospice are:
   a) To provide quality care regardless of race, religion, gender, sexual orientation, age, physical or mental disabilities, or ability to pay.
   b) To train all professional staff and volunteers adequately for the levels of service they will provide.
   c) To provide care which is ethical and in my best interest. Front Range Hospice will be respectful of my family's and my life values, beliefs, religious preferences, dignity, individuality, privacy in treatment, and personal needs.
   d) To provide caregivers who respect my personal property.
   e) To provide special attention to privacy, choice, and dignity.
   f) To provide care regardless of whether or not an Advance Directive has been issued.

HOSPICE BENEFIT ELECTION FORM

1). Under (**circle one**) Medicare, Medicaid, Private Insurance, VA, a Hospice Benefit Program is available so that people who have a terminal illness may receive a full scope of medical and support services for their terminal condition while continuing to live in their own homes or other settings outside of a hospital.

2). By choosing the Hospice Benefits, I will not receive payment for other services related to the illness (often referred as primary diagnosis or terminal diagnosis) for which I am receiving hospice care. Only Front Range Hospice will receive payments for the care of services provided for this illness or any other condition related to this illness. These services include home visits by the hospice team, medical equipment and supplies, and pharmacy services. The benefit may also include continuous home care during a crisis situation, respite care for a maximum of 5 days, and general inpatient care authorized by the hospice team.

3). My health insurance will continue to make payments to my primary physician for services rendered as long as my physician is neither an employee nor receiving payments from Front Range Hospice.

4). I understand that I am not waiving the right for payment of services by the health plan for treatment of any condition *not* related to my terminal diagnosis.

5). I understand that I will be responsible for the cost of all care for my terminal illness if I seek care beyond what is considered medically necessary by the Hospice Interdisciplinary Team and documented in my plan of care.

6). Under Medicare and Medicaid, the Hospice benefit will make payment for unlimited days of hospice care with a certification signed by a physician that you continue to meet hospice criteria. The days are broken down into benefit periods as follows:

a. First Benefit Period – 90 days
b. Second Benefit Period – 90 days
c. Subsequent 60 day periods.

7). I may choose to discontinue hospice care at any time by completing a revocation statement, which can be obtained from any Front Range Hospice employee. If I revoke hospice care during a benefit period, I forfeit the remaining days of that benefit period. I would be eligible for the next benefit period when I meet the requirements for hospice care as certified by a physician.

8). I may choose to transfer my care to another hospice at any time during a certification period but I may only transfer one time during a benefit period. I may make the arrangements myself or I may request the assistance of the staff at Front Range Hospice in making the transfer arrangements. Before a transfer may occur, the receiving hospice must agree to accept me as a patient, a physician must order the transfer and a physician must be willing to sign the certification paperwork and subsequent orders and plan of care for the receiving hospice. Front Range Hospice will ensure that the receiving hospice receives all pertinent copies of my medical record including my plan of care, my medication list, and all pertinent chart notes. The transfer will occur at a date that is specified by me and agreed upon by the receiving hospice. I understand that I cannot receive hospice care from two hospices at any one time and agree to coordinate my transfer in a manner that best ensures my safety.

9). I understand that Front Range Hospice may discharge me from hospice services under the following situations: the interdisciplinary team determines that I no longer meet hospice criteria, I move out of their service territory and do not make arrangements for my care to be transferred to another hospice, or under extraordinary circumstances where we are not able to agree on an appropriate plan of care.

10). All medical care is physician directed, through my attending physician and the Medical Director for Front Range Hospice. Front Range Hospice respects my continued relationship with my attending physician. I acknowledge my choice for attending physician to direct my hospice cares:
Physician or NP full name: ____
Address: ____
NPI # ___________________________________
Phone # _________________________________

11). All care delivered by non Front Range Hospice staff must be pre-authorized by Front Range Hospice. This includes but is not limited to, ambulance transports, ER or outpatient services, hospital admissions, and procedures and treatments during doctor office visits. If I receive services related to my terminal illness that are not included in the plan of care, or are not authorized by Front Range Hospice, regardless of whether the services are palliative or curative in nature, neither Medicare, Medicaid, Private insurance is financially liable for the services. All of these activities and charges are the responsibility of me or my estate. If I want to pursue treatment not authorized or not included in the plan of care for my terminal condition I will pay privately or revoke my hospice benefit.

12). Medicare, Medicaid, and some private insurance provide four levels of hospice care. These levels are routine, respite, continuous care, and inpatient. Most hospice care is rendered under the routine benefit. Respite care is available when the interdisciplinary team determines that my primary caregiver needs a rest. This care will be delivered at a contracted nursing home and is limited to 5 consecutive days. Continuous care is available during a crisis for periods of eight hours or more and only as necessary to maintain the patient safely at home and in lieu of inpatient care. Inpatient care is available when needed for symptom control and will be arranged through a hospice-contracted Medicare/Medicaid approved facility.

13). FOR MEDICAID RECIPIENTS RESIDING IN A NURSING HOME: I understand Medicaid will continue to pay the room and board during my stay in the nursing home but the amount will be reduced by 5%. From the date of my admission to Front Range Hospice, I understand that Front Range Hospice will bill Medicaid for my room and board and will pass this payment on to the nursing home. I will remain responsible for my share of costs as determined by Medicaid.

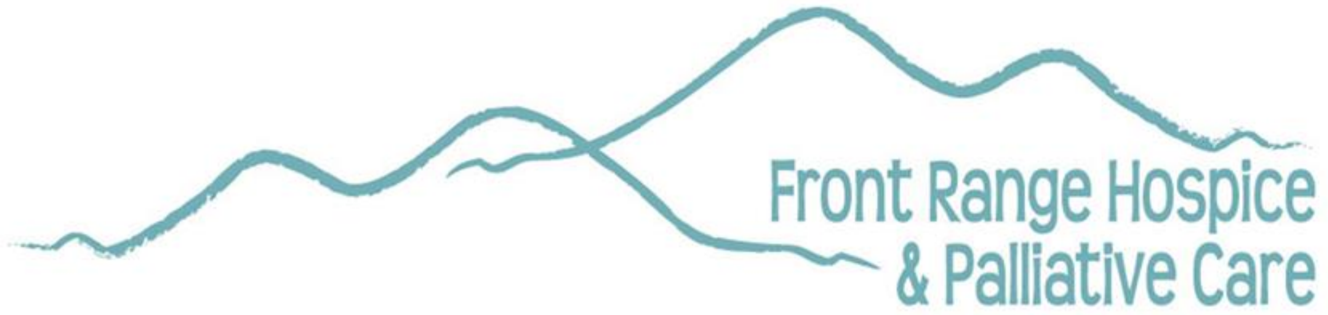
14). FOR MEDICARE RECIPIENTS RESIDING IN A NURSING HOME: I understand that Medicare has no room and board coverage and I will remain responsible for the room and board charges during my stay. Medicare does have a general inpatient benefit, which will pay room and board during an *acute crisis only*. The implementation of this benefit and the discontinuation of this benefit will be under the direction of the Hospice Medical Director.

15). I understand that the hospice benefit includes emotional, educational, and spiritual support for my family during my hospice stay and for 13 months after my death.

ACKNOWLEDGING AND UNDERSTANDING THE ABOVE, I AUTHORIZE HOSPICE SERVICES FROM FRONT RANGE HOSPICE TO BEGIN ON _________________. I FURTHER AUTHORIZE MY INSURANCE TO REIMBURSE FRONT RANGE HOSPICE DIRECTLY FOR THE SERVICES COVERED BY MY INSURANCE.

Signature of Patient or Agent: ____ Date: _______________

Signature of Hospice Representative: ____ Date: _______________



3770 Puritan Way, Suite E
Frederick, CO 80516
P. 303.957.3101 or 970.776.8080
F. 303.957.3113

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Section 1

Patient Name | Social Security # | Date of Birth

Street Address | Apt #

City | State | Zip Code | Phone Number

(*Initial*) __________
□ I authorize the following health care provider to release health information to **Front Range Hospice and Palliative Care** about the above named individual:

____
Provider

____ ____________________ ____________________
Address City/State Zip Code

____ ____
Phone # Fax #

(*Initial*) __________
□ I authorize **Front Range Hospice and Palliative Care** to release health information to the following health care provider about the above named individual:

____
Provider

____ ____________________ ____________________
Address City/State Zip Code

____ ____
Phone # Fax #

Section 2

Reason for Disclosure: **HOSPICE SERVICES**

Section 3

The type and amount of information to be disclosed is as follows: *(specify dates where appropriate)*

☐ Laboratory Results, from date________ to date ________

☐ Radiology Reports, from date________ to date ________

☐ Most recent History and Physical

☐ Physician Progress Notes, from date________ to date ________

☐ HIV/AIDS information, from date________ to date ________

☐ Other: ____

Please complete the following information to clarify above request (as applicable):

Attending Physician: ______________________________ Date Hospitalized: __________ to _________

Records related to the diagnoses of: ____

AUTHORIZATION TO DISCLOSE /OBTAIN PROTECTED HEALTH INFORMATION

____ ___________________________

Patient's Name (Please print) Date of Birth

- I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
- I understand this authorization will expire, without my expressed revocation one year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
- I understand that Front Range Hospice will only release requested records up to the date of my signature, and does not include future records. If I request to have records disclosed in the future, I will be required to complete a new authorization.
- I understand that authorization for the disclosure of health information is voluntary and I can refuse to sign this authorization. Front Range Hospice cannot condition treatment, payment or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

____ ___________________________

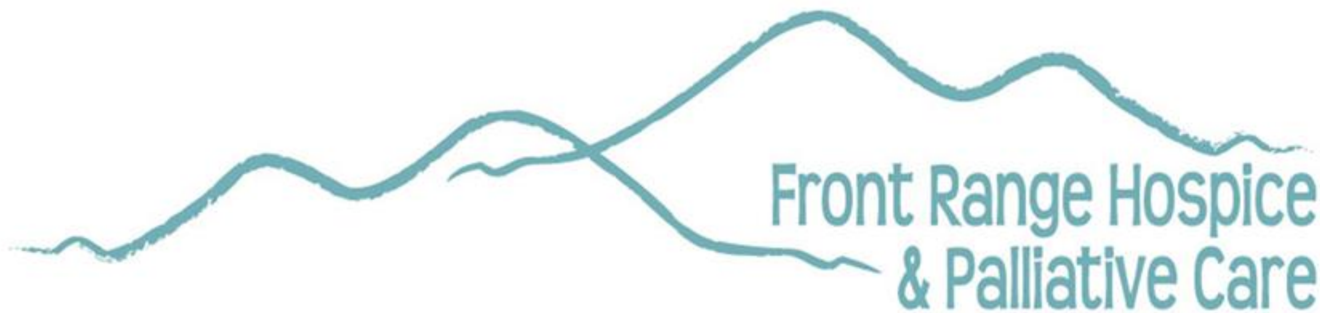
Signature of Patient/Representative Date

____ ___________________________

Personal representative's Name (print) and Relationship Date

(Please attach applicable legal documentation of authority)

NOTE TO RECEIVING PERSON/PARTY: If this release pertains to alcohol or drug abuse information, please note that: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation (42C F.R. Part 2) prohibits you from making further disclosure of it without the specific written consent of the patient to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.



AUTHORIZATION FOR RELEASE OF PHOTOGRAPH

I, _____________________________ give permission for Front Range Hospice and Palliative Care to use a photograph of
__________________________ as a means of identification. I understand that this photograph will become part of my medical record in accordance with The Red Flags Rule Program created by the Federal Trade Commission for the purpose of protecting our clients from Identity Theft and will not be used for any other reason than patient identification.

____ ________________
Printed Name of Patient or Legal Representative Date

____ ________________
Patient or Legal Representative Signature Date

____ ________________
Signature of Front Range Hospice Representative Date

Patient ID Verification

For FRH use only

Patient ID Verified: ________ ID Type: _____________

____ Date: ___________
FRH Representative

Front Range Hospice & Palliative Care

NOTES

*Patient Name:*_________________________________

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Signature: ______________________________________Date: _______________________________________