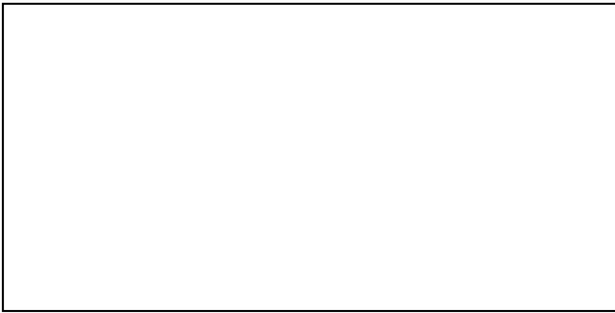

730 Holly Lane
Salina, KS 67401
785-825-1717

Hospice Election Statement, Informed Consent and Medicare Secondary Payer Form

Program Purpose

I,_____________________________________, choose to receive hospice care from Hospice of Salina for the treatment of_____________________________________. I the patient or my representative acknowledge that I/we has been given a full understanding of hospice care, that it is a palliative, rather than a curative, approach to treatment and that as a Hospice program patient I will not receive treatment for cure or life prolongation.

I elect:

____Hospice Medicare Benefit

_____Medicaid

____Veterans administration program

_____Private Insurance

____Self Pay

I understand I will be entering my: ____First 90 day Benefit period
____Second 90 day Benefit period
____Unlimited 60 day Benefit period

I understand that certain Medicare services are waived when I elect the Hospice Medicare Benefit and this has been fully explained to me.

I also understand that I may withdraw from the Hospice program at any time but in doing so, I will forfeit any remaining days of the certification period in which I am enrolled. I understand that I may elect to change Hospices only once in each certification period.

Home Care/Caregiver

I understand that services available to me under the Hospice of Salina, Inc. program include home care services such as intermittent nursing, social work, counseling, pastoral care and personal care services, as well as coverage of some equipment, supplies and prescriptions as ordered for my Hospice care. I/we the family understand that for the patient to receive services from Hospice of Salina, and the patient is deemed unsafe to be alone, I/we the family agree to either have family or a paid caregiver available to me 24 hours/day or I will agree to placement in an assisted living facility or nursing home.

I understand that, should short term inpatient care be necessary to treat a medical crisis related to symptom control or respite care for relief of care givers, my admission to a hospital contracting with Hospice of Salina, Inc. be approved by the Hospice team prior to admission or I may be financially liable for the bill.

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FOLLOW-UP CARE

The caregiver, companions and others who are important to me may choose to participate in the bereavement program. Services include individual and group counseling, educational materials and programs, and help with practical matters and social activities.

CARE PLAN

I have the opportunity to join the Hospice of Salina, Inc. team in making decisions about the variety, frequency and intensity of services and interventions the Hospice team will use to help me. I have access to my Hospice of Salina, Inc. plan of care and may participate in discussions about the services and techniques being used to assist me.

RELEASE OF INFORMATION

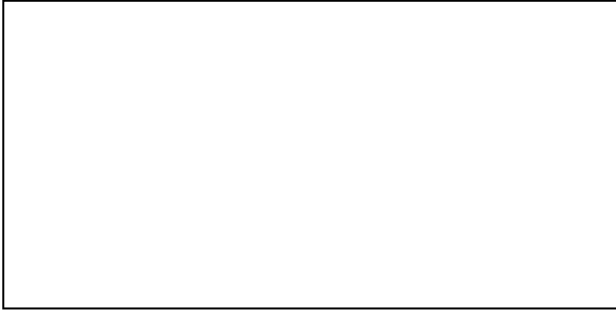
I give consent/authorize any hospital, skilled nursing facility, doctor's office or home health agency, to include any source of third party reimbursement in which I am or have been a patient to disclose all or any part of my medical record to or from Hospice of Salina, Inc. I authorize Hospice of Salina, Inc. or its agent to release any medical or other information about me needed for insurance claims.

I give consent and approval for notations to be made on the Hospice of Salina, Inc. records concerning the medical, nursing, psychosocial, spiritual and personal information necessary for Hospice of Salina, Inc. to fulfill its functions.

The estimated cost and expected reimbursement of hospice care has been explained to me. I understand that I am responsible for payment of those services not covered by insurance (deductibles, co-payments, services that have been requested without prior approval from Hospice of Salina, Inc., or services that are not covered benefits under my insurance) unless other arrangements have been made. I have been given the opportunity to discuss my financial needs with a representative of Hospice of Salina, Inc. I understand that I will not be denied admission to the program because of inability to pay.

I have discussed Hospice care with a member of the Hospice staff, have had all questions answered to my satisfaction and fully understand the nature of Hospice care.

I have been provided a copy of the: Patient Bill or rights; Hospice of Salina Notice of Privacy Practices/Health Information Rights; Safety in the Home information and Advance Directive Brochure.



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Hospice Election Statement, Informed Consent and Medicare Secondary Payer Form

Medicare providers are required to obtain/ retain proof that screening for other primary insurance has been conducted.

Date: ________________________ Patient Name:_____________________________

DOB: _______________________ Medicare Number:_________________________

As my primary hospital and medical insurance,

I, ______________________________________, carry

Medicare Part A: _____ Medicare Part B: ______ Other: ______

Insurance Company Name:____

Policy Number:____

I do not carry primary hospital and medical insurance: ______

My secondary health insurance is provided by:

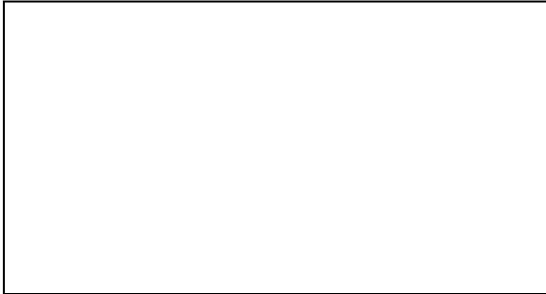
Insurance Company Name: ____

Policy Number:____

I do not carry any secondary health insurance: _______

Please answer "Yes" or "No" to the following questions.	**YES**	**NO**
1.Do you or your spouse work for a company that provides you with health insurance?	___	___
2.Are you entitled to Medicare because of disability or end stage renal disease?	___	___
3.Is this service needed as the result of an automobile accident or other injury?	___	___
4.Is this illness or injury the result of an accident or illness that occurred at work?	___	___
5.Has this treatment been authorized by the Veteran's Administration benefits?	___	___
6.Are you entitled to any benefits under the Federal Black Lung Program?	___	___

Patient's Termination of Employment or Retirement Date ________________________



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Hospice Election Statement, Informed Consent and Medicare Secondary Payer Form
Signature Page

ELECTION OF SERVICE / MEDICARE SECONDARY PAYER

I elect to receive Hospice services provided by Hospice of Salina, Inc. and request that payment of authorized benefits begin on______________________________ (election date).

Signed:_______________________________________ _____________ #____________________
Beneficiary Date Policy Number

Signed: **X**______________________________ Relationship to Patient: **X**___________________
Power of Attorney/Authorized Representative

Witness:____________________________________ Date:____________________

****

If patient unable to sign, state reason:____

****

If patient is non-English speaking, individual who has interpreted statement/consent for patient or responsible party:
Type or Print Name:___________________________ Date:__________________

****

I have explained the purpose of this consent/election form and services that will be provided. I have answered all questions about Hospice by the patient or by responsible person(s) on behalf of the patient.

Signed:_______________________________________ Date:___________________