

The following outline specifies _____
(print patient's name)

wishes concerning the withholding and removal of Life Sustaining Treatment. Treatment options have been discussed and the following are the wishes and decisions I have made:

DO WANT	DO NOT WANT	
<input type="checkbox"/>	<input type="checkbox"/>	CPR
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotic Therapies
<input type="checkbox"/>	<input type="checkbox"/>	Feedings via Gastrostomy tube (GT)
<input type="checkbox"/>	<input type="checkbox"/>	Feeding via Nasal Gastric Feeding Tube (NGT)
<input type="checkbox"/>	<input type="checkbox"/>	Intravenous (IV) Fluids and Therapies
<input type="checkbox"/>	<input type="checkbox"/>	Transferring to Acute Hospital
<input type="checkbox"/>	<input type="checkbox"/>	Laboratory and X-ray Services
<input type="checkbox"/>	<input type="checkbox"/>	Others: _____

The above Advance Directives decisions may be changed, modified or cancelled at anytime. We the undersigned, have made these decisions in good faith and parties involved are in agreement regarding these decisions.

- I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.
- I understand this decision will not prevent me from obtaining other emergency medical care by pre-hospital emergency medical care personnel and/or medical care directed by a physician prior to my death.
- I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.
- I give permission for this information to be given to the pre-hospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.
- I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Surrogate Signature

Date

Surrogate's Relationship to Patient

Hospice Touch Representative

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilation, intubation, defibrillation, or cardiotoxic medications are to be initiated.

Physician's Signature

Date

Print Name

Telephone

Address

I request admission to Hospice Touch, Inc. ("Hospice") for the provision of hospice services. I understand and agree to the following:

1. I understand that the care provided by the Hospice program is palliative, not curative, in nature and is aimed at management of my symptoms and to help me attain a level of maximum comfort during my terminal illness. My right to management of pain and symptom control will be respected, supported and addressed appropriately.
2. I understand that my care will be provided by and/or under the direction of a hospice team composed of a physician, nurse, social worker, chaplain and other disciplines that may be deemed necessary. I may also request a volunteer.
3. I understand that my attending physician may collaborate with the hospice team to provide my care. He/she may also consult with the Hospice medical director, as necessary, for management of the symptoms associated with my terminal illness, such as discomfort, nutrition, etc.
4. I understand that Hospice services are designed to be delivered primarily in my residence and are available 24 hours a day, 7 days a week. However, if inpatient care is required for pain control, symptom management or respite purposes, Hospice will provide continuity of care through admission to a contracted inpatient facility.
5. I understand that room and board is the responsibility of the patient/family. Should I apply for Medi-Cal for nursing facility room and board I accept responsibility for participating fully in the application process.
6. I understand that Medicare/Medi-Cal/Champus Hospice program consists of two 90-day periods and unlimited 60 day periods if no revocations or discharges occur. I will use the benefit periods in the above order. However, I understand that if I have commercial insurance, my benefit periods may not be exactly the same as described above.
7. I understand that I can revoke this benefit at any time in writing and resume those insurance benefits which are waived during the period I am a Hospice Touch patient. I understand that with revocation I will lose days remaining in the benefit period in which I revoke. I understand that I may at any time file a re-election of the hospice benefit, for any other election period that is still available to me.
8. I understand that I may change hospice providers only once in each benefit period. A change in hospice providers is not a revocation and I will not lose any benefit days. I understand that to change hospice programs, I must file this change in writing with Hospice Touch and specify a date to discontinue care and the name of the hospice I wish to receive care and the date care will start.
9. I understand that if during the continued evaluation of the appropriateness of care, I no longer meet the criteria for hospice care, I will be discharged. I will be notified as soon as possible of the planned discharge from Hospice Touch.
10. I waive all rights to regular Medicare benefits for the duration of the election of hospice care for the following services.
 - a. Hospice care provided by a hospice other than the Hospice Touch (*unless provided under arrangements made by Hospice Touch*);
 - b. Any Medicare services related to the terminal condition or that are equivalent to hospice

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care except:

1. Services provided (either directly or under arrangement) by Hospice Touch;
2. Services provided by another hospice under arrangements made by Hospice Touch, or
3. Services provided by the beneficiary's independent attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

11. Hospice provides four levels of care: I understand that it is the professional hospice team which makes the determination when a level of care change is needed and which level of care is most appropriate. Hospice provides routine home care, general inpatient care, continuous care, and respite care.

- a. Routine home care is provided wherever the patient resides at home or in a nursing facility.
- b. Acute inpatient care is provided during periods of crisis in a hospice inpatient unit, or skilled nursing facility.
- c. Continuous care is provided during periods of crisis when a patient remains at home while acute symptoms are being resolved.
- d. Respite care is provided, in a skilled nursing facility for a period of 5 days when needed.

12. I understand that I may be responsible to Hospice Touch for any balance of service charges over and above this insurance payment. I understand that I am fully responsible for all services rendered by Hospice Touch, subject to the following:

- a. If I am eligible for Medicare or Medi-Cal hospice benefits, all costs will be paid under these programs and I will have no financial obligation.
- b. If I am not eligible for Medicare or Medi-Cal hospice benefits, but I have hospice benefits under a commercial medical insurance policy, I will be responsible for all or a portion of those costs not paid under the policy, i.e., deductibles, co-payments, and costs that exceed policy limits. The actual amount of these costs for which I am responsible will be determined based on a personal assessment of my finances and/or my family's finances.
- c. If I am not eligible for Medicare or Medi-Cal hospice benefits and I have no commercial insurance coverage, I will be responsible for all or a portion of the cost for hospice services based on a financial assessment to be performed on me and/or my family.
- d. I understand that admission to Hospice is not based upon my ability to pay, and Hospice will not discontinue or diminish care because of lack of insurance coverage for medically necessary hospice care.
- e. I understand that I may be financially responsible for any hospital care, emergency services or medical treatment related to the terminal illness, which is not arranged by Hospice Touch and not included in the hospice Plan of Care.
- f. I understand that Hospice Touch will pay for consultant physician bills that are related to the terminal illness, home health aide, and medically necessary durable medical equipment approved by the Hospice and medications related to terminal illness.
- g. I understand I may use Medicare/Medi-Cal/Champus in the usual manner to pay for:
 - i. Attending physician charges if he/she is not a Hospice employee and/or
 - ii. Treatment of condition(s) unrelated to the terminal illness for which I am

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receiving hospice care.

13. Hospice Touch may require the following to ensure my safety, comfort and appropriate medical care:
- a. Acceptance of personal medical alert system to summon help in an emergency.
 - b. Lock box to enable Hospice personnel to obtain entry into my home.
 - c. Participation in planning for my care if and when I reach the point that I must have someone with me at all times. This may include hiring of additional help or admission to a nursing facility if other arrangements cannot be made.
 - d. Acceptance of recommendations by the Hospice staff and my physician as to when additional help or placement is needed.
 - e. Disclosure of my financial status, as needed, only to determine my ability to hire additional help not furnished by Hospice.
 - f. When Hospice personnel determine that I am unsafe to be alone, my alternative plan for care will be: _____
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14. I understand that I have the right to formulate Advance Directives, but that I am not required to have an Advance Directive in order to receive services. I further understand that any Advance Directive I have executed will be followed by hospice and my caregivers to the extent permitted by law. I have executed the following:
- Durable Power of Attorney
 - Designation of Health Care Surrogate
 - Living Will
 - I have not formulated Advance Directives at this time
15. If you have a complaint regarding the services you have received from Hospice Touch, please contact the **Administrator or Director of Patient Care Services at 886-553-5553**. Additionally, you also have the right to file a complaint against Hospice Touch by contacting the Department of Health Services office hours are M-F, 8 am – 5 pm, except holidays at 1-800-824-0613. You may write to them at the following address: Department of Health Services 7575 Metropolitan Drive, Suite 104 San Diego, CA 92108.
16. I understand that Hospice Touch, Inc. 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. I authorize the above persons and entities to release to Hospice Touch, Inc. and its representatives medical records and related information necessary to be helpful to the provision of hospice care. I also authorize Hospice Touch, 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 these authorizations specifically include my permission and consent to release any information regarding a diagnosis of AIDS or 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.

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17. My signature on this form acknowledges that I elect to receive hospice services from Hospice Touch on the effective date below. The nature of my terminal illness and of hospice care, the palliative, rather than curative nature of the services provided by hospice, and the coverage provided through Hospice Touch have been fully explained to me by Hospice Touch. I have been given the opportunity to discuss the services, requirements, and limitations of the hospice benefit; our questions regarding the hospice care have been answered to our satisfaction and we have been given a full understanding of hospice care. I have been provided a handbook containing the following written materials: Notice of Privacy Practices, Patient's Rights and Responsibilities and information regarding preparation of an Advance Directive.

18. The physician I have chosen to serve as my attending physician is:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

I authorize hospice services from Hospice Touch, Inc. effective _____

Signature of Patient or Legal Guardian/Health Care Surrogate

Name and Address of Legal Guardian/Health Care Surrogate

Hospice Touch Representative

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