CaringEdge

CaringEdge Hospice of Hermantown
4195 Westberg Rd. Hermantown, MN 55811
P: 218-216-7243 F: 612-254-8243

Patient Name: _____

Medical Record No: _____

Date of Birth: _____

Today's Date: _____

Hospice Election of Benefits

I, _____ choose to elect the Medicare hospice benefit
(Patient Name)

and receive Hospice services from CaringEdge Hospice of Hermantown
(Name of Hospice Agency)

to begin on _____ . Benefit Period: ■1 ☐2 ☐3 ☐4 ☐ ___
(Start of Care Date)

(Note: The start of care date, also 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.)

Right to choose an attending physician

- I understand that I have a 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:

Physician Full Name: Jeffrey B Rapp NPI: 1386612653

Office Address: 512 Skyline Blvd. Cloquet, MN 55720

Hospice Philosophy and Coverage of Hospice Care

By electing hospice care under the Medicare hospice benefit, I acknowledge that:

- I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of hospice care 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 was provided 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 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.

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Right to Request "Patient Notification of Hospice Non-Covered Items, Services and Drugs"

- As a Medicare beneficiary who elects to receive hospice 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 the 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.

Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)

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 your area is:

BFCC-QIO Name: Livanta LLC

BFCC-QIO Phone Number: (888) 524-9900

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

(**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**"

Beneficiary or Representative Signature | **Date**

Relationship to Beneficiary (If unable to Sign) | **Reason Beneficiary Unable to Sign**

Signature of CaringEdge Representative | **Date**

Printed Name of CaringEdge Representative, Title

CaringEdge

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4195 Westberg Rd. Hermantown, MN 55811
P: 218-216-7243 F: 612-254-8243

Patient Name: _____

Medical Record No: _____

Date of Birth: _____

Today's Date: _____

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

Date of Request: _____ **Furnished Date:** _____

(Hospice must furnish this addendum within 5 days if requested at the time of hospice election and within 72 hours if requested during the course of hospice care)

Diagnoses Related to Terminal Illness and Related Conditions

(Hospice is responsible to cover all items, services, and drugs)

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

Diagnoses Unrelated to Terminal Illness and Related Conditions

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

Non-Covered items, services, and drugs determined by hospice as not related to 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.

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Date of Birth: _____

Today's Date: _____

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

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.

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

_____ _____

Beneficiary or Representative Signature **Date**

_____ _____

Relationship to Beneficiary (If unable to Sign) **Reason Beneficiary Unable to Sign**

_____ _____

Signature of CaringEdge Representative **Date**

_____

Printed Name of CaringEdge Representative, Title

CaringEdge

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Date of Birth: _____

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Hospice Services Disclosure Form

Required Services Covered by the Medicare Hospice Benefit

All of the following services are required and covered if they are needed to palliate the symptoms of a terminal diagnosis and are included in the patient's Plan of Care.

- Medicines, medical supplies, and durable medical equipment (hospital bed, walker, etc.)
- Laboratory Services
- X-ray and radiation therapy
- Emergency services
- Ambulance and transport services
- Short-term inpatient stays in a hospice facility, hospital or skilled care facility for management of acute symptoms
- Short-term continuous nursing care in the home for crisis care of acute symptoms that can be managed at home with extra support from the hospice team
- Five-day inpatient respite periods when caretakers require a break from care giving responsiblities
- Bereavement support and counseling services
- Use of an interdisciplinary team
  - Medical supervision and physician services
  - Individual case management and coordination of care by a registered nurse
  - Intermittent nursing visits
  - Social work services
  - Pastoral counseling and spiritual support provided or coordinated by a hospice chaplain
  - Home health aide and homemaker services
  - Volunteer services
  - Dierary counseling and physical, occupational, speech and respiratory therapy services as appopriate

Medicare Hospice Levels of Care

☒ **Routine Home Care** is provided in a patient's residence or a nursing facility if they reside there.

☐ **Continuous Care** is used to provide intensive are for short periods of time to manage a crisis situation. At least 8 hours of direct one-on-one care must be required during a 24-hour period, and at least half of that care must be provided by a licensed nurse.

☐ **Inpatient Care** is used for the control of acute pain or symptoms that cannot be adequately managed in the home, short-term care is provided in a hospital or skilled nursing facility.

☐ **Respite Care** is provided in a hospital or skilled nursing home to allow the patient's primary care giver a rest. Up to 5 days of respite care are allowed at a time.

Special Services

I understand that if I need hospitalization or special services not provided by hospice, I or my legal representative must make arrangements for these services. The hospice shall in no way be responsible for failure to provide the same and is hereby released from any liablity arising from the fact that I am not provided with such additional care.

I have read and understood the services provided by CaringEdge Hospice and the four levels of care as outlined above. I have also received a copy of this form.

Your signature on the affirmations page acknowledges you have received and fully understand CaringEdge's Hospice Services Disclosure Form.

CaringEdge

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Patient Name: _____

Medical Record No: _____

Date of Birth: _____

Today's Date: _____

911/Emergency Services Notice to Protect You

It is an honor to care for you, or your loved one during this difficult time. We would like to take a moment to explain the Medicare/Medicaid hospice benefit and what it covers in terms of emergency/urgent care services.

Once a person chooses to receive hospice care, they enable the hospice benefit election. Part of that benefit is that a patient chooses not to receive curative treatment for their terminal diagnosis. A patient can still call 911 or go to the emergency room for injuries/illnesses that are not related to their terminal diagnosis. However, the hospice agency must be aware of all treatments and services the patient is going to receive prior to receiving care. Hospice can provide most services and treatments, so contact hospice prior to calling 911.

If you or your loved one wish to enable 911 or emergency services, the hospice agency must first obtain a revocation notice from you.

By signing below, you acknowledge that you must sign a revocation notice prior to obtaining any other medical interventions such as emergency services or calling 911. This will enable you to use those services and they will get billed to your insurance instead of you. In the event that you don't sign the revocation form before seeking treatment, the hospital and/or emergency services can bill you for the services instead of your insurance.

Your signature on the affirmations page acknowledges you have received and fully understand CaringEdge Hospice's explanation of the Medicare/Medicaid Hospice Benefit as it applies to emergency and urgent care services.

CaringEdge

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Date of Birth: _____

Today's Date: _____

Authorization to Release Information for Payment and Reimbursement Purposes

I,_____, have been informed that CaringEdge Hospice offers hospice care to those who have a terminal illness. I understand that hospice is palliative rather than curative in its goals, and that hospice emphasizes the relief of symptoms, and or emotional/spiritual distress that may accompany my illness. Care is physician directed, through my attending physician and the medical director for CaringEdge Hospice. Hospice care may involve skilled nursing care, volunteer companions, certified hospice aide care, emotional and spiritual care, social workers and inpatient care.

In consideration of the mutual promises and obligations related to treatment to be rendered to the patient/family by CaringEdge Hospice, it is agreed as follows:

Treatment: Consent is given for examinations and treatments as prescribed by the patient's physician (or CaringEdge Hospice physician) rendered by CaringEdge Hospice licensed nurses, physical therapists, occupational therapists, speech pathologists, registered dietitians, clergy, home health aides, hospice volunteers, social workers and their clinical supervisors.

Patient Information Authorization & Release: By signing this consent, you authorize CaringEdge Hospice to use and/or disclose your health information for treatment, payment, or health care operations. Consent is also given for the release of information to CaringEdge Hospice by any insurer of the patient and all other agencies or medical facilities from who the undersigned has received medical or social services. You have the right not to sign this consent. However, if you refuse to sign this consent, we have the right to refuse to treat you.

1. Along with this consent form, we have also provided you a copy of our Notice of Privacy Practices, which details how we may use & disclose your health information. You have the right to review this notice before signing this consent. We may amend the notice from time to time.
2. You have the right to request that we restrict how we use and/or disclose your protected health information for the purpose of providing treatment, obtaining payment for our services, and/or conducting health care operations. Such requests must be made in writing. Please note that we are not required to agree to any restriction you may request. If, however, we decide to agree to a restriction you have requested, we must restrict our use and/or disclosure of your health information in the manner described in your request.
3. You have the right to revoke this consent at any time. Your revocation of this consent must be in writing. If you wish to revoke this consent, please contact our office. Note that our revocation of this consent will not be effective for disclosures we have already made based on prior consent. We also have the right to refuse to provide further treatment if you revoke this consent.
4. You have a right to receive a copy of this consent form after you sign it.
5. This consent is effective unless and until you revoke it in writing.

Termination: Except for Medicare-eligible hospice patients, CaringEdge Hospice, upon due notice of no less than 30 days, may terminate services for lack of payment for its services. In addition, CaringEdge Hospice may terminate services, when in its sole medical judgment determines there is no longer any reasonable expectation that it can meet the patients' and/or family's needs.

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Date of Birth: _____

Today's Date: _____

Authorization for Release of Medical Information

Patient Name: _____

Date of Birth: _____

To: _____

You are hereby authorized and requested to furnish to CaringEdge Hospice, or their representative, all of medical and drug records including:

- History and Physical Exam
- Progress Notes
- Clinical Summary
- Physician's Notes
- Consultation Reports
- Laboratory Reports
- Operative Reports
- Nurse's Notes
- Pathology Reports
- Outpatient Information
- X-Ray Reports
- Other: (Specify):

I also hereby give consent to CaringEdge Hospice to make copies of said records for the purpose of coordinating and providing my medical care.

This authorization will remain in effect a maximum of six months from the date of signature and may be canceled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.

The following email address can be used to inform, update or coordinate care with myself, family, or care providers.

Email Address: _____

Beneficiary or Representative Signature **Date**

CaringEdge

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Patient Name: _____

Medical Record No: _____

Date of Birth: _____

Today's Date: _____

Consent for Primary Caregiver

I, (print name) _____ , agree to accept the role of primary caregiver(s) for _____ who is requesting admission into CaringEdge Hospice program of care.

The commitment and responsibilities of this role and of hospice care/services are described below:

1. I understand the goal of hospice is not to cure the terminal illness but to provide symptom relief and supportive care in this final phase of life.
2. I understand the hospice interdisciplinary team will provide education, training, and support in the management of the patient's physical, emotional, psychosocial, and spiritual needs.
3. I understand the hospice staff will provide emotional, psychosocial, and spiritual support to help me cope with my caregiver responsibilities, the eventual patient's death, and my bereavement.
4. I understand that in my role as a primary caregiver, I will be responsible for meeting or arranging for the patient's 24 hours a day care needs. I will arrange for care in my absence.
5. I understand the hospice medical record will contain information about me. Every effort will be made to keep this information confidential. I authorize this information to be released to the attending physician and other appropriate healthcare providers for the patient's care. I also authorize the release of this information, as needed, to process insurance claims.
6. I understand hospice services are primarily provided on a prearranged, appointment basis, but crisis or consultation assistance with hospice is available 24 hours a day, 7 days a week. I will consult hospice in case of any emergency.
7. I understand to receive full benefits of hospice care it is important for me and the patient to make our needs and concerns known to the hospice interdisciplinary team and to participate in the planning for care.
8. I understand I may choose to change my mind about this method of care and withdraw from this primary caregiver agreement. However, I agree not to do so without giving advance notice to the patient and hospice, so another primary caregiver can be arranged for.
9. I have received the Patient/Family Orientation for Hospice Care Packet. At this time, I believe I understand the responsibility of being primary caregiver, the nature of the patient's illness, and the goal of hospice care. My questions about the hospice program have been answered to my satisfaction by the hospice staff.

Your signature on this page acknowledges you have received and fully understand CaringEdge Hospice's Consent for Primary Caregiver as well as the role and responsibilities of the primary caregiver.

Printed Caregiver Name(s): _____

_____ _____

Beneficiary or Representative Signature **Date**

CaringEdge

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Today's Date: _____

Pinnacle Quality Insights Survey Notice

CaringEdge Hospice is participating in a national survey to provide the United States Department of Health and Human Services with information about the quality of health care delivered to people in their homes. You may be selected to take part in this important telephone interview. We have partnered with Pinnacle Quality Insight to contact you via telephone to complete this interview. Phone calls from Pinnacle Quality Insight will appear on your caller ID as being from a toll-free area code.

The number that will appear on your caller ID is 1-888-444-9961.

This will help you know when Pinnacle might be calling, so that you will feel safe to answer. Please keep this in mind so that you do not miss this survey opportunity.

The interviewer will ask for your opinions about the hospice care your loved one received. We hope that you will take a few minutes to go through this important call. The survey is designed to measure caregiver's perspectives on hospice care for public reporting. The data collected from the survey will be provided to consumers to help them make informed choices when selecting a hospice. It will also be used to help improve the quality of care provided by hospices. Your participation is important.

It is important that your answers reflect your own opinions about the Hospice care your loved one received, so please do not ask anyone from this Hospice Agency for help completing the survey.

All information you give in this survey will be held in confidence and is protected by the Privacy Act. Your name will not be attached to the publicized results.

If you have any questions about the survey, please contact Pinnacle Quality Insight at 1-888-444-9961.

Thank you in advance for your participation.

Sincerely,

Belinda Day Saylor RN

Belinda Saylor

CaringEdge Hospice

Administrator

CaringEdge

CaringEdge Hospice of Hermantown
4195 Westberg Rd. Hermantown, MN 55811
P: 218-216-7243 F: 612-254-8243

Patient Name: _____
Medical Record No: _____
Date of Birth: _____
Today's Date: _____

Oxygen Use Waiver

To: _____ Date: _____

As our patient, we want to make sure that you get the education, tools, and training you need to remain safely in your home. If you use oxygen the following conditions can put you at risk. Please ask questions or state your concerns should you have any at any time.

(Please Check Any That Apply)

- ☐ Being a smoker and having oxygen in your home
- ☐ Smoking while using oxygen
- ☐ Others around you smoke while you are using oxygen
- ☐ The presence of candles, fireplace, wood burning stove, oven, and/or barbecue
- ☐ N/A

This is a very serious concern as your personal well-being and safety are of the utmost importance to us. The purpose of this letter is to stress how important it is to follow CaringEdge Hospice's well defined safety precautions.

The CaringEdge Hospice Patient/Family Orientation for Hospice Care binder refers to fire safety and oxygen use precautions. Oxygen greatly enhances combustion and is therefore a primary safety concern while you are on oxygen. Please see Section 6: Safety in the Patient/Family Orientation for Hospice Care binder for further information. Fire Safety/Burn Precautions starts on page 23 and continues through page 24. Specific Oxygen Safety is on page 27.

Your signature on the affirmations page acknowledges you have received and fully understand CaringEdge Hospice's Oxygen Safety and Fire Precaution Recommendations. Your signature also indicates you will follow the recommendations as set forth in the Patient/Family Orientation Binder for Hospice Care. Failure to do so may lead to serious injury, up to and including death. The patient assumes responsibility for any injury incurred by failure to follow this policy.

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Today's Date: _____

TB Screening Upon Admission

1.	Have you had a cough for two or more weeks duration?	☐ Yes	☐ No
2.	Has your cough been productive of sputum?	☐ Yes	☐ No
	Is it blood stained?	☐ Yes	☐ No
3.	Have you had:		
	Fever	☐ Yes	☐ No
	Night Sweats	☐ Yes	☐ No
	Unintentional Weight Loss	☐ Yes	☐ No
	Lethargy	☐ Yes	☐ No
	Weakness	☐ Yes	☐ No
4.	Do you or your family have TB now, or a history of TB?	☐ Yes	☐ No

Comments:

*Any patient who is considered high risk AND has exibited a cough and at least one other symptom will be identified as a potential TB patient, refer to exposure control plan.

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Date of Birth: _____

Today's Date: _____

Disaster Preparedness Plan

Emergency Contact: _____ Phone: _____

PATIENT DISASTER CLASSIFICATION CODES

In the event of a man-made or natural disaster (e.g. tornado, flood, chemical toxicity, pollution, fire and nuclear power plant disaster) CaringEdge will prioritize visits according to the following classifications:

☐ **Category 1 - Within 24 hours:** Patients who cannot safely forgo care and require health care intervention regardless of other conditions. Patients in this category may include: highly unstable patients with a high probability of inpatient admission if home care is not provided; IV therapy patients; highly skilled wound care patients with no family/caregiver or other outside support.

☐ **Category 2 - Within 24-48 hours:** Patients with recent exacerbation of disease process; patients requiring moderate level of skilled care that should be provided that day; patients with essential untrained families/caregivers not prepared to provide needed care.

☐ **Category 3 - Within 48-72 hours:** Patients who can safely forgo care or a scheduled visit without a high probability of harm or deleterious effects; this category may include home-maker patients, routine supervisory visits, evaluation visits, patients with frequencies of one or two times a week if health status permits, or if a competent family/caregiver is present.

DISASTER INSTRUCTIONS

In the event of a disaster (man-made or natural), that could cause a major disruption in your home care services:

1. An agency employee will contact you by phone to make arrangements for your care.
2. If phone services is not available, agency employees will coordinate your care with appropriate community resources and your physician based on your above assigned classification.
3. Call CaringEdge to voice any needs or concerns.

_____ _____

Beneficiary or Representative Signature **Date**

_____ _____

Relationship to Beneficiary (If unable to Sign) **Reason Beneficiary Unable to Sign**

_____ _____

Signature of CaringEdge Representative **Date**

_____

Printed Name of CaringEdge Representative, Title

CaringEdge

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Today's Date: _____

Disaster Preparedness Plan (Continued)

Are you on life support equipment? ☐ Yes ☐ No

Do you require special transporation or equipment to leave the home? ☐ Yes ☐ No

If yes, what is needed (please mark all that apply):

☐ Wheelchair ☐ Van ☐ Ambulance ☐ Hoyer Lift ☐ Other: _____

Medical Suppliers:

☐ Lake Superior Medical Equipment
218-727-0600

☐ Essentia Health Medical Suplies
218-727-3420

☐ Other: _____

☐ Horizon Healthcare Supply
218-740-2110

☐ Arrowhead Healthcare Supply
855-453-8190

Utilities:

☐ Minnesota Power
218-722-2625

☐ Allete Inc.
218-279-5000

☐ Comfort Systems
218-730-4000

Police/Fire/EMS-911

Physician Name: Jeffrey B Rapp Phone: (218) 216-7243

Pharmacy Name: Thrifty White Pharmacy Phone: (218) 749-6333

Neighbor Name: _____ Phone: _____

American Red Cross

218-722-0071

Emergency Management Offices: Contact emergency officials in the event of an emergency requiring assistance such as:

☐ St Louis County Emergency Management
218-625-3960

☐ Carlton County Emergency Management
218-384-9141

Listen to local radio stations for emergency broadcast announcements:

Creating a disaster plan and practicing it are your responsiblity.
Keep it simple but be sure it will meet your needs.

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Patient Name: _____

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Date of Birth: _____

Today's Date: _____

Family/Friend Contact List

Contact: _____ Relationship: _____

Phone: _____ Email Address: _____

Address: _____

Contact: _____ Relationship: _____

Phone: _____ Email Address: _____

Address: _____

Contact: _____ Relationship: _____

Phone: _____ Email Address: _____

Address: _____

Contact: _____ Relationship: _____

Phone: _____ Email Address: _____

Address: _____

Contact: _____ Relationship: _____

Phone: _____ Email Address: _____

Address: _____

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Insurance Benefit Form

Check all insurance sources the patient currently has:

☐ Medicare ☐ Medicaid ☐ Private Insurance

Medicare

Information listed below should be copied directly from the patient's Medicare card, and to be completed by the admission discipline.

Name of Beneficiary: _____ Medicare Claim #: _____

Yes	No	
☐	☐	Is the patient now or ever been a participant in the Hospice program?
☐	☐	Was illness/injury due to a work related accident covered by Workers Comp or Black Lung?
☐	☐	Was illness/injury due to a Non-Work related accident?
☐	☐	Is the patient on kidney dialysis for End Stage Renal Disease?
☐	☐	Is the patient covered under a Group Health Plan by their employer or spouse's employer?
☐	☐	Is the patient currently working full or part-time?
☐	☐	Is the patient a disabled Medicare Beneficiary under the age of 65?
☐	☐	Is the patient's spouse employed and under the age of 70?

Medicaid

Patients Medicaid ID Number: _____

☐ Number unknown(follow up needed)

☐ Patient has applied for Medicaid & is pending

Medicaid HMO: _____

(Contact CaringEdge billing prior to admitting HMO patient)

Private Insurance

Name of Insurance: _____ Customer Service Phone #: _____

Insured's Name: _____ Relationship to patient: _____

Insured's D.O.B.: _____ Insured's Social Security #: _____

Insured's Employer: _____ Employers Phone #: _____

Skilled Nursing Facility Only ■ N/A

Effective Date: _____ ☐ Admission ☐ Change Facility: _____

Facility billing office informed of hospice admission/change. Notified Date: _____

Room & board will be paid by:

- ☐ Pt/family will be responsible (facility to bill patient)
- ☐ Patient is on skilled days under a diagnosis other than the hospice admission diagnosis. (Contact hospice prior to admit)
- ☐ CaringEdge Hospice will be responsible while the patient is on in-patient level of care.
- ☐ Medicaid (facility to bill hospice)

Level of Hospice Care:

- ☐ Routine
- ☐ Inpatient
- ☐ Respite
- ☐ Continuous Care

Your signature on the affirmations pages acknowledges you have received, answered correctly, and fully understand CaringEdge Hospice's Insurance Benefit Form.

CaringEdge

CaringEdge Hospice of Hermantown
4195 Westberg Rd. Hermantown, MN 55811
P: 218-216-7243 F: 612-254-8243

Patient Name: _____
Medical Record No: _____
Date of Birth: _____
Today's Date: _____

Medicare Secondary Payer Worksheet

Section A

1) Are you receiving Black Lung (BL) Benefits?
☐ Yes: Date benefits began:_____ ☒ No. Go to 2.
BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.
2) Are the services to be paid by a government program such as a research grant? ☐ Yes. Government program will be primary.
☒ No. Go to 3.
3) Has the Department of Veterans Affairs (DVA) authorized to pay for care at this facility? ☐ Yes. DVA is primary. ☒ No. Go to 4.
4) Was the illness/injury due to a work related accident or condition? ☐ Yes. Date of Injury/illness_____
Complete payer info. Workers Comp. is primary payer only for claims related to the injury/illness that is work related. ☒ No. Go to Section B.

Section B

1) Was the illness/injury due to a non-work related accident? ☐ Yes. Date of accident:_____ ☒ No. Go to Section C.
2) What type of accident caused the illness/injury? ☐ Automobile ☐ Non-Automobile. ***Complete payer info.*** NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. Go to Section C. ☐ Other
3) Was another party responsible for this accident? ☐ Yes. ***Complete payer info.*** LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. ☐ No. Go to Section C.

Section C

1) Are you entitled to Medicare based on: ☒ Age. Go to Section D
☐ Disability. Go to Section E. ☐ ESRD. Go to Section F.

Section D - Age

1) Are you currently employed? ☐ Yes. ***Complete Payer Info***. ☒ No. Date of Retirement:_____ ☐ No. Never employed
2) Is your spouse currently employed? ☐ Yes. ***Complete Payer info.*** ☒ No. Date of Retirement:_____ ☐ No. Never employed. IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER.
3) Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment? ☐ Yes. ☒ No. Stop. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO THE QUESTIONS IN SECTIONS A OR B.
4) Does the employer that sponsors your GHP employ 20 or more employees? ☐ Yes. STOP. GHP is primary. ***Complete payer info.*** ☒ No. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES TO QUESTIONS IN SECTIONS A OR B.

Section E - Disability

1) Are you currently employed? ☐ Yes. ***Complete Payer Info***. ☐ No. Date of Retirement:_____ ☐ No. Never employed
2) Is your spouse currently employed? ☐ Yes. Complete Payer info. ☐ No. Date of Retirement:_____ ☐ No. Never employed. IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER.
3) Do you have GHP Coverage based on your own, or a family member's current employment? ☐ Yes.
☐ No. STOP MEDICARE IS PRIMARY.
4) Are you covered under the GHP of a family member other than your spouse? ☐ Yes. ***Complete payer info.*** ☐ No.
5) Does the employer that sponsors the GHP employ 100 or more employees? ☐ Yes. STOP. GHP IS PRIMARY. ***Complete payer info.*** ☐ No. STOP. MEDICARE IS PRIMARY.

Section F – ESRD

1) Do you have GHP coverage? ☐ Yes. ***Complete payer info.*** ☐ No. STOP. MEDICARE IS PRIMARY
2) Have you received a kidney transplant? ☐ Yes. Date of Transplant:_____ ☐ No.
3) Have you received maintenance dialysis treatments? ☐ Yes. Date Began_____. If you participated in a self-dialysis training program, provide date training started:_____. ☐ No.
4) Are you within the 30-month coordination period that starts_____? (The coordination period-CP- starts the first day of the month an individual is eligible for Medicare, even if not yet enrolled. If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the coordination period starts with the first day of the month of dialysis or kidney transplant)
☐ Yes. ☐ No. STOP. MEDICARE IS PRIMARY
5) Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability? ☐ Yes. ☐ No.
6) Was your entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?
☐ Yes. STOP. GHP IS PRIMARY THROUGH 30M CP.
☐ No. Initial entitlement based on age or disability.
7) Does the working aged or disability MSP provision apply? (Is the GHP primarily based on age or disability entitlement)
☐ Yes. GHP IS PRIMARY THROUGH 30M CP. ☐ No. MEDICARE IS PRIMARY.

PRIMARY PAYER INFORMATION

EMPLOYER (Patient):_____

ADDRESS:_____

EMPLOYER (Spouse):_____

ADDRESS:_____

INSURER/GHP:_____

ADDRESS:_____

POLICY ID NUMBER:_____

GROUP ID NUMBER:_____

MEMBERSHIP NUMBER:_____

NAME OF POLICY HOLDER:_____

RELATIONSHIP TO PATIENT:_____

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Hospice Benefit Authorizaion

Medicare Benefit Recipients: The patient understands that application for payment under Title XVIII of the Social Security Act may be made and the information must be provided by the patient in order to receive such payment. The patient hereby certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. The patient hereby requests payment of authorized Medicare benefits are to be made on the patient's behalf.

Initials

_____ 1. CaringEdge Hospice will receive payment for my care, relating to my terminal illness. Medicare will continue to make payment to my attending physician for services if my physician is neither a hospice employee nor receiving payments from CaringEdge Hospice. If my physician is a hospice employee, CaringEdge Hospice will bill Medicare for visits to my physician. I understand that I have the right to seek treatment or therapy for any condition unrelated to my terminal illness in the normal manner. Any such care is not reimbursed by CaringEdge Hospice.

_____ 2. I accept Medicare benefits related to my terminal illness while enrolled in the Medicare Hospice program. I understand that I must have prior approval from hospice before ordering or receiving treatments, supplies, equipment, or any other service related to my terminal illness. I understand that if I fail to get pre-authorization from CaringEdge Hospice for any services, treatments, supplies, equipment, etc., related to my illness, I may be financially responsible for charges incurred.

_____ 3. The Medicare hospice program is divided into benefit periods consisting of two 90-day periods and unlimited 60-day periods. I must use the benefit periods in the above order. I may discontinue hospice care at any time by completing a revocation statement. If I revoke during a benefit period, I lose the remaining days in that benefit period. I have the option of changing to another hospice once per benefit period.

_____ 4. I acknowledge that I have been given a copy of the Patient's Rights and Responsibilities and Notice of Hospice Privacy Practices.

_____ 5. As a Medicare recipient I understand the above and authorize hospice Medicare services from CaringEdge Hospice by signing below.

Certification: The undersigned hereby certifies that he or she has read the foregoing, received a copy thereof, and is the patient or is the duly authorized patient's agent/representative authorized by the patient to execute the above and accept its terms.

Your signature on the affirmations pages acknowledges you have received and fully understand CaringEdge Hospice's Hospice Benefit Authorization

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Payment Responsibility

The patient and/or the patient's authorized agent have full responsibility for the payment of all fees and charges in accordance with CaringEdge Hospice's fee schedule. It is understood that for hospice patients, CaringEdge Hospice assumes financial responsibility for medications, durable medical equipment and medical supplies related to the terminal illness. The patient and/or patient's agent assumes financial responsibility for all other unauthorized charges. CaringEdge Hospice, in accordance with this agreement, shall assist the patient in obtaining financial assistance from thirdparty payers, such as Medicare, Medicaid and private insurers.
Rates: Should a patient choose to receive care from CaringEdge Hospice without having Medicare, Medicaid, other private insurance, or third a party payer source, the following rates will apply:

Routine Home Care: $166/Day **Inpatient Care:** $704/Day
Continuous Care: $48/Hour **Respite Care:** $171/Day

If your ability to pay changes after you are admitted to hospice, you will not be removed from hospice care due to inability to pay.

Agency Choice

Hospice care is a Medicare or Medicaid benefit. As such, patients can choose what hospice agency provides their hospice care. I confirm that I am aware that I have a choice over which agency provides my hospice care and I have chosen CaringEdge Hospice of my own free will. If at any time I wish to discontinue care with CaringEdge Hospice, I or my legal representative must contact CaringEdge Hospice at (218) 216-7243 to cancel.

Advance Directives

I have been made aware of my right to make health care decisions for myself. I am also aware that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself. **I have a:**

☐ **Living Will** ☐ **Durable Power of Attorney for Health Care** ☐ **POLST Form** ☐ **N/A**

Consent to Film/Record

I hereby consent for the agency to record or film my care, treatment, and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition, or for insurance providers to document my condition for payment purposes.

Frequencies

You are receiving the following care at the following daily/weekly/monthly frequencies. If there is a change in any of these services or frequencies, they will be communicated to you:

Skilled Nursing: _____
Aide: _____
Social Worker: _____
Spiritual Care: _____
Volunteer: _____

Non-discrimination

CaringEdge Hospice does not discriminate against any person on the basis of race, color, national origin, disability, age on admission, treatment, publication in its programs, services, activities, or in employment. For further information about this policy, contact the CaringEdge Hospice Administrator at **(218) 216-7243**.

Administrator: Belinda Saylor, RN **Director of Nursing:** Sarah Warren, RN

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Statement Affirmations

Initials

_____ 1. I have read the Name of Beneficiary of Health Insurance form and its contents, and furthermore acknowledge that if I have a Medicare HMO or Advantage Plan, I am responsible for any co-pays and/or co-insurance costs.

_____ 2. I have read the Consent for Care, Patient Rights and Responsibilities, to include, the State Home Health Hotline phone number, Release of Information, Liability for Payment, Consent to Photograph, Statement of Patient Privacy Rights/Notice About Privacy, Privacy Act Statement – Health Care Records, Notice of Privacy Practices, Your Rights as a Patient to Make Medical Treatment Decisions, Advance Directives, and the Complaint and Grievance Process.

_____ 3. I have read Advance Directive for Health Care, Patient Bill of Rights and HIPAA Information.

_____ 4. I have read Authorization to Release Information for Payment and Reimbursement Purposes.

_____ 5. I have read Authorization for Release of Medical Information.

_____ 6. I have read Medicare Secondary Payer Worksheet.

_____ 7. I have read the Pinnacle Quality Insight survey notice and its contents.

_____ 8. I have received the Quality Improvement Organization (QIO) contact information (Livanta: 888-525-9900)

_____ 9. I have read and understand the Oxygen Use Waiver.

_____ 10. I have read TB Screening upon Admission

_____ 11. I have read and understand the explanation of the Medicare/Medicaid hospice benefit as it applies to emergency/urgent care services.

_____ 12. I have read and understand the Consent for Primary Caregiver.

_____ 13. I have read and understand the Hospice Insurance Benefit form.

_____ 14. I have read and understand the Hospice Services Disclosure form.

_____ 15. I have read and understand the Hospice Benefit Authorization.

_____ 16. I have read the Emergency Preparedness Plan and its contents.

BY SIGNING BELOW YOU AGREE TO THE ABOVE STATEMENTS OF AFFIRMATION

Beneficiary or Representative Signature _____ **Date** _____

Relationship to Beneficiary (If unable to Sign) _____ **Reason Beneficiary Unable to Sign** _____

Signature of CaringEdge Representative _____ **Date** _____

Printed Name of CaringEdge Representative, Title _____