Jefferson Healthcare Hospice
Informed Consent to Elect Hospice Care

Patient Name (First, Last)_____ Date_____

I, _____, herby request admission to and care from Hospice of Jefferson County.

I understand that Hospice of Jefferson County is palliative (comfort-oriented), not curative, in its goals. The program emphasizes the relief of symptoms such as pain and physical discomfort. It addresses the emotional and spiritual needs of both patient and family, which may accompany a life-threatening illness. Hospice care does not include heroic or resuscitative measures.

I understand that services are delivered by a team of hospice professionals and volunteers. Home is defined as a private home, skilled nursing facility, assisted living, hospital or other living arrangement. Services are available both on a scheduled basis and as needed twenty-four (24) hours a day, seven (7) days a week. Services may include but are not limited to nursing care, physician care, medical social work services, counseling services, spiritual care, home health aide services, volunteer services, physical therapy, occupational therapy, speech therapy, nutrition counseling, medical supplies, durable medical equipment, and medications for palliation of symptoms related to the terminal diagnosis. All care is directed through the patient's independent attending physician and the Medical Director for Hospice of Jefferson County. The exact services offered to an individual patient are determined by the medically directed interdisciplinary team and recorded in the patient's plan of care. The patient and family are encouraged to participate with the hospice team in establishing the variety, frequency, and intensity of services utilized. Bereavement follow-up will be offered for a period of thirteen months. Bereavement services may include limited counseling, support groups, and bereavement literature.

I understand hospice care is provided at four levels, or types of care, as follows:

- **Routine Care** – this is care provided by a caregiver at the patient's place of residence with assistance from the hospice team.
- **Continuous Care** – this is primarily skilled nursing service supplemented with caregiver and hospice aide services and are intended to maintain the terminally ill patient at home during a pain or symptom crisis.
- **General Inpatient Care** – is provided for pain control or other acute symptom management that cannot feasibly be provided in any other setting. Inpatient care begins when other efforts to manage symptoms have been ineffective.
- **Respite Care** – is available to provide temporary relief to the patient's primary caregiver. This care is provided in a hospital or appropriately certified nursing home for up to five days.

I understand that The Medicare Hospice Benefit consists of two initial 90-day benefit periods and an unlimited number of 60-day benefit periods if the patient does not revoke or is not discharged. Initial and ongoing assessment of hospice appropriateness will occur for certification of terminal illness prior to admission and re-certification prior to each subsequent benefit period. The benefit periods must be used in order. I understand hospice care may be discontinued at my request at any time without prejudice or penalty by completing a revocation statement. I understand Hospice of Jefferson County may discharge me from the program because: 1) I am no longer hospice appropriate 2) I move outside the geographically defined service area. 3) It is determined that there is a situation that is seriously impairing the delivery of care. When discharged from the Medicare hospice program, regular Medicare benefits are reinstated.

I understand that if I am dually eligible for Medicare and Medicaid services, that election of either the Medicare or the Medicaid Hospice benefit is an election to both programs. Likewise, a revocation from either program is a revocation from both programs.

I acknowledge that I have received a copy of Hospice of Jefferson County's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Hospice of Jefferson County and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information. I have been provided the Patient's Bill of Rights, the Grievance Procedures and the Disaster Preparedness Handbook.

I authorize Hospice of Jefferson County to obtain copies of medical records and to document and maintain records, which include necessary personal information about my medical condition and family during the time I am under care. This information may be obtained from or given to health institutions including, but not limited to, hospitals, home health agencies, hospices, skilled nursing/assisted living facilities, health organizations, private physicians, and /or third-party payers. I hereby release Hospice of Jefferson County from any liability and all claims pertaining to the disclosure of pertinent medical and nursing information to my insurance company from my medical record.

I understand hospice services are not intended to take the place of care provided by family members, physician, nursing home staff, or others. Hospice of Jefferson County believes a patient has the right to remain in his/her home if that is his/her choice.

My Primary Caregiver is_____

I understand that Hospice of Jefferson County recognizes that all persons have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care. Washington state statutes recognize that all competent persons have the right to control decisions related to their own medical care. Competent individuals have the right to make a declaration expressing wishes regarding end of life care and/or to designate another competent person to make treatment decisions. Hospice encourages individuals and their families to participate in decisions regarding their care and treatment. I have been offered material explaining how to prepare an advance directive for health care and POLST form. If I have previously prepared advance directives/POLST I agree to provide a copy to Hospice of Jefferson County.

I have prepared an advance medical directive ☐ **Yes** ☐ **No**

I have prepared a POLST form ☐ **Yes** ☐ **No**

Patient Signature: _____ Date/Time: _____

If patient is unable to sign:

Legal Decision Maker Signature: _____ Date/Time: _____

Print Name: _____ Relationship: _____

Reason patient is unable to sign: _____

I have explained the hospice program and answered all related questions asked by the patient or the legal decision maker on behalf of the patient.

Hospice of Jefferson County
Representative Signature: _____ Date/Time: _____