Hand In Hand HOSPICE

PATIENT/FAMILY ELECTION STATEMENT
ASSIGNMENT OF BENEFITS

I/We have read the Informed Consent. We agree to and seek Hospice care and hereby elect to receive the benefits listed below for which I am eligible and assign these Benefits to Hand In Hand Hospice. Check all that apply.

MEDICARE
WE, THE PATIENT, FAMILY, OR RESPONSIBLE PARTY ELECT THE HOSPICE MEDICARE BENEFIT TO BE PROVIDED TO HAND IN HAND HOSPICE, AND WE ACKNOWLEDGE, CONSENT AND AGREE TO THE FOLLOWING:
The approximate cost and methods of reimbursement through Medicare for Hospice care has been explained to us. We understand that Medicare will be billed directly for the cost of our Hospice care whether provided within the home, hospital or nursing homes. We waive the right to other Medicare programs while in the Hospice program, so as to prevent duplication of services. All care that is provided by the attending physician can be billed to Medicare Part B.

The patient, family, attending physician and Hospice interdisciplinary team together tailor an individual plan of care for the patient/family and determine the appropriate level of care. I/we will work with Hand in Hand Hospice and our attending physician to make all necessary arrangements for care which is directly related to the condition for which Hospice is treating me.

Medicare will pay Hand In Hand Hospice the costs of hospice care which is related to my diagnosis and is within the plan of care. I/we agree to pay for co-payments on medications related to respite care from the assets or estate of the patient. Would I/we secure care outside of the Hospice program and without the involvement of Hand in Hand Hospice interdisciplinary team, I/we understand to be financially responsible for any charges incurred. We understand that the patient will be responsible for any health insurance deductibles and coinsurance or any other amount not covered by Medicare insurance.

We understand that we may revoke the Medicare hospice benefit in the event that we decide to discontinue hospice care from Hand in Hand Hospice by seeking care that is non-palliative (without the involvement of the Hospice program), and /or by seeking care from another provider which duplicates care provided by Hospice. We understand that we may re-elect the Medicare Hospice benefit an any point.

We understand that we may withdraw from the Hospice program at any time and have traditional Medicare benefits fully restored immediately. Care for all illnesses other than the primary diagnosis for which Hospice is treating me can be billed to Medicare in the traditional manner.

Medicare covers most of the Hospice Benefit plan. The patient will be notified in writing if services to be provided are not considered to be covered. Our current charges are: Hospice Routine Home Care $192.00/day; Hospice Continuous Home Care $150.00/hr; Hospice Inpatient Care/Respite $360.00/day; Hospice General Inpatient/Non-Respite $823.00/day.

MEDICAID
WE, THE PATIENT, FAMILY, OR RESPONSIBLE PARTY, ELECT THE HOSPICE MEDICAID PROGRAM TO BE PROVIDED BY HAND IN HAND HOSPICE, AND WE ACKNOWLEDGE, CONSENT AND AGREE TO THE FOLLOWING:
The approximate cost and methods of reimbursement through Medicaid for Hospice care has been explained to us. We understand that Medicaid will be billed directly for the cost of our Hospice care provided within the home, hospital or nursing home. All care that is provided by the attending physician can be billed to Medicaid.

Medicaid covers most of the Hospice Benefit plan. Current charges for Medicaid: Hospice Medicaid Room and Board Nursing Facility varies between difference Nursing Facilities; Medicaid Routine Care $192.00/day; Hospice Continuous Home Care $150.00/hr; Medicaid Respite Care $360.00/day; General Inpatient Care $823.00/day.

The patient, family, attending physician and Hospice interdisciplinary team together tailor an individual plan of care for the patient/family and determine the appropriate level of care. I/we will work with Hand in Hand Hospice and our

attending physician to make all necessary arrangements for care which is connected to the condition for which Hospices is treating me.
Medicaid will pay for care which is related to my terminal diagnosis and within the plan of care. Should I/we secure care outside of the Hospice program and without the involvement of Hand in Hand Hospice, I/we may revoke our Hospice benefit. I/we further understand that certain services rendered may not be covered by Medicaid. In the event these services are considered non-covered, I/we agree that the patient will be personally and fully responsible for payment.

We understand that we may withdraw from the Hospice program at any time and then may be eligible for other Medicaid benefits. Care for all illnesses other than the primary diagnosis for which Hospice is treating me can be billed to Medicaid in the traditional manner. I understand that if I am eligible for both Medicare and Medicaid, and elect hospice care under this benefit, I must first exercise my election for hospice under Medicare.

Effective Date ____/____/____

INSURANCE
WE, THE PATIENT, FAMILY, ELECT INSURANCE COVERAGE OF HOSPICE SERVICE TO BE PROVIDED BY HAND IN HAND HOSPICE IN EMPORIA, KS, AND WE ACKNOWLEDGE, CONSENT AND AGREE TO THE FOLLOWING;

We authorize payment of benefits from any third party vendor directly to Hand In Hand Hospice, for services rendered by it. We understand that we will be billed for services not covered by insurance as incurred.

Hospice will bill our third party payor as a courtesy to us and we will work with Hand In Hand Hospice personnel to design a schedule of payment based upon our individual financial status for any costs of care not paid.

Patient/Caregiver responsibility at_____per day, this is not covered by insurance.

SELF PAY
WE, THE PATIENT, FAMILY, ELECT SELF PAY FOR HOSPICE SERVICE TO BE PROVIDED BY HAND IN HAND HOSPICE IN EMPORIA, KS, AND WE ACKNOWLEDGE, CONSENT AND AGREE TO THE FOLLOWING;

The approximate cost and methods of reimbursement for Hospice Care has been explained to us.

We understand that we will be billed for services provided by Hand In Hand Hospice.

We will work with Hand In Hand Hospice personnel to design a schedule of payment based upon our individual financial status.

Patient/Caregiver responsibility at $192.00 per day.

WE ACKNOWLEDGE THAT WE HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK ANY AND ALL QUESTIONS WE HAVE CONCERNING THE HOSPICE PROGRAM.

_____ _____ _____
Print Patient Name **Patient Signature** **Date**

_____ _____
Caregiver/Responsible Party Signature (Spouse, DPOA, Guardian/Conservator) **Date**

I have explained the purpose of the Hospice program of care and the nature of the involvement requested of the participants. I have answered all questions about the project asked by the patient or by responsible concerned person(s) on behalf of the patient.

_____
Reason if patient unable to sign

_____ _____
Hospice Representative **Date**