Patient Number:

Receipt of Notice of Privacy Practices

Patient Name: _____

Date of Admission: _____

My signature on this form acknowledges that I have received a copy of Hospice of Central Ohio'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 Central Ohio and of my rights with respect to my health information.

I understand that my medical records may contain information about my care and treatment, including drug or alcohol use, mental health status and treatment, HIV/AIDS status, or pregnancy termination. Hospice of Central Ohio enforces strict policies on maintaining the confidentiality and privacy of my medical records.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

☐ I wish to have a copy of the Notice of Privacy Practices.

_____ _____

Patient's Signature *Date*

_____ _____

Signature of Patient's Representative (if patient is unable to sign) *Date*

_____ _____

Signature of HOCO Representative *Date*

TO BE COMPLETED BY HOCO REPRESENTATIVE IF RECEIPT IS NOT SIGNED

1. Did the patient/representative sign the Receipt of Notice of Privacy Practices?
   ❑ Yes ❑ No IF "NO" CLICK ON THE DROP DOWN ON THE USER TAB OF THE FACE SHEET
2. Briefly describe efforts made to obtain the patient's acknowledgment of receipt of the Notice and explain why the patient was not able or willing to sign this form:

   _____

   _____

Patient Rights and Responsibilities

Hospice of Central Ohio Patients have a right to be notified in writing of their rights and responsibilities before treatment begins, and to exercise those rights. The patient's family or guardian may exercise the patient's rights when the patient has been judged lacking capacity or incompetent. Hospice of Central Ohio has an obligation to protect and promote the rights of their patients, including the following rights:

RESPECT AND DIGNITY

Hospice of Central Ohio patients and their care givers, have a right to not be discriminated against based on race, color, religion, national origin, age, gender, sexual orientation, diagnosis, handicap or ability to pay. Furthermore, patients and care givers have a right to mutual respect and dignity, including respect for property. Hospice of Central Ohio employees are prohibited from accepting personal gifts or borrowing from patients or care givers.

Patients have the right:

- to have a relationship with Hospice of Central Ohio that is based on honesty and ethical standards of conduct.
- to be informed of the procedure they can follow to lodge complaints about issues with care, or lack of care, and regarding lack of respect for property. (To lodge complaints with us, call the Vice President of Clinical Services at 740-788-1400 or 800-804-2505.)
- to know about the disposition of such complaints.
- to voice their grievances without fear of discrimination or reprisal for having done so.
- to be advised of the telephone number and hours of operation of the state's Hospice "hotline" which receives questions and complaints about local agencies, including complaints about implementation of advanced directive requirements. The hours are Monday – Friday, 8 a.m. to 5 p.m., and the number is: Ohio Department of Health Complaint Hotline, 1-800-342-0553.

DECISION MAKING

Patients have the right:

- to be informed of the patient's condition and about treatment or services planned, and to have questions answered honestly.
- to be notified in writing and in advance about the care that is to be furnished, the types (disciplines) of the health care providers who will furnish the care and the frequency of the visits that are proposed to be furnished.
- to choose their own attending physician.
- to be able to identify visiting personnel members through proper identification.
- to be advised of any change in the Plan of Care before the change is made.
- to have an individualized Plan of Care, to participate in the development of the Plan of Care, and to be advised of their right to do so.
- to be in formed in writing, of the rights under state law to make decisions concerning medical care, including the right to accept or refuse treatment, and the right to formulate advance directives.
- to be informed in writing, of policies and procedures for implementing advance directives, including any limitations if the provider cannot implement an advance directive on the basis of conscience.
- to refuse services and to be advised of the consequences of refusing care.

- to have health care providers comply with advance directives in accordance with state law requirements.
- to receive care without condition, or discrimination based on the execution of advance directives.
- to refuse care or services, or request a change in their Hospice team members without fear of reprisal or discrimination.
- to be free from mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source.
- to be free from misappropriation of patient property by anyone furnishing services on behalf of Hospice.
- to withdraw from the Hospice Program at any time.
- to receive effective pain management and symptom control from the Hospice for conditions related to their terminal illness.
- to live and die with peace and dignity.
- to retain their individuality, to express their feelings and emotions, and to follow their spiritual belief in their own way.
- to maintain a sense of hopefulness, however changing its focus may be.

Hospice of Central Ohio or the patient's physician may be forced to refer the patient to another source of care if the patient's refusal to comply with the Plan of Care threatens to compromise the provider's commitment to quality care.

PRIVACY

Patients have the right:

- to confidentiality of the medical record as well as information about their health, social and financial circumstances and about what takes place in the home.
- to expect Hospice of Central Ohio to release information only as required by law or authorized by the patient and to be informed of procedures for disclosure.

FINANCIAL INFORMATION

Patients have the right:

- to be informed of the extent to which payment may be expected from Medicare, Medicaid or any other payor known to Hospice of Central Ohio.
- to be informed of the charges that will not be covered by Medicare, Medicaid or any other payor.
- to be informed of the charges for which the patient may be liable.
- to receive this information orally, and in writing, before care is initiated and within 15 working days from the date Hospice of Central Ohio becomes aware of any changes.
- to have access, upon request, to all bills for services the patent has received regardless of whether the bills are paid out-of-pocket or by another party.
- to be informed of the Hospice's ownership status and its affiliation with any entities to which the patient is referred.

QUALITY OF CARE

Patients have the right:

- to receive care of the highest quality and to receive information regarding the scope of services Hospice will provide and specific limitations, if any, on those services.
- in general, to be admitted to Hospice of Central Ohio only if it has the resources needed to provide care safely and at the required level of intensity as determined by a professional assessment; if

Hospice of Central Ohio has less than optimal resources it may nevertheless admit the patient if a more appropriate service is not available, but only after fully informing the patient of its limitations and the lack of suitable alternative arrangements.

- to reasonable continuity of care if a transfer of services becomes necessary.
- to be informed of what to do in case of an emergency.

Hospice of Central Ohio shall assure that:

- all medically related Hospice care is provided in accordance with physician's orders.
- care will be provided according to frequency and duration as set forth in the patient's Plan of Care, which will be developed by the patient's physician and the Hospice interdisciplinary group in conjunction with the patient.
- all medically related personal care is provided by an appropriately trained Hospice Aide who is supervised by a Hospice Registered Nurse or other qualified Hospice professional.

PATIENT RESPONSIBILITIES

Patients have the responsibility to Hospice of Central Ohio to:

- notify the Hospice staff of changes in their condition (e.g. hospitalization, changes in the Plan of Care, need for emergency care and change in symptoms).
- inform the Hospice staff of any religious belief and/or ethnic custom that would in any way affect and/or conflict with health care services and in the manner which they may be provided.
- treat the Hospice staff with respect and dignity.
- provide the Hospice staff with current and past medical history and functional limitations including: illnesses, hospitalizations, medications, allergies, and any other pertinent items to the best of their knowledge.
- participate in the development and update of their Hospice Plan of Care.
- follow the Plan of Care.
- notify the Hospice staff if the visit schedule needs to be changed.
- inform the Hospice staff if they do not understand the diagnosis, treatment, treatment alternatives, risks, prognosis or Plan of Care.
- inform the Hospice staff of the existence of any changes made to their advance directives.
- advise the Hospice staff of any problems or dissatisfaction with the services provided.
- provide a safe environment for care to be provided.
- carry out mutually agreed upon responsibilities, including financial responsibility for which you have been informed and/or which have been incurred for services outside the Hospice Plan of Care.
- show respect and consideration for staff and equipment.

It is your responsibility to inform Hospice of Central Ohio staff if your physician has changed any current medication, treatments, procedures and/or nutritional guidelines.

The Hospice of Central Ohio staff has reviewed my Right and Responsibilities with me, and has provided me with a copy.

(Signature of Patient/Legal Representative)	*(Date)*
(Printed Patient Name)	*(HOCO Representative)*

Patient Rights and Responsibilities

Hospice of Central Ohio Patients have a right to be notified in writing of their rights and responsibilities before treatment begins, and to exercise those rights. The patient's family or guardian may exercise the patient's rights when the patient has been judged lacking capacity or incompetent. Hospice of Central Ohio has an obligation to protect and promote the rights of their patients, including the following rights:

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- follow the Plan of Care.
- notify the Hospice staff if the visit schedule needs to be changed.
- inform the Hospice staff if they do not understand the diagnosis, treatment, treatment alternatives, risks, prognosis or Plan of Care.
- inform the Hospice staff of the existence of any changes made to their advance directives.
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The Hospice of Central Ohio staff has reviewed my Right and Responsibilities with me, and has provided me with a copy.

(Signature of Patient/Legal Representative)	*(Date)*
(Printed Patient Name)	*(HOCO Representative)*

Informed Consent for Hospice Program and Hospice Benefit Election

We the patient and the care giver, request admission to the Hospice of Central Ohio program and understand and agree to the following:

- ***Residential Care:*** I understand that my family and/or primary care giver and I will be cared for primarily through intermittent visits made to my home/place of residence. The Hospice of Central Ohio ("Hospice") team is not intended to take the place of my family, but be supportive to the family while they are caring for me during my illness. I understand that care in the home is the main focus of the Hospice program. Hospice will provide intermittent supportive care by prearranged scheduled visits. Emergency consultations and/or visits are available through our on-call service twenty-four (24) hours a day, seven (7) days a week when needed.

- ***Consent:*** I provide consent for the medical care and nursing services along with other services that will be provided by the Hospice and its staff and affiliates.

    - I give Hospice of Central Ohio permission to take wound images, if needed, for treatment and educational purposes. ☐ Yes ☐ No

- ***Staff:*** The Hospice staff includes Registered Nurses, Social Workers, Hospice Aides, Chaplains, Volunteers, and a Medical Director. I understand that my care will continue under my primary physician and the Hospice staff will work with my primary physician to provide supportive, palliative (comfort) care. I understand that hospice care is not curative in nature but palliative care. Hospice will work to maintain quality of life through the management of my pain and/or other symptoms.

- ***Inpatient Care:*** I understand that if it is deemed necessary by Hospice and my physician, that I can receive short term care in an inpatient facility.

- ***Rights and Responsibilities:*** I understand that Hospice has the responsibility to inform me of my rights and responsibilities. Hospice has reviewed and provided me with a copy of the patient rights and responsibilities and the self determination act assessment packet. Hospice has also explained to me what resuscitation is, and my rights regarding resuscitation. Hospice has provided me with the necessary form to complete if I choose non-resuscitation (Do Not Resuscitate).

    - I do / do not *(Circle One)* have a Living Will.
    - I do / do not *(Circle One)* have a Power of Attorney for health care decisions.

- ***Living Arrangements:*** I understand if I do not have a care giver living with me in my home or a hired care giver or combination of both, and it is deemed unsafe by the Hospice staff and myself for me to continue living alone, I agree to make the necessary changes to my living arrangements for my safety and well being. (For example: Move in with family/friend, be admitted to an extended care facility, hire a full-time care giver, or have family/friend move in with me.) Hospice will help me make these arrangements, but I or my family must assume all financial responsibilities for the cost of my living arrangements.

- ***Improvement of Condition:*** I understand that if my condition improves, the Hospice Medical Director may not recertify me and I could be discharged from Hospice and all Hospice services would stop. I also understand that all supplies, equipment, and medications which may have been covered by Hospice that I wish to continue after a discharge will be my financial responsibility. I also understand that if I am discharged, I will be given notice and provided with supportive assistance from Hospice during the discharge process. I may be able to be readmitted to Hospice care if my condition would deteriorate and I would again meet Hospice eligibility criteria.

- ***Medical Information Confidentiality:*** I understand that Hospice medical records will contain information about me, my family and/or my primary care giver. All information will be kept confidential and will not be released without my permission.

- ***Medical Information Release:*** I hereby permit the release of necessary medical records and other information to or from any private agency, accrediting agency or medical person/physician as required to assure continuity of care and as necessary for reimbursement. I give my permission to fax necessary medical information as needed to appropriate agencies or health care providers as allowed by law.

- ***Terminating Services:*** I understand that I can discontinue Hospice care at any time by notifying Hospice.

- ***Explanation of Payment****:* I understand that Hospice considers payment from Medicare and Medicaid as payment in full for hospice services as identified in the plan of care. Hospice bills Third Party Payors such as insurance companies, when applicable. A list of charges for services are available upon request from Hospice of Central Ohio's billing department.

- ***Payment Procedures for Hospice Care:*** I understand that Medicare, Medicaid, and Third-Party payors such as insurance companies establish payment amounts for specific categories of covered hospice care and that the payment amounts are determined within each of the following categories:
    - Routine home care day. This is a day on which the hospice patient is at home and is not receiving continuous care.
    - Continuous home care day. This is a day when the hospice patient is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief period of crisis and only as necessary to maintain the terminally ill patient at home.
    - Inpatient respite care day. This is a day on which the hospice patient receives care in an approved facility on a short-term basis for respite care for not more than 5 consecutive days.
    - General inpatient care day. This is a day on which the hospice patient receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

I understand that payment is made to Hospice for each day during which I am eligible and for only one of the categories of hospice care described regardless of services furnished on any given day.

- ***Patient Financial Responsibility:*** I understand the following:
    - I am obligated to sign over to Hospice of Central Ohio, any reimbursement for hospice services sent directly to me from my insurance company.
    - I am financially responsible for annual deductibles and co-payments.
    - If requested, I will receive from Hospice of Central Ohio an explanation of charges for which I am responsible.
    - Hospice of Central Ohio will do a financial needs assessment if I cannot afford to pay my bill.
    - Hospice of Central Ohio is a non-profit organization and services will not be denied based on inability to pay.

    Note: Hospice is not financially responsible for services not authorized in the patient's plan of care.

- ***Explanation of Medicare/Medicaid Benefits:*** For the duration of this benefit, I waive the right to Medicare/Medicaid payments for the following services:
    - Hospice care provided by hospice other than Hospice of Central Ohio (unless provided under arrangements made by Hospice of Central Ohio)
    - Any Medicare/Medicaid services that are related to the treatment of the terminal condition, or a related condition for which hospice care was elected, or Medicare/Medicaid services that are equivalent to hospice care except for services provided by:
        - Hospice of Central Ohio
        - Another hospice under arrangements made by Hospice of Central Ohio; and
        - My attending physician, if my physician is not an employee of Hospice of Central Ohio or receiving compensation from Hospice of Central Ohio for those services.

Informed Consent for Hospice Program and Hospice Benefit Election *(continued)*

Note: I understand that if I have Medicare Part D, once I elect the Medicare Hospice Benefit some medication may need to be pre-authorized.

I understand that the Hospice Medicare/Medicaid Benefit provides coverage for the following services: nursing, medical social services, counseling, pastoral care, hospice aides, volunteers, short term in-patient care, physician services, medical supplies and equipment, pharmaceuticals related to the terminal illness and related conditions, physical therapy, occupational therapy, speech and language pathology, and dietary consultations when appropriate.

I have had the opportunity to ask questions concerning any information I do not understand.

- ***Patient's Attending Physician:*** The attending physician is identified by the patient or their representative as the physician having the most significant role in the determination and delivery of the patient's medical care. That physician must be listed as the attending physician, if the physician accepts the role.

I have selected the following physician to be my attending physician: _____

Physician's First/Last Name

_____

Attending Physician's NPI#

I acknowledge this is my choice for my attending physician: _____

Patient/Patient Representative Initials

I ACKNOWLEDGE THAT I HAVE REVIEWED THIS FORM AND HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS.

_____ _____

Patient Name (Print) *Patient Number* *Signature of Patient or Legal Representative* *Date Signed*

_____

Relationship to Patient

Reason Patient Unable to Sign:_____

_____

Acknowledging and understanding the above, I authorize *(Circle all that apply):* Hospice Medicare, Medicaid, or Private Insurance coverage to begin on this date: _____ and I hereby authorize payment to be made directly to Hospice of Central Ohio for services provided.

Disclaimer: Individuals under age 21 in Ohio can receive both curative and hospice care at the same time and both are covered by Medicaid.

_____

Signature of Patient or Legal Representative *Date Signed*

_____

Signature of Hospice Representative *Date Signed*

A copy of this agreement shall serve as a release form in lieu of the original.

Informed Consent for Hospice Program and Hospice Benefit Election

We the patient and the care giver, request admission to the Hospice of Central Ohio program and understand and agree to the following:

- ***Residential Care:*** I understand that my family and/or primary care giver and I will be cared for primarily through intermittent visits made to my home/place of residence. The Hospice of Central Ohio ("Hospice") team is not intended to take the place of my family, but be supportive to the family while they are caring for me during my illness. I understand that care in the home is the main focus of the Hospice program. Hospice will provide intermittent supportive care by prearranged scheduled visits. Emergency consultations and/or visits are available through our on-call service twenty-four (24) hours a day, seven (7) days a week when needed.

- ***Consent:*** I provide consent for the medical care and nursing services along with other services that will be provided by the Hospice and its staff and affiliates.

    - I give Hospice of Central Ohio permission to take wound images, if needed, for treatment and educational purposes. ☐ Yes ☐ No

- ***Staff:*** The Hospice staff includes Registered Nurses, Social Workers, Hospice Aides, Chaplains, Volunteers, and a Medical Director. I understand that my care will continue under my primary physician and the Hospice staff will work with my primary physician to provide supportive, palliative (comfort) care. I understand that hospice care is not curative in nature but palliative care. Hospice will work to maintain quality of life through the management of my pain and/or other symptoms.

- ***Inpatient Care:*** I understand that if it is deemed necessary by Hospice and my physician, that I can receive short term care in an inpatient facility.

- ***Rights and Responsibilities:*** I understand that Hospice has the responsibility to inform me of my rights and responsibilities. Hospice has reviewed and provided me with a copy of the patient rights and responsibilities and the self determination act assessment packet. Hospice has also explained to me what resuscitation is, and my rights regarding resuscitation. Hospice has provided me with the necessary form to complete if I choose non-resuscitation (Do Not Resuscitate).

    - I do / do not *(Circle One)* have a Living Will.
    - I do / do not *(Circle One)* have a Power of Attorney for health care decisions.

- ***Living Arrangements:*** I understand if I do not have a care giver living with me in my home or a hired care giver or combination of both, and it is deemed unsafe by the Hospice staff and myself for me to continue living alone, I agree to make the necessary changes to my living arrangements for my safety and well being. (For example: Move in with family/friend, be admitted to an extended care facility, hire a full-time care giver, or have family/friend move in with me.) Hospice will help me make these arrangements, but I or my family must assume all financial responsibilities for the cost of my living arrangements.

- ***Improvement of Condition:*** I understand that if my condition improves, the Hospice Medical Director may not recertify me and I could be discharged from Hospice and all Hospice services would stop. I also understand that all supplies, equipment, and medications which may have been covered by Hospice that I wish to continue after a discharge will be my financial responsibility. I also understand that if I am discharged, I will be given notice and provided with supportive assistance from Hospice during the discharge process. I may be able to be readmitted to Hospice care if my condition would deteriorate and I would again meet Hospice eligibility criteria.

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    Note: Hospice is not financially responsible for services not authorized in the patient's plan of care.

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Informed Consent for Hospice Program and Hospice Benefit Election *(continued)*

Note: I understand that if I have Medicare Part D, once I elect the Medicare Hospice Benefit some medication may need to be pre-authorized.

I understand that the Hospice Medicare/Medicaid Benefit provides coverage for the following services: nursing, medical social services, counseling, pastoral care, hospice aides, volunteers, short term in-patient care, physician services, medical supplies and equipment, pharmaceuticals related to the terminal illness and related conditions, physical therapy, occupational therapy, speech and language pathology, and dietary consultations when appropriate.

I have had the opportunity to ask questions concerning any information I do not understand.

- ***Patient's Attending Physician:*** The attending physician is identified by the patient or their representative as the physician having the most significant role in the determination and delivery of the patient's medical care. That physician must be listed as the attending physician, if the physician accepts the role.

I have selected the following physician to be my attending physician: _____

Physician's First/Last Name

_____

Attending Physician's NPI#

I acknowledge this is my choice for my attending physician: _____

Patient/Patient Representative Initials

I ACKNOWLEDGE THAT I HAVE REVIEWED THIS FORM AND HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS.

_____ _____

Patient Name (Print) *Patient Number* *Signature of Patient or Legal Representative* *Date Signed*

_____

Relationship to Patient

Reason Patient Unable to Sign:_____

_____

Acknowledging and understanding the above, I authorize *(Circle all that apply):* Hospice Medicare, Medicaid, or Private Insurance coverage to begin on this date: _____ and I hereby authorize payment to be made directly to Hospice of Central Ohio for services provided.

Disclaimer: Individuals under age 21 in Ohio can receive both curative and hospice care at the same time and both are covered by Medicaid.

_____

Signature of Patient or Legal Representative *Date Signed*

_____

Signature of Hospice Representative *Date Signed*

A copy of this agreement shall serve as a release form in lieu of the original.

Medication Usage Agreement

Patient Name: _____ **Patient Number:** _____

This agreement between Patient and Hospice of Central Ohio is entered into this _____ day of _____(MM/YYYY) The purpose of this agreement is to clearly identify the goals of symptom relief for the patient based on the instruction, direction, and guidance of the Hospice Physician and Hospice staff.

The patient agrees to the following:

1. Dosage and frequency of medication administration will not deviate from what is prescribed.
2. Illicit, and/or illegal medications, and medications not prescribed will not be consumed.
3. Sharing, selling or otherwise giving personal medications to others regardless of reason is not acceptable and is in violation of Federal Law.
4. Prescribed medications will be stored appropriately to prevent loss or theft.
5. All newly prescribed medications from other medical providers will be reported by me to the Hospice team for the purpose of safety and to avoid drug-to-drug interactions.
6. Lost or stolen medications are a serious matter and should be immediately reported to the Hospice.
7. A medication usage log for the purpose of tracking dosages and times of administration will be kept and made available to any Hospice personnel for review.
8. I understand that the Hospice is obligated by the State of Ohio to count my pain medications and keep a record in my medical chart.
9. I understand that someone must sign for any pain medications delivered to my home.
10. I understand that driving or operating machinery while taking pain medications can be dangerous.
11. I understand that all pain medications no longer being used will be disposed of or destroyed per Hospice policy.
12. I will notify Hospice if I am worried about misuse or diversion of my pain medications in my home.
13. I understand that the Hospice will notify the police of suspected diversion of pain medications.

I acknowledge I have received information from Hospice staff about medications, and a copy of the Hospice's Medication Disposal Policy. I agree that this agreement is essential to the Hospice's ability to treat my symptoms effectively, and that failure to abide by the terms of this agreement may result in the withdrawal of all prescribed medication, termination of the physician/patient relationship and discharge from the hospice program.

I ACKNOWLEDGE THAT I HAVE REVIEWED THIS FORM AND HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS.

_____	_____	_____
Signature of Patient or Legal Representative	*Relationship to Patient*	*Date Signed*

_____	_____
Signature of Hospice Representative	*Date Signed*

A copy of this agreement shall serve as a release form in lieu of the original.

Medication Usage Agreement

Patient Name: _____ **Patient Number:** _____

This agreement between Patient and Hospice of Central Ohio is entered into this _____ day of _____(MM/YYYY) The purpose of this agreement is to clearly identify the goals of symptom relief for the patient based on the instruction, direction, and guidance of the Hospice Physician and Hospice staff.

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I ACKNOWLEDGE THAT I HAVE REVIEWED THIS FORM AND HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS.

_____	_____	_____
Signature of Patient or Legal Representative	*Relationship to Patient*	*Date Signed*

_____	_____
Signature of Hospice Representative	*Date Signed*

A copy of this agreement shall serve as a release form in lieu of the original.

Entitlement Verification Process

Patient Name: _____ Member ID # _____ Patient #: _____
(Exactly as shown on Insurance Card)

NOTE: *There may be situations where more than one insurer is primary to Medicare (e.g. automobile insurance and employee group health plan (EGHP).* ***Be sure to identify all possible insurers.***

PART I

1. Was illness/injury due to a work related accident or condition, and covered by a Worker's Compensation plan or the Federal Black Lung Program?
   - ☐ **Yes**
     (STOP: Worker's Compensation or Federal Black Lung Program is primary payor.)
   - ☐ **No (Go to Part II)**

Part II

1. Was illness/injury due to non-work related accident?
   - ☐ **Yes** ☐ **No (Go to Part III)**
2. What type of accident caused illness/accident?
   - ☐ Automobile
   - ☐ Other (explain) _____
3. Was another party responsible for this accident?
   - ☐ **Yes** (***STOP: Liability Insurer is primary payor.)***
   - ☐ **No (Go to Part III)**

PART III

1. Is the patient's age 65 or over?
   ☐ **Yes** ☐ **No (Go to Part IV)**
2. Is the patient undergoing kidney dialysis for End Stage Renal Disease?
   - ☐ **Yes** ***(Go to Part IV)***
   - ☐ **No**
3. Is the patient employed and covered by the Employer's Group Health Plan (EGHP)?
   - ☐ **Yes** ***(STOP: EGHP is primary payor.)***
   - ☐ **No (Go to Question 4)**
4. Is the patient's spouse employed?
   - ☐ **Yes**
   - ☐ **No** ***(Stop: Medicare is primary payor)***
5. Is the patient covered under the group health plan of the spouse's employer?
   - ☐ **Yes** ***(STOP: EGHP is primary payor.)***
   - ☐ **No** ***(STOP: Medicare is primary payor)***

PART IV

1. Is the patient entitled to benefits solely on the basis of End Stage Renal Disease?
   ☐ **Yes** ☐ **No (Go to Part V)**
2. Is this patient covered by an Employer Group Health Plan (EGHP)?
   - ☐ **Yes**
   - ☐ **No** ***(Stop: Medicare is primary payor)***
3. Has the patient been undergoing kidney dialysis for more than 30 months or been entitled to Medicare for more than 30 months?
   - ☐ **Yes** ***(Stop: Medicare is primary payor)***
   - ☐ **No**
4. Has the patient been under care for Renal Dialysis and/or Kidney Transplant for less that 30 months? (as defined in S252.4)
   - ☐ **Yes** ***(Stop: EGHP is primary payor)***
   - ☐ **No** ***(Stop: Medicare is primary payor)***

PART V

1. Is the patient a disabled Medicare beneficiary under age 65?
   - ☐ **Yes** ***(Stop: Medicare is primary payor)***
   - ☐ **No (Go to Question 2)**
2. Is the patient covered by a group health plan based on the patient's own employment?
   - ☐ **Yes** ***(Stop: Group Health Plan is primary payor)***
   - ☐ **No (Go to Question 3)**
3. Is there another reimbursement source?
   - ☐ **Yes**
   - ☐ **No** ***(No payor source)***

_____
(Clinician's Signature)

_____
(Date)

2269 Cherry Valley Road, Newark, Ohio 43055
Ph: 740-788-1400 Fax: 740-788-1401

Facility Notification of Hospice Responsibilities

This is to inform you _____ that your
(Facility Name)

resident _____, was admitted to the services of Hospice of
(Patient's Name)

Central Ohio on _____ under the Hospice Medicare/Medicaid Benefit.
(Date)

As part of that benefit, Hospice of Central Ohio is responsible for any services necessary to provide for the resident's terminal needs as indicated on the hospice plan of care as being appropriate for the terminal illness of _____ .

Items of which we will be responsible include:

- Medical Direction
- Intermittent nursing by RN's
- Personal Care by Hospice Aides
- Counseling, both psycho-social and spiritual
- Volunteer Services
- On-Call 24 Hour Services available by the RN, Social Worker and Chaplain
- Ancillary Therapies related to the hospice diagnosis
- Pharmacy items related to the hospice diagnosis, as indicated on the hospice medication profile
- Oxygen: Concentrator/Portable
- Medical Supplies related to the hospice diagnosis
- Hospice is not responsible for personal care items. If the resident is experiencing difficulties obtaining these items, please discuss with the hospice social worker.

Signature: _____ Date: _____

2269 Cherry Valley Road, Newark, Ohio 43055
Ph: 740-788-1400 Fax: 740-788-1401

Facility Notification of Hospice Responsibilities

This is to inform you _____ that your
(Facility Name)

resident _____, was admitted to the services of Hospice of
(Patient's Name)

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(Date)

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- Medical Direction
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- Oxygen: Concentrator/Portable
- Medical Supplies related to the hospice diagnosis
- Hospice is not responsible for personal care items. If the resident is experiencing difficulties obtaining these items, please discuss with the hospice social worker.

Signature: _____ Date: _____