A Hug Away Health Care, Inc.

Patient Name: ____ DOB: ______________________

Advance Directive Status Sheet

The patient has a **Living Will**? ☐Yes ☐No
Does the family have a copy of **Living Will**? ☐Yes ☐No
The patient was **The Advance Directive** Information? ☐Yes ☐No
Patient informed to notify physician of **Advanced Directives**? ☐Yes ☐No
The patient has a **Medical Power of Attorney (MPA)**? ☐Yes ☐No

If yes, the following must be completed:

Name of individual with **Medical Power of Attorney** ____
Address ____
Telephone ____
Emergency # ____
Relationship to Patient _________________________ Has copy of **MPA**? ☐Yes ☐No

Complete Below

Patient Does Not Have Advance Directives

Does the patient/family wish to obtain additional information regarding **Advance Directives**? ☐Yes ☐No
If yes, patient/family given: ____
The patient/family desires to execute a **Living Will** today? ☐Yes ☐No
If yes, does the patient authorize the agency to obtain a copy? ☐Yes ☐No

Declination of Medical Services

On this __________ day of ____________________________ patient ____________________________
With the Medical Record #_____________________ was instructed to visit his/her physician or the emergency room for medical services.
I _____________________________ am refusing to follow the request of the physician or visiting nurse at this time. I accept full responsibility for refusing requests and or instructions.
Signature _________________________ Relationship _____________________ Date _________

Versión española

En este día del __________ del _________________ del paciente del _________________________
Con el #______________________ de registro médico fue mandado para visitar su médico o el cuarto de emergencia para los servicios médicos.
Yo ______________________________ que rechaza seguir la petición del médico o de la enfermera que visita en este tiempo.
Acepto la responsabilidad completa de rechazar peticiones y o instrucciones.
________________ Firma _________ _____-Relacion Femenino __________________ Fecha

Hospice Advance Beneficiary Notice (HABN)

☐We expect Medicare will not pay for **any** hospice services for you.
☐We expect Medicare will stop paying for **some** of your hospice services.
☐We expect Medicare will stop paying for **all** hospice services for you.

Why Won't Medicare Pay For Your Services?
This is our opinion based on our understanding of Medicare's home health coverage rules. It is our suggestion that you converse with your doctor, family, and us about your need for those specified services.

What Does This Mean For You?
You may still receive specified hospice services if you think that you need them. The payment for services rendered will be covered by yourself or through any other insurance that you may have. The estimate for all of those services will cost about $ __________.

Medicare makes the official decision about Medicare payment. (You can ask Medicare for an official decision if you):

- Request that we provide the specified services pending Medicare's decision.
- Instruct us to submit a claim to Medicare for Medicare to make a decision on payment services. You may give us additional evidence to submit with the claim supporting your need for services, including a letter from your doctor.
- **Choose Option A**. If your hospice services are paid for by Medicare and/or by your other insurance, you will be refunded any amounts that you are due.

3. Choose an option (check only one box below).

   ☐ **A. I want to receive the specified hospice services and obtain a Medicare official decision.** Please submit a claim, with any supporting evidence that I include, to Medicare for its official decision. Please bill my other health insurance (__________________________________) if necessary. I understand that, if I have no insurance other than Medicare, I might have to pay for these services while Medicare is making a decision. If Medicare or another insurer does decide to pay and I have made any payments, I will be refunded any amounts that I am due. I agree to be fully and personally responsible for payment of any amount for which Medicare and my other insurance will not pay.

   ☐ **B. I do not want to receive the specified services.**

   ☐ **C. I want to receive the specified hospice services**. I do not want you to submit a claim or any health information to Medicare for an official decision. I know that I will be fully responsible for payment.

What happens if Medicare decides not to pay for requested services?
You have the right to appeal Medicare's decision not to pay for your hospice services. Medicare will send you notice of its official decision not to pay that explains its decision in your case and how you can appeal the decision. If you do not hear from Medicare in 90 days call Medicare ____________________ TTY/TDD ________________

4. Sign and date form, to authorize the option you chose. 3. Return the form to us at our facility.

Date of signature ____________
Signature of beneficiary or person acting on beneficiary's behalf ____

Note: Your health information will be kept confidential. Information we collect about you on this form is kept with your personal medical records at our offices. Any claim submitted to Medicare, may require that your health information on this form may be shared with Medicare. Medicare keeps your health information confidential.

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Medicare Secondary Payer Worksheet

For determination of Primary Payer Source Only (Not Required for Non- Medicare Patients)

- ✓ The illness or injury due to a work related accident or condition covered by Worker's Compensation. Dept. of Veterans Affairs or The Federal Black Lung Program? ☐Yes ☐No (If Yes, enter ID# and address of applicable below)
- ✓ Illness or injury due to a Non-work related injury or accident. ☐Yes ☐No Injury Date ________ if yes indicate below ☐Auto ☐Non-Auto ☐Other ________ If yes, location of accident ☐Home ☐Business ☐Other ______________ (If yes, enter name, address details below of responsibility for accident related claims)
- ✓ Is the Patient entitled to Medicare based on age (65 or over)? ☐Yes ☐No (skip to #4)
  - A. The patient is ☐Employed ☐Retired as of ________ and covered by Group Health Plan/HMO ☐Yes ☐No
  - B. Or, the patient is covered under a spouse's Group Health Plan/HMO ☐yes ☐No
  - C. Or, the patient selected an HMO to manage Medical Benefits? ☐Yes ☐No

  (If A, B, and C is No, Medicare is the Primary unless answered Yes to questions above)
- ✓ The patient is disabled Medicare Beneficiary under the age 65. ☐Yes ☐No (If yes, complete Plan/HMO data below)
  - A. The patient is covered by a Group Health Plan/HMO ☐Yes ☐No If Yes, does the Group Health Plan cover 100 or more? ☐Yes ☐No
  - B. Or, the patient is covered under a spouse's Group Health Plan/HMO ☐Yes ☐No If Yes, does the Group Health Plan cover 100 or more? ☐Yes ☐No
- ✓ Is the patient entitled to Medicare Based on End Stage Renal Disease (ESRD)? ☐Yes ☐No
  - A. The patient is within 30 month coordination period? ☐Yes ☐No
  - B. The patient initial entitlement to Medicate Based on ESRD? ☐Yes ☐No
  - C. Has the patient been undergoing kidney dialysis for more than 12months? ☐Yes ☐No

  (The Group Health Plan/HMO is primary payer during 30 month period if A, B, C is No, Medicare is the primary payer)

Other Payer Responsibility Information (Select one below)

☐Worker Compensation ☐Department of Veterans Affairs ☐Champus ☐Federal Black Lung

Name ______________________ Phone ______________________ Policy# or ID ______________

Address ____

Group Health Plan of HMO

Name ______________________ Phone ______________________ Policy# or ID ______________

Address ____

General Data ____

Billing Authorization

I, ______________________, agree for **A Hug Away Health Care, Inc**. to bill Medicaid or Private Insurance carriers. I request the payments of authorized benefits be made on my behalf. I authorize release of all records required to act on this request. The agency expects services to be paid by.

☐*State Medicaid (regular provider service benefit, no cost to patient **Not** available at this time)*

☐*Medicare A or B (regular home health benefits no cost to patient)*

☐*The patient is responsible for any balance after any insurance payment has been made or if the insurance company does not pay any or the claims.*

☐*None of the above applies if the services will not be covered by; Medicare, Medicaid, or other federally funded aided program. The Agency expects the patient or patient's family to be responsible for payment to the Agency.*

Medicaid # ______________________ **Effective Date** ______________

Patient's Health Insurance Claim# ______________ **SS#** ______________

Medicare# ______________ **Effective Date: Part A** __________ **Part B** ______________

I have been informed to the cost of the services that I will receive and fully understand that my portion of the cost of the services will be $ ___________.

Signature of Patient/Caregiver ______________________ Date ______________

Signature of Agency's Representative ______________________ Date ______________

NOTICE OF SERVICES NOT COVERED BY HOSPICE

The following services will not be covered by Hospice:

1. Medications that are not related to the terminal diagnosis and related conditions.
2. If the patient goes to a hospital that the Hospice does not have a contract with.
3. If the patient goes to the hospital without contacting and arranging with the hospice nurse.
4. If the patient uses an ambulance without Hospice approval.
5. If the patient goes to a physician without notifying the Hospice nurse.
6. If the patient/family decides to seek curative or life extending therapies such as blood or blood products, chemotherapy, radiation, or insertion of PEG feeding tubes.
7. Anything not related to the hospice diagnosis and related conditions.
8. Sitter services.

The above services are not covered by Hospice. The Hospice philosophy is based on comfort care rather than curative care. Hospice is reimbursed through Medicare, Medicaid, private insurance, or private pay. This is done on a per diem basis. Due to this, Hospice must be financially responsible for the terminal diagnosis related needs of the Hospice patient. Medicare guidelines instruct Hospices to be professional managers of the patient's care. To do this, Hospice must be aware of the situations as they arise and be allowed to manage the care of the patient. If the patient/family desire any of the above non-covered items, the patient/family will be given a choice of either reinstating the patient's traditional Medicare services and discontinuing Hospice services or allowing the patient/family to pay for the non-covered services. I have read and understand services NOT covered by Hospice. I agree to notify the nurse before proceeding with any of the above services.

I must seek pre-approval from the hospice for all treatments and services not included in the Plan of Care. I will be responsible for all bills incurred for treatments/services with a physician or facility not contracted with the hospice.
I have received a list of all inpatient and respite facilities with which the hospice has a contract.

ELECTION OF THE MEDICARE/MEDICAID HOSPICE BENEFIT

❑ N/A Patient is non-Medicare/Medicaid

❑ N/A I was transferred from ______________________________ Hospice on ____________ (Date).

I elect the above named Hospice to provide palliative hospice care to me.

I understand, by election of the Hospice Medicare or Medicaid benefit, the hospice benefits and limitations as the hospice has informed me. All care and treatment for my hospice diagnosis must be facilitated through Hospice. All services related to the terminal condition for which hospice care was elected will be waived, except for:

1. Services provided by the designated hospice,
2. Services provided by another hospice through arrangements made by the designated hospice,
3. Services provided by the individual's attending physician if that physician is not employed by the designated hospice or receiving compensation from the hospice for those services.

Palliative medications, medical supplies and durable medical equipment related to my hospice diagnosis and related conditions will be provided by Hospice.

Medicare will continue to pay as usual for all medical services related to medical conditions *other* than my hospice diagnosis and related conditions.

I understand that I may revoke my election of Hospice care at any time during a certification period and thereby resume the Medicare or Medicaid coverage of the benefits I waived. To revoke the election I understand I must file a written revocation statement with this hospice agency. At a later date, I may elect to receive hospice coverage again for the next certification period if I am eligible.

I acknowledge that I have been given a full understanding of hospice care, particularly the palliative rather than curative nature of treatment in hospice.

My attending physician ________________________ or ❑ Hospice Medical Director will direct my care. If I have designated an attending physician, that physician is chosen by me of my own free will without coercion.

Physician Address: ____

____ NPI #______________________

I am electing the (1st, 2nd, 3rd, 4th, etc) ______________ benefit period. The effective date of election to the Medicare or Medicaid Hospice Benefit is ____________________.

____ ____

Patient's Signature/POA Date Witness Date

HOSPICE INFORMED CONSENT

24 Hour Number:

CONSENT FOR SERVICE/RELEASE OF RECORDS

I ______________________________________ understand that I have a Hospice-appropriate diagnosis and have been informed that the above named Hospice, referred to in this consent as Agency, is licensed to provide services according to the IDT Plan of Care established by the Hospice team, the attending physician and the Hospice Medical Director. Admission Policy: Agency will admit you only if Agency is able to provide care appropriate to your needs. If the Agency is unable to meet your needs, the Agency will assist you and your family in locating resources of your choice who can provide the needed services. After hours access: Agency has a nurse "on-call" during unscheduled business hours. To access on-call nurse: Call the Agency number; the answering service will answer, tell the operator that you wish to speak to the hospice on-call nurse; the operator will contact the RN on-call. If you do not hear from the nurse within 20 minutes, contact the operator again. The Agency will coordinate inpatient care at a contracted facility to provide palliative support. I understand that if I call 911, go to the hospital, or choose care for any conditions related to my admitting hospice diagnosis, without preauthorization from Hospice, I may be responsible for those associated bills. It is the policy of the Agency to protect all clinical records against loss, defacement, tampering and use by unauthorized persons. I authorize the agency to release medical information to my physician, the facility of my choice, payer source, or accrediting/regulatory/consulting organizations, as appropriate. I authorize the release of the Plan of Care and Discharge Summary upon my transfer to another health care facility.

FINANCIAL AUTHORIZATION

I authorize benefits to be made on my behalf:
Bill Medicare 100% - Medicare#: ______________________________ Effective Date: ________________
Bill Medicaid 100% - Medicaid#: ______________________________ Effective Date: ________________
PRIVATE INSURANCE:
Bill Primary Insurance: __________% Insurance Co: ____
Bill Secondary Insurance: ________ % Insurance Co: ____
❑ I will pay any service or supply charge not reimbursed by my insurance company on a monthly basis. I will pay all charges incurred on a monthly basis if I do not have insurance coverage.

SERVICES/RIGHTS/HOTLINE/PROCEDURES

I understand that a Registered Nurse will case manage all services and I have accepted the following services:
❑ RN/LVN ❑ Hospice Aide ❑ Social Worker ❑ Chaplain ❑ Dietician ❑ Volunteer ❑ PT ❑ OT ❑ SP
❑ Other: ______________________

I understand that Hospice is not to cure my disease, but rather to provide symptom control and comfort in dealing with my illness.
I have received a copy and an explanation of my Patient Bill of Rights and the Rights of the Elderly, as appropriate.
I understand that Hospice will review all of my medications to determine if they are related to my hospice diagnosis and related conditions to determine whether medications will be covered by Hospice or my Part D plan.

I have been notified of my right to voice a complaint. I may direct that complaint to the Texas Health and Human Services Commission (HHS), Consumer Rights and Services Division, Mail Code E249, PO Box 149030, Austin, TX 78714-9030, or by calling 1-800-458-9858. The line is open 24 hours a day. This includes a complaint regarding advance directives. Complaints regarding Utilization Review or HMO services can be made directly to Texas Department of Insurance Consumer Protection, at PO Box 149091, Austin, TX, 78714, at 1-800-252-3439.
I may also voice a complaint to the Agency Administrator or designee at the above referenced phone number. An investigation of the complaint will be initiated within 10 calendar days and resolved within 30 calendar days of receipt.
I have received information and Agency policy on Advance Directives. I have ❑ or have not ❑ signed a
❑ Directive to Physician/Living Will ❑ Medical Power of Attorney ❑ Out of Hospital DNR
I am ❑ am not ❑ providing a copy for my record. Designated Medical Power of Attorney. ______________________
Phone: ____________________
I understand that it is my right and responsibility to be involved in my care and that I will be informed as to the nature and purpose of any procedures. I also understand that I must have a primary caregiver.
I have been given an explanation and written information regarding Safety in the home. I have also been informed of what to do in an emergency/natural disaster and have received education on completing an emergency preparedness plan for myself and my family. I understand the importance of completing this plan and know that Agency staff may assist in this process.
I have been informed verbally and in writing regarding Agency policy on abuse, neglect and exploitation, Agency drug testing policy, medication disposal policy, and hazardous waste disposal in the home.

HIPAA - I have received "Notice of Privacy Practices" and consent to the agency's use and/or disclosure of protected health information for payment, treatment and Agency's health care operations.
I have been informed of the availability of clergy.

______________________________	______________________________
Patient/Authorized Agent Signature (Relationship)	Reason patient is unable to sign
______________________________	______________________________
Agency Representative Signature	Date of Signatures