HOSPICE ELECTION OF BENEFIT

I, _____ **(Patient Name)**, choose to elect the Medicare hospice benefit and receive hospice services from Bloom Hospice ("the hospice") to begin on _____ **(Start of Care Date)**.

This Hospice Election of Benefit pertains specifically to beneficiaries electing the Medicare of Medicaid hospice benefit. For beneficiaries with insurance other than Medicare or Medicaid ("Private Insurance") electing to receive hospice care, the Hospice will work closely with the beneficiary's Private Insurance carrier to determine which medications, durable medical equipment, medical supplies, and services are covered by the Private Insurance carrier. Private Insurance beneficiaries/representatives will be responsible for unpaid deductibles, co-pays, and/or other out-of-pocket expenses as determined by the insurance carrier. When possible, details of patient responsibility will be provided to Private Insurance beneficiaries/representatives within 5 days of the Start of Care Date. Private Insurance beneficiaries must immediately notify the Hospice of any changes in insurance status.

Right to Choose an Attending Physician

- I understand that I have the right to choose an attending physician to oversee my care.
- My attending physician will work in collaboration with the Hospice to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician and understand the Hospice's physician will manage my medical care related to my terminal illness and related conditions.

☐ My choice for an attending physician is:_____**(Physician Full Name)**.

Hospice Coverage and Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" (Medicare Patients Only)

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 ("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 3 days if you request this form during the course of hospice care.

☐ I elect to receive the Addendum at this time.

Initials _____ Date _____

☐ I decline to receive the Addendum at this time, although I understand I can request it at a later time.

Initials _____ Date _____

Beneficiary and Family-Centered Care Organization (BFCC-QIO) (Medicare Patients Only)

- 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 Acentra (1-888-317-0891; TTY 855-843-4776).

Hospice Philosophy and Coverage of Hospice Care

By electing hospice care under the Medicare and Medicaid 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 or Medicaid hospice benefit, I waive (give up) the right to Medicare or Medicaid payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in effect, Medicare or Medicaid will make payments for care related to 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 this election is in effect. The items, services, and drugs determined to be unrelated to my terminal and related conditions continue to be eligible for coverage by Medicare or Medicaid under separate benefits.

Acknowledgment and Signature

By signing, I acknowledge that I understand the information provided to me about:

- The right to choose an attending physician.
  Hospice coverage and the right to request the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" addendum (Medicare Patients Only)
- The right to Immediate Advocacy through the BFCC-QIO Acentra (Medicare Patients Only); and
- The Hospice Philosophy and effects of Medicare or Medicaid hospice election.

_____ _____

Signature of Beneficiary/ Representative *Date of Signature*

Beneficiary is unable to sign due to:

☐ *Physical disability* ☐ *Confusion/Dementia/Unresponsiveness* ☐ *Other*_____

_____

Printed Name of Signer (if Not Beneficiary)

_____ _____

Bloom Representative Signature *Date of Signature*

INFORMED CONSENT FOR BLOOM HOSPICE'S PROGRAM

Patient Name:_____ MRN:_____

Receipt of forms

By signing below, I acknowledge receipt of the following in verbal and written notice/policy, in a language I understand:

- Hospice Care Guide
- Coordination of Care
- Rights and Responsibilities/ Rights of the Elderly
- Home Care Consumer Rights
- Grievance Procedure/Complaints
- Contracted Facilities (list of)
- Hazardous Material and Waste
- Controlled Drug Disposal
- Non-Discrimination
- Emergency Preparedness
- Advance Directive Information
- Infection Control Program Review
- HIPPA Notice/Privacy Practice
- Hospice Benefit/Levels of Care
- Abuse, Neglect and Exploitation
- Medicare Part D information, if applicable
- Financial Responsibility
- Drug Testing
- Alternative Communication
- Contact Information
- Operating Hours

I have received:
☐ Patient Information & Emergency / Disaster Preparedness Plan
☐ Emergency Preparedness was discussed.

Release of Information and Medical Records

By signing below, I authorize Bloom Hospice to release and/or to obtain personal/medical information from any appropriate agency/person/physician, my insurance company/companies, and/or regulatory and accrediting agencies as necessary to assure continuity of care, payment of services, compliance with the law, and/or for regulatory and accreditation purposes.

Advanced Directives

☐ I do not have an advance directive ☐ I wish to receive assistance with advance directives.

☐ I have an advance directive for: ☐ Directive to physician ☐ Out of Hospital DNR ☐ Medical Power of Attorney

Alternative Communication

☐ I have a need for alternative communication ☐ I do not have a need for alternative communication.

Complaints

I understand I may file a complaint regarding my care to include concerns about my advance directives with the hospice Administrator, and an investigation will be initiated within 10 days and completed within 30 days, or I may file the complaint with:

Texas Health and Human Services Call toll-free 800-458-9858 Business Hours: Monday – Friday 7a.m. to 7 p.m.	Texas Health and Human Services Consumer Rights and Services — Complaint Intake Unit Mail Code E249 P.O. Box 149030 Austin, TX 78714-9030 Fax: 512-438-2724 or 877-438-5827 via email: ciiprovider@hhs.texas.gov

Financial Agreement

I understand I should contact the hospice prior to receiving treatments or services related to my hospice diagnosis and not included in my plan of care, and that I will be responsible for all bills for treatments or services related to my hospice diagnosis with a physician or facility not contracted with the hospice.
I understand that for services unrelated to my hospice diagnosis, I may seek treatment according to my Medicare/Medicaid/Private insurance benefits.

I authorize benefits to be made on my behalf:

☐ Bill Medicare 100% - Medicare Beneficiary Identifier (MBI): _____ Effective Date: _____
☐ Bill Medicaid 100% - Medicaid Beneficiary Identifier (MBI): _____ Effective Date: _____
☐ Private Insurance:
Bill Primary Insurance: _____% Insurance Co-Pay: _____
Bill Secondary Insurance: _____% Insurance Co-Pay: _____
☐ I will pay any charge not reimbursed by insurance company monthly.
☐ I will pay all charges incurred on a monthy basis if I do not have insurance coverage.

I understand the following hospice services are covered and provided according to my individualized plan of care and I accept the following services indicated with a checkmark at the time of my admission:

☐ Nursing Services (required) ☐ Physician Service ☐ Spiritual Counseling Services ☐ Medical Social Services
☐ Hospice Aide Services ☐ Dietitian/Nutritionist ☐ Volunteer Service ☐ Therapy Services ☐ Homemaker Services

Understanding Hospice Care

By signing below, I acknowledge that I understand the following:

- I understand that the hospice operating hours are 8:30 am -5:00 pm and I may contact the hospice 24/7 at 303-459-4000.
- My Bloom hospice team collaborates with me/my caregiver to develop an individualized plan of care that will focus on controlling my pain and symptoms and providing services to enhance my quality of life.
- Bloom Hospice does not discriminate or refuse services because of a patient's inability to pay. Bloom Hospice coordinates, directs, and provides care and services for my illness.
- I am responsible to notify Bloom Hospice of any treatments, change in medications, and/or services or appointments regarding my overall health and wellbeing to ensure collaboration of care.
- I agree to allow Bloom Hospice to obtain a copy/picture of my Insurance/Medicare/Medicaid card and social security number for the purpose of verification of insurance status.
- I understand that the Hospice may need to take photographs solely for the purposes of providing medical information to the physician or others involved in my care, or to record in my medical record.

  ☐ I also understand the photograph(s) will be treated and managed in a confidential manner and I may request possession of the photographs, or they be destroyed at any time.

  ☐ I further release the hospice agency from all liability related to any photographs and acknowledge that they may be submitted as a part of the record to insurance companies, Medicare or Medicaid and other payers.

By signing below, I consent to admission to Bloom Hospice's Program under the terms and conditions discussed.

_____ _____
Signature of Beneficiary/ Representative Date of Signature

Beneficiary is unable to sign due to

☐ *Physical disability* ☐ *Confusion/Dementia/Unresponsiveness* ☐ *Other*_____

_____
Printed Name of Signer (if Not Beneficiary)

_____ _____
Bloom Representative Signature *Date of Signature*