Mesilla Valley Hospice
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Informed Consent and Medicare Benefit Election Form

Patient Name_____#_____
Effective Date (Admission) _____

Consent for Treatment

I understand that with hospice care **I am shifting the focus of care for my terminal illness from cure to comfort measures and choosing to waive the Medicare benefits for curative care. I/my family will work with the hospice team to develop a plan of care** and to follow hospice guidelines, policies and procedures. I understand the team is not intended to provide 24 hour care in the home and I will work with my caregivers to understand my Plan of Care with the support of the Hospice team. The family will hire 24 hour caregivers if this is desired.

Hospice care may involve skilled nursing, spiritual or emotional counseling, social workers, nurse aids, and companionship. The team promotes comfort, dignity and support for the family. **Care is directed through my Attending Provider** and/or the Medical Director.

I may refuse treatment or terminate services at any time. If I choose La Posada, I agree to the financial responsibilities. La Posada staff will administer prescribed medications according to regulation and policy.

Payment for Services

I elect to use the Medicare Hospice Benefit consisting of two 90-day periods, and unlimited 60 day periods if no revocation or discharges occur. I will use the benefit periods in the above order. **I can discontinue hospice care at any time** by completing a revocation statement, losing the remaining days in the existing benefit period. **I may, however, re-elect hospice care at any time I am eligible**. I am responsible for the cost of care beyond what is documented in my hospice Plan of Care. I understand Medicare payments will cover the cost of my care although I may be responsible for 5% for each prescription, up to $5.00 each.

☐ **Medicare Hospice Benefit** ☐ **Medicaid** ☐ **Private Insurance** ☐ **DAC Health Services Fund** ☐ **Self Pay**

I may be responsible for co-payment or deductibles not covered by Insurance. Level of care in La Posada is based on Medicare guidelines and may be changed as necessary, resulting in Room and Board charges.

Acknowledgements

I can change from one hospice to another if I wish to, and will confirm that I may be admitted to the new program and inform MVH I wish to discontinue care. By working with my hospice team I will not lose any patient days. I am eligible for care unrelated to the terminal illness which can be pursued in the traditional manner. I understand a transfer/discharge may occur should my condition warrant it or at my request. I authorize MVH staff to take my photograph for identification purposes in La Posada.

I confirm I have been given, have signed and understand the following forms:

☐ Patient Rights/Responsibilities ☐ Notice of Privacy Practices ☐ Release of Information ☐ Advance Directives

The undersigned certifies that all above statements have been read and understood and authorize Hospice Medicare services and name as my Attending Physician: _____NPI: _____

Patient Signature_____ Date_____

Authorized Representative_____ Relationship_____

Pt Unable to sign because_____

MVH Representative_____Date_____

HIPAA

I authorize MVH to release medical information to any authority or organization necessary for treatment, payment of care or health care operations without limitation. I have the right to review the hospice's Notice of Privacy Practices prior to signing this consent. If the Notice is revised, MVH will provide me with a copy. I have the right to request restrictions of the uses and disclosures of protected health information and that, while hospice does not have to agree, it must abide by those restrictions to which it agrees. I have the right to revoke consent in writing, except to the extent that hospice has taken action based on prior consent. MVH has the right to refuse treatment to patients who refuse to provide consent.

Signature of Patient/authorized representative_____Date_____

Client: _____
Date of Birth: _____
Record #: _____

The Rights and Responsibilities of the Patient

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The patient has the right to the following:

- To be treated with respect, dignity and compassion. To exercise my rights to receive effective pain management and system control from the terminal illness; to be involved in developing my hospice plan of care, including the scope of services and any limitations; refusal of care, and choosing a physician.
- To have a confidential record including access to or release of patient information (CFR 160 and 174); to voice grievances about my care without discrimination or reprisal for exercising these rights; to have all alleged violations investigated immediately with corrective action as appropriate including reporting to the authorities.
- To be free from mistreatment, neglect, verbal, mental, sexual, and physical abuse, injuries and misuse of , or lack of respect for, my property.
- To receive information about the Medicare Hospice Benefit, and be informed in advance of the extent to which payment may be expected from Medicare, Medicaid, or other third party payer and any costs which I may be responsible for.

Responsibilities of the Patient:

- To provide accurate information for use in developing the plan of care, and to participate in its development by notifying my nurse of changes in my needs at least 24 hours in advance
- To have respect for the safety of all staff involved in my care and to treat them in a courteous and respectful manner.
- To respond to requests for information including visits from the care team when asked.

Rights and Responsibilities for La Posada

- I will pay the room and board daily rate for Routine Care, one week due in advance and agree to the bed-hold policy.
- To have a safe and sanitary living environment without the use of any restraints where my privacy is respected, and I may keep my personal property with me in my room.
- To leave the facility freely and return, to participate in social activities, to freely associate with staff and other residents, and have my family and friends visit at will. My room will not change without justification.
- I will participate in the development and implementation of my care plan with my caregivers, doctors and family.
- My family will respect the rules, guidelines and policies of La Posada and the staff.

La Posada Guidelines for Family Members and Visitors

- Family and visitors are welcome around the clock, however patients/families have the right to restrict hours or visitors. The front doors are locked from 7pm to 7am. **After hours, please use the intercom to call the nurse**. Children must be supervised by an adult and act in a manner respectful of other residents. They may not run throughout the halls and are encouraged to use the children's' area or play outside under supervision at all times. Pets are welcome, however a copy of immunization record is needed.
- The patient will receive meals from the kitchen. Families and guests are welcome to bring special meals in for the patent.
- Up to two family members may spend the night in the patient suite, however they may not move in or establish La Posada as their residence. Living rooms and public areas may not be used for overnight sleeping. Linen service is provided to residents, however there are no laundry facilities for families.
- Staff retain the right to ask disruptive visitors to leave.

For problems or complaints about your care call the MVH Clinical Directors, 523-4700 or
***New Mexico Department of Health Hotline 1-800-752-8649 M-F 8am-5pm or**
Dona Ana County Health and Human Services Department 575-525-5833
***Immediately report any suspected cases of physical, sexual, emotional or psychological abuse, neglect or exploitation**

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Making Medical Choices
Patient Self-Determination Act

In compliance of The Patient Self-Determination Act (PSDA) passed by U.S. Congress in 1990 and New Mexico Uniform Health Care Decisions Act, Mesilla Valley Hospice (MVH) provides information about advance health care directives upon admission.

1. As a competent adult you have the right to make your own health-care decisions and give individual instruction. The instruction can be oral or written; if oral it must be made by personally informing a health-care provider (Mesilla Valley Hospice care team member).
    a. Be involved in developing your hospice plan of care;
    b. Choose your own attending physician/provider for hospice care;
    c. Refuse medical care or surgical treatment
2. Advance Directive for Health-Care is a legal written document giving you the right to appoint a person as your healthcare agent (POA ,surrogate, or proxy) and states Instructions for Health Care if you become incapable of making health care decisions for yourself.
    a. Advance Directive for Health-Care is <u>not</u> required to receive hospice care;
    b. MVH social worker or nurse case manager can assistance with obtaining and completing an Advance Directive for Health-Care;
    c. You have the right to revoke any section or part of your Advance Directive for Health-Care.
    d. Mesilla Valley Hospice is not required to provide care that conflicts with an advance directive; and
    e. Are not required to implement an advance directive if, as a matter of conscience, it cannot implement an advance directive and NM State law allows MVH to conscientiously object.
3. If an adult is incapacitated (due to incapacitating conditions or a mental disorder) at the time of admission and is unable to receive information or articulate his or her health-care decisions, New Mexico law allows a family member who is reasonably available to make health care decisions on behalf of the incapacitated adult and MVH will deliver information, hospice policies and procedures in the same manner in accordance to NM State law.
    a. Family members are selected in the following order (as listed in the New Mexico Advance Directive for Healthcare): 1) spouse, 2) significant other, 3) adult child, 4) parent, 5) adult brother or sister, 6) grandparent;
    b. If no family member is available, a close friend may act as a surrogate;
    c. Once an individual is no longer incapacitated or is able to receive information, MVH is obligated to provide hospice information, procedures, and policies.

For more information:

New Mexico Advance Directives
NHPCO/Caring Connections
1731 King St., Suite 100
Alexandria, VA 22314
or
http://hsc.unm.edu/ethics/doc/UniformHealthCareDecisionsAct.pdf

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HIPAA AUTHORIZATION FORM for Use, Disclosure or Release of My Personal Health Information

I authorize Mesilla Valley Hospice to OBTAIN confidential healthcare information from another provider:

List where the records will be requested from: _____

List and describe the purposes: _____

The following has been identified as the minimum necessary PHI for admission and care of the hospice patient:

❒ Discharge summary ❒ History/Physical ❒ Pathology reports ❒ Consultation report ❒ Labs
❒ X-ray report ❒ EKG/ ECG report ❒ Admission Face Sheet ❒ Orders/progress note ❒ Entire Chart
❒ _____

CONDITIONS:

- The patient agrees to authorize the above named individuals/organization to access his/her confidential healthcare information only for the purpose listed above.
- The information authorized to be released will not be covered under the federal privacy laws.
- The organization will provide the patient with a copy of the confidential healthcare information for which this authorization is being sought, if requested.
- The patient is voluntarily signing this authorization and has the right to refuse to sign this authorization without affecting treatment. The patient will receive a copy of the signed authorization.
- The patient reserves the right to revoke this authorization at any time. This revocation must be writing.
- This authorization will be maintained by Mesilla Valley Hospice for a period of six (6) years.
- This authorization is in effect from _____ to _____ (length of time). Upon the conclusion of that time period, this authorization is automatically revoked and no further use of the patient's confidential healthcare information is permitted beyond that date.

Patient/Legal Representative: _____ Date: _____

Mesilla Valley Hospice Representative: _____ Date: _____

For MVH use

TO:_____

ATTENTION PROVIDER: Please send the records to the following fax #:

Mesilla Valley Hospice

Admissions: 575-527-2204 / **Medical Records:** 575-525-5774

Thank you!

Client: _____
Date of Birth: _____
Record #: _____

EMS DNR

INSTRUCTIONS

Purpose

This standardized **EMS-DNR Order (Order)** has been developed by the EMS Bureau within the Epidemiology and Response Division of the New Mexico Department of Health (DOH). It is in compliance with Section 24-10B-4I, NMSA 1978 which directs the EMS Bureau to develop a program to authorize EMS providers to honor advance directives to withhold or terminate care. The program is described fully in NMAC 7.27.6. A copy may be obtained by calling the EMS Bureau at 505-476-8200 or online at www.nmems.org.

For covered persons in cardiac or respiratory arrest, resuscitative measures to be withheld include external chest compressions, intubation, defibrillation, administration of cardiac medications and artificial respiration. The **Order** does not effect the provision of other emergency medical care, including oxygen administration, suctioning, control of bleeding, administration of analgesics and comfort care.

Applicability

This **Order** applies only to resuscitation attempts by health care providers in the **prehospital** setting --i.e., in patients' homes, in a long term care facility, during transport to or from a heath care facility, or in other locations outside acute care hospitals.

Instructions

Any adult person may execute an **Order** in conjunction with a physician. The physician, or physician's designee, shall explain to the person the full meaning of the **Order**, the available alternatives and how the **Order** may be revoked. Both the physician, or the physician's designee upon a verbal order from the physician, and the person for whom the **Order** is executed, shall sign the **Order**.

If the person for whom the **Order** is contemplated is unable to give informed consent, or is a minor, the physician, or physician's designee, shall provide the same explanation of the **Order**, the available alternatives, and how the **Order** may be revoked to an authorized heath care decision maker. If the authorized health care decision maker gives informed consent, both the physician, or the physician's designee upon a verbal order from the physician, and the authorized health care decision maker shall sign the document

ONE SIGNED COPY of the **Order** should be retained by the patient and placed in an envelope. Staple the Envelope Cover Sheet (which is included in this PDF document) **"EMS DNR Order inside"** to the envelope. The completed form (and/or the approved EMS bracelet or neck medallion) must be readily available to EMS personnel in order for the **Order** to be honored. Resuscitation attempts may be initiated until the form (or EMS bracelet/medallion) is presented and the identity of the patient is confirmed by the EMS personnel. It is recommended that the white envelope containing the **Order** be located in an obvious place that is readily available to emergency responders.

ONE SIGNED COPY should be retained by the physician and made part of the patient's permanent medical record. Additional copies should be made so that the **Order** can be maintained in all of the appropriate medical records.

ONE SIGNED COPY of the form may be used by the patient to order an ***optional*** EMS bracelet or neck medallion inscribed with the words "DO NOT RESUSCITATE - EMS" The MedicAlert Foundation (2323 Colorado Avenue, Turlock, CA 95382) is the EMS Bureau approved supplier of the medallions, which will be issued only upon receipt of the properly completed **Order** (together with an enrollment form and the appropriate fee). If a MedicAlert enrollment form is needed, call 1-800-432-5378 and ask for an EMS-DNR form. The fee can be waived for patients who cannot afford it, as certified by the physician or the physician's designee. Although optional, use of an EMS-DNR bracelet facilitates prompt identification of the patient and therefore is strongly encouraged.

Revocation

An **Order** may be revoked at any time orally or by performing an act such as burning, tearing, canceling, obliterating or by destroying the order of any part of it by the person on whose behalf it was executed or by the persons' authorized health care decision maker. If an **Order** is revoked, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with MedicAlert Foundation. All medallions and associated wallet cards should be destroyed.

Additional Resources available

To obtain a New Mexico Durable Power of Attorney for Health Care Decision Form or a Values History Form, contact the Center for Health Law and Ethics, 1111 Stanford, N.E., Albuquerque NM 87131 or call 505-277-5006. The cost for the Values form is $3.00 and may be requested in English or Spanish.

To order EMS-DNR forms or to ask questions about implementation of this program, please call the EMS Bureau at 505-476-8200 or online at www.nmems.org.

ENVELOPE COVER SHEET

EMS **DNR**

ORDER INSIDE

Note: Staple this cover sheet to the envelope containing the signed EMS-DNR Order

EMS DNR

EMERGENCY MEDICAL SERVICES (EMS)
DO NOT RESUSCITATE (DNR) FORM

AN ADVANCE DIRECTIVE TO LIMIT THE SCOPE OF EMS CARE

NOTE: THIS ORDER TAKES PRECEDENCE OVER A DURABLE HEALTH CARE POWER OF ATTORNEY FOR EMS TREATMENT ONLY

I, _____, request limited EMS care as described in this document. If my heart stops beating or if I stop breathing, no medical procedure to restore breathing or heart functioning will be instituted, by any health care provider, including but not limited to EMS personnel.

I understand that this decision will not prevent me from receiving other EMS care, such as oxygen and other comfort care measures.

I understand that I may revoke this Order at any time.

I give permission for this information to be given to EMS personnel, doctors, nurses and other health care professionals. I hereby agree to this DNR order.

_____ OR _____

Signature

Signature/Authorized
Health Care Decision Maker

I affirm that this patient/authorized health care decision maker is making an informed decision and that this is the expressed directive of the patient. I hereby certify that I or my designee have explained to the patient the full meaning of the Order, available alternatives, and how the Order may be revoked. I or my designee have provided an opportunity for the patient/authorized health care decision maker to ask and have answered any questions regarding the execution of this form. A copy of this Order has been placed in the medical record. In the event of cardiopulmonary arrest, no chest compressions, artificial ventilations, intubation, defibrillation, or cardiac medications are to be initiated.

_____ _____

Physician's Signature/Date

Physician's Name—PRINT

_____

Physician's Address/Phone

Note: please print three (3) copies

ONE SIGNED COPY: To be kept by patient in white envelope and immediately available to Emergency Responders
ONE SIGNED COPY: To be kept in patient's permanent medical record
ONE SIGNED COPY: If DNR Bracelet/Medallion is desired send to MedicAlert with enrollment form

HATCH AMBULANCE SERVICE
P O BOX 370
HATCH, NEW MEXICO 87937

STATEMENT OF FINANCIAL RESPONSIBILITY

I, the undersigned, understand that the payment of any ambulance charges is my sole responsibility. I will provide Hatch Ambulance Service with any pertinent insurance information.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I, the undersigned, hereby authorize payment directly to Hatch Ambulance Service any ambulance benefits otherwise payable to me. These charges will not exceed the regular charges for this type of service. I understand that I am financially responsible to Hatch Ambulance Service for charges not covered by this authorization and do hereby guarantee payment of this bill in the event my insurance does not cover any/all/or part of this claim. I authorize the release of any medical information necessary to process this claim.

MEDICARE/MEDICAID BENEFITS: I, the undersigned, authorize any holder of medical information about me to release to Health Care Financing Administration and its agents (any Medicare/Medicaid agents) any information needed to determine these benefits or the benefits payable for related ambulance services. I also authorize any Medicare/Medicaid agents to release any and all payment and claim information regarding this claim to Hatch Ambulance Service. I understand that I am financially responsible to Hatch Ambulance Service for charges not covered by this authorization and do hereby guarantee payment of this bill in the event Medicare/Medicaid does not cover any/all/part of this claim.

_____ _____
Signature of Patient or Responsibility Date of Signature

_____ _____
Name of Patient Witness

_____ _____
Social Security Number Medicare Number

_____
Medicaid Number

_____ _____
Employer Employer Phone Number

Insurance Name, Policy & Group Number, Address and Telephone Number

Name_____

Policy Number_____

Group Number_____

Address_____

Phone #_____

Mesilla Valley Hospice
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Levels of Care

Name_____#_____
Effective Date (Admission) _____

Routine Home Care

This level of care is the same level of hospice team care provided to patients in their own homes. We recognize there are times when a patient cannot remain in their home and a stay in La Posada is preferable. In this case, the Medicare Hospice Benefit will continue to cover hospice care provided by members of the patients care team. However, Medicare Hospice Benefit does not cover Room and Board, and a rate of $250 per day, will be billed to the patient and/or family or appropriate payor source. In some instances, proof of income, expenses, assets and liabilities will be required.

General Inpatient Care

General Inpatient Care is provided when short term crisis management is required for symptoms that cannot be controlled at home. This level of care can be provided at Memorial Medical Center or La Posada. The determination of when this level of care is appropriate is based on Medicare guidelines and the patient's Plan of Care. When General Inpatient care is not longer appropriate, the hospice care team will work with the patient and family to help the transition to Routine Home Care.

Respite Care

Respite Care is available to families who need a short break from care-giving. It is available for a maximum of 5 days per benefit period. The hospice care team will work with the patient and family to help with the transfer from La Posada back home for routine home care.

Agreement

I/we have read the requirements for the different levels of care available and understand the level will be determined by Medicare Guidelines and the Plan of Care. I understand that Medicare does not pay for Room and Board for the Routine level of care and I will be billed $250 per day for my stay. If I need assistance I will work with my Social Worker.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
MVH Representative Date

File Name: Levels of Care
Form # 105 (05/13, 03/154)

Client: _____
Date of Birth: _____
Record #: _____