WE, THE PATIENT AND FAMILY AND/OR LEGAL REPRESENTATIVE, REQUEST ADMISSION TO THE HOSPICE PROGRAM OF CARE AND WE ACKNOWLEDGE, CONSENT AND AGREE TO THE FOLLOWING:

We understand Prairie Haven Hospice provides palliative care to patients, families and caregivers who elect hospice care. Prairie Haven Hospice defines palliative care as care that enhances comfort for patients, families and caregivers. Determination of palliative care is made in agreement with the attending physician, patient/family/caregivers and the hospice team. Goals of intervention are pain control, symptom management and emotional and spiritual comfort for patients, their families/caregivers. Prairie Haven Hospice will determine with each patient, family, caregiver and their attending physician a plan of care based on these goals. Each patient's needs will be assessed on a continual basis and interventions/care explored and evaluated in the context of the patient's symptoms and the patient/family values.

Prairie Haven Hospice does not consider surgical placement of feeding tubes, administration of TPN or chemotherapy, intravenous hydration, blood transfusions, intravenous antibiotic therapy or radiation therapy part of the hospice plan of care and would not generally authorize these services or pay for these services.

While DO NOT RESUSCITATE orders are not a prerequisite for admission to hospice, cost of resuscitative measures are not covered under the hospice benefit.

We understand the hospice program as being primarily services delivered in the patient’s place of residence by a team of hospice professionals and volunteers. These services are available both on a scheduled basis and as needed twenty-four hours a day, seven days a week. We understand that these services may include nursing, physician care, social work, spiritual care, counseling, home health aides/homemakers, medical supplies, medical equipment, physical therapy, occupational and speech-language therapy and medications ordered for relief of pain or discomfort.

Initials: _____

PRAIRIE HAVEN HOSPICE
Two West 42nd, Suite 2300
Scottsbluff NE 69361
We understand the hospice program provides inpatient services when it is deemed necessary by the interdisciplinary team to have round-the-clock inpatient care and intensive symptom control under continual observation. We understand that hospice inpatient beds are not licensed for or able to legally provide long-term hospitalization, custodial or nursing home care but are designed for short-term stays, which will have as their goal, getting the patient and family stable enough emotionally and physically to go home, if at all possible. We understand inpatient care can be provided only at Regional West Medical Center (Scottsbluff), Morrill County Community Hospital (Bridgeport), Box Butte General Hospital (Alliance), Kimball Health Services (Kimball) or Community Hospital (Torrington, WY.)

We understand that the hospice team is not intended to take the place of the family but rather to support the family in caring for the patient. We understand that the hospice medical director is not intended to take the place of the attending physician, but rather to provide consultation and direct symptom control services as requested by the attending physician.

As the patient, I ask that my family member(s) or legal representative, respect my choice of hospice care and, insofar as they are able, that they fulfill the role of primary caregiver for me. As the family member(s) or legal representative, I/we understand the role of primary caregiver and, insofar as I/we are able, pledge to undertake the role with the training and support of the hospice team. I/we pledge to work with the hospice team to make alternate care arrangements if I/we cannot serve as primary caregiver.

We give consent and approval for entries to be made on hospice record and care plan concerning the medical, nursing, psychosocial, spiritual and personal information necessary for the hospice to fulfill its functions. We understand that we have the opportunity to join the hospice team in making the decisions about the variety, frequency and intensity of the services and techniques the hospice team will use to help us. We understand that we may review the patient's plan of care, which details those services and techniques with changes noted as necessary.

Initials: ________

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We understand that we are invited to attend hospice care conferences to hear and participate in discussions about the services and techniques being used to assist us. We give consent and approval for the release of information and appropriate medical records to or from any skilled facility, hospital, home health agency, health organization, private physician, county coroners office, and emergency responders in order to coordinate patient care.

The cost and reimbursement of hospice care has been explained to us. We have been given an opportunity to discuss our financial needs and situation with a representative of Prairie Haven Hospice, to the extent we wish. We understand that the decision to accept us into the hospice program of care will not be based solely upon our ability or inability to pay; that services of the hospice will neither be withheld nor curtailed based solely upon any change in our ability or inability to pay. **We understand that we are responsible for the following charges:**

___Medicare Patients: No charges will be incurred by the patient/family/legal representative for care and services provided by/authorized by Prairie Haven Hospice as part of the Hospice Plan of Care.

___Medicaid Patients: No charges will be incurred by the patient/family/legal representative for care and services provided by/authorized by Prairie Haven Hospice as part of the Hospice Plan of Care.


___Nursing Facility Patients: Prairie Haven Hospice is not responsible for room and board charges when patient resides in a nursing facility, an assisted living facility or is receiving residential care in an acute care hospital.

Initials: ______

**PRAIRIE HAVEN HOSPICE**
Two West 42nd, Suite 2300
Scottsbluff NE 69361
I/we hereby authorize that payment for Prairie Haven Hospice be made on my be-
half directly to Prairie Haven Hospice. I authorize release of all records required to
implement this authorization. I understand that I am responsible to Prairie Haven
Hospice for charges (including deductible and coinsurance) not covered by my
health insurance policy.

Patient Signature
___ Patient lacks cognitive ability to sign.
___ Patient is physically unable to sign
due to advanced disease/illness process.

Signature of person identified by the patient as being family
member or legal representative responsible for the care of this
patient.

Date

Relationship to patient

Witness

PRAIRIE HAVEN HOSPICE
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