Home Health and Hospice Care Services, Inc.

131 Sand Creek Road Suite K
Brentwood, CA 94513
PH. 925-684-7979
FAX 925-684-7287

PATIENT VERIFICATION

PATIENT NAME _____

PATIENT DATE OF BIRTH _____

TYPE OF IDENTIFICATION _____

PATIENT ID NUMBER _____

PATIENT CURRENT ADDRESS _____

_____

_____

PATIENT REPRESENTATIVE (DPOA) _____

REPRESENTATIVE ADDRESS _____

_____

_____

HOSPICE REPRESENTATIVE

ADMISSION NURSE _____

SIGNATURE _____

DATE _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the release of my records (protected health information) to:

AMAVI HOME HEALTH AND HOSPICE CARE SERVICES, INC.
131 Sand Creek Rd., Suite K
Brentwood, CA 94513

DISCLOSURE OF PROTECTED HEALTH INFORMATION: I understand that Amavi Hospice may need to obtain medical records and related information from hospitals, nursing homes, physicians, pharmacies, insurance companies, health care benefit plans, or others to assure continuity of care and proper reimbursement. I authorize the above entities to release to Amavi Hospice and its representatives' medical records and related information necessary to be helpful in the provision of hospice care. I also authorize Amavi Hospice and its representatives to release medical records and related information to others for the purposes of my health care, administration, and management of my health care (including utilization review), or processing and obtaining payment for services and supplies rendered to me. I understand and agree that these authorizations specifically include my permission and consent to release any information regarding a diagnosis of AIDS or results of Human Immunodeficiency Virus (HIV) tests to the extent permitted by law. A photocopy of this authorization shall be valid as the original. I understand I may revoke this authorization in writing at any time. The revocation must be received by the above agency before it becomes effective. This release of records authorization to Amavi is good for duration of hospice service.

I also hereby authorize Amavi Home Health and Hospice Care Services, Inc. to furnish to an agent, designee or representative of **(Patient Name**) _____ **medical records** and information pertaining to medical history, services rendered, or treatment given to stated patient, for purposes of review and evaluation.

DURATION:
This authorization shall become effective immediately and shall remain in effect starting admission until discharged.

RESTRICTIONS:
I understand that the requestor may not further use or release the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
ADDITIONAL COPY:
I further understand that I have a right to receive a copy of this authorization upon my request.

____ YES ____ NO Copy requested.
____ YES ____ NO Requested copy received.

_____ _____
Patient/Representative Name and Signature Date

_____ _____
Hospice Representative Name and Signature Date

PATIENT NAME	DOB	MR#

Hospice Benefit Election

Check the appropriate benefit:

___ As a Medicare Part A Beneficiary, I am electing the Medicare hospice benefit.
___ As a Medicaid/Medi-Cal beneficiary, I am electing the Medicaid/Medi-Cal hospice benefit.
___ As a Veterans Benefit beneficiary, I am electing the Veterans hospice benefit.
___ As a Commercial insurance beneficiary, I am electing my Commercial insurance hospice benefit.

Hospice Philosophy

I acknowledge that I have been given a full explanation and understand the purpose of hospice care. 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/caregiver.

Effects of a Medicare Hospice Election

I understand that by electing hospice care under the Medicare Hospice Benefit, I am acknowledging that I understand the palliative rather than curative nature of hospice care, as it relates to my terminal illness and related conditions. I understand that by electing hospice care under the Medicare Hospice Benefit, I am waving (give up_) all rights to Medicare payments for services related to my terminal illness and related conditions and I understand that while this election is in force, Medicare will make payment for care related to my terminal and related conditions only to the designed hospice and attending physician that I have selected.

Hospice Coverage and Right to Request "Patient Notification of Hospice Non-covered items, services, and Drugs"

I acknowledge that I have been provided with information about my financial responsibility for certain hospice services (drug co-payments and inpatient respite care) I understand that I have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items services and drugs" addendum that lists the items, services and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions that would not be covered by the hospice. I acknowledge that I have been provided information regarding the provision of Immediate Advocacy thought the Beneficiary and Family-centered care quality organization (BFCC-QIO) If I disagree with any of the hospice's determinations and I have been provided with the contact information for the BFCC-QIO that services my area.

Call your BFCC-QIO at LIVANTA (877) 588-1123 to appeal, or if you have questions

You must make your request to your Quality Improvement Organization (also known as a BFCC-QIO) a BFCC-QIO is the independent reviewer authorized by Medicare to review the decision to end these services.

Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated.

The BFFC-QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of the notice if you are in Original Medicare. If you are in the Medicare health plan, the BFFC-QIO generally will notify you of its decision by the effective date of this notice.

PATIENT NAME	DOB	MR#

Right to choose an attending physician

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

_____ I do not wish to choose an attending physician

ATTENDING PHYSICIAN: the physician I have chosen to serve as my attending is:

HOSPICE MEDICAL DIRECTORS

_____ Initial Dr. Anthony E Allen NPI: 1104846054 2512 Telegraph Ave, Suite 350 Berkeley, CA 94704 P: 415-420-4325 F: 510-775-1888	_____ Initial Dr. Andrew Ng NPI:1871716910 423 Broadway Suite 604 Millbrae, CA 94030 P :650-732-9721 F: 510-323-4286

_____ Initial Preferred attending physician other than hospice Medical Directors:

Name: _____

Address: _____

_____

Phone No. _____

Fax No. _____

Financial Authorization

Primary Payer Source: ___Medicare ___Medicaid/Medi-Cal ___Commercial Insurance ___Patient ___Other

Secondary Payer Source: ___Medicare ___Medicaid/Medi-Cal ___Commercial Insurance ___Patient ___Other

We have verified eligibility and coverage with your insurance/program plan(s) for the hospice services you requested. As a service to you, we have listed below the insurance coverage we have estimated based on our discussion with your insurance/program carrier. Please review the information and keep it for your records.

Level of Care	Routine Care	Continuous Care	General Inpatient	Respite
Your Estimated Liability				

If I am electing my Commercial insurance hospice benefit, I agree to pay Amavi Hospice any deductibles and/or co-payment amounts in accordance with my insurance/program plan.

I acknowledge and understand that above and authorized Medicare hospice coverage to be provided by AMAVI HOME HEALTH AND HOSPICE CARE SERVICES, INC. to begin on _____

Effective date of Election

NOTE: The effective date of the election which may be the first day of hospice care or a later date but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.

PATIENT NAME	DOB	MR#

FINANCIAL CERTIFICATION:

I certify that the information given by me to Amavi Hospice in requesting and applying for payment under Title XVII and/or XIX of the Social Security Act or from any third-party payer is correct. I authorize the release of all records required to act on this request. I request that payment of authorized payments be made on my behalf.

I agree to notify and update Amavi Home Health and Hospice Care Services, Inc. within 2 business days of change to my insurance information.

Initial:

____ I will notify and update Amavi within 2 business days of change to my insurance information.

____ I will pay my share of cost listed above Monthly as follows: _____

____ I cannot afford to pay my share of cost. Reason: _____

If you are eligible for Medicare/Medicaid, our agreements with these programs require that we accept as payment in full the amounts they require allowable.

Your responsibility for these programs is limited to:

- The share of cost required by some state programs, as mentioned above.
- Cost of share for your terminal illness if you seek care beyond what is considered medical necessary by the hospice interdisciplinary team and documented on your plan of care
- Amavi Hospice will not cover any amounts that are not specifically related to hospice care, including but not limited to: (1) aggressive medications and/or treatments, (2) medications not related to the terminal diagnosis, (3) medical care not coordinated with and authorized by Amavi Hospice, (4) room and board, except while under respite or general inpatient care, (5) any services received prior to being admitted to hospice or received after discontinuation of service, and (6) any other services not specifically ordered and authorized by Amavi Hospice.

_____ _____

Patient/Representative Name and Signature Date

_____ _____

Hospice Representative Name and Signature Date

PATIENT NAME	DOB	MR#

PATIENT NOTIFICATIN OF HOSPICE NON-COVERED ITEMS, SERVICES AND DRUGS.

Date of Request: _____

(Hospice must furnish this addendum within 5 days if requested at the time of hospice election and within 72 hours if requested during the course of hospice care)

PATIENT NAME	DOB	MR#

Diagnosis Related to Terminal Illness and Related Conditions (hospice is responsible to cover all items, services and drugs.

1.	4.
2.	5.
3.	6.

Diagnosis Unrelated to Terminal Illness and Related Conditions:

1.	4.
2.	5.
3.	6.

Non-covered items, services and drugs determined by hospice as not related to my terminal illness and related conditions:

Items/Services/Drugs	Reason for Non-coverage

Note: the hospice makes the decision as to whether or not condition, items, service, and drugs are related for each beneficiary. This addendum should be shared with other healthcare provides from which you seek items, services, or drugs unrelated to your terminal illness and related conditions to assist in making treatment decisions.

Right to Immediate advocacy

As a Medicare Beneficiary you have the right to appeal the decision of the hospice agency on items are not covering because the hospice has determined they are unrelated to the individuals' terminal illness and related conditions. You have the right to contact the Medicare beneficiary and Family Center Care Quality Improvement Organization (BFCC-QIO) for immediate assistance

Call your BFCC-QIO at LIVANTA (877) 588-1123 to appeal, or if you have questions

Acknowledgement of non-covered items, service and drugs not related to my terminal illness and related conditions. The purpose of this addendum is to notify the beneficiary (or representative) in writing of those conditions, items services and drugs the hospice will not be covering because the hospice has determined they are unrelated to the individual's terminal illness and related conditions. I acknowledge that I have been given a full explanation and have an understand of the list of items, services, and drugs not related to my terminal illness and related conditions not being covered by hospice. Signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessary agreement with the hospice determination

_____ _____

Patient/Representative Name and Signature Date Furnished

Beneficiary is unable to sign (REASON) _____

_____ _____

Hospice Representative Name and Signature Date Furnished

ADVANCE DIRECTIVES – Your Right to Make Decisions

I have been provided a Patient Caregiver Handbook with information/Amavi Policies regarding Advance Directives.

Initial:

____ I have been informed of my rights to formulate an Advance Directive.

____ I am not required to have an Advance Directive to receive medical treatment by any healthcare provider.

____ The terms of any Advance Directive that I have executed will be followed by any healthcare provider and my caregivers to the extent permitted by law.

____ The patient does NOT have an advance directive. Assistance may be obtained from Amavi staff for setting up and preparation of the document.

____ The patient has an advance directive

Name of agent: _____

Address: _____

Phone: _____

SIGNED:

_____ _____

Patient/Representative Name and Signature Date

_____ _____

Hospice Representative Name and Signature Date

PATIENT NAME	DOB	MR#

TREATMENT AUTHORIZATION, RELEASE OF PATIENT INFORMATION AND RECEIPT OF INFORMATION.

This agreement is entered by and between ***Amavi Home Health & Hospice Care Services, Inc.*** (hereinafter called Agency) and _____ (hereinafter called Patient). This agreement is entered pursuant to a desire by patient or representative to obtain hospice services.

I request admission to ***AMAVI HOSPICE***: I understand and agree to the following conditions.

TREATMENT AUTHORIZATION. The undersigned Patient or Patient's legally authorized representative hereby consents to all examinations and treatments prescribed the Patient's physician (or hospice physician) rendered by the Agency's licensed nurses, physical therapists, occupational therapists, speech therapists, registered dietitians, social workers, spiritual counselors, home health aides and volunteers.

RELEASE OF PATIENT INFORMATION. I understand that Amavi Hospice may need to obtain medical records and related information from hospitals, nursing homes, physicians, pharmacies, insurance companies, health care benefit plans, or others to assure continuity of care and proper reimbursement. I authorize the above entities to release to Amavi Hospice and its representatives' medical records and related information necessary to be helpful in the provision of hospice care. I also authorize Amavi Hospice and its representatives to release medical records and related information to others for the purposes of my health care, administration, and management of my health care (including utilization review), or processing and obtaining payment for services and supplies rendered to me.

RECEIPT OF INFORMATION. Hospice services have been explained to me; I have been given the opportunity to ask any questions I have concerning the hospice program of care, and my questions have been answered to my satisfaction.

Acknowledgment: By checking each box below, I acknowledge that I have been provided the corresponding information and agree to the terms and conditions in the documents listed: _____Initial

Admission Consents Packet – Includes the following information:	**Acknowledgment**
• Authorization for Use and Disclosure of Protected Health Information	
• Election of Hospice Benefit, Attending Physician and Financial Authorization	
• Financial Certification and Advance Directive Status	
• Treatment Authorization, Release of PHI, Release of Pt Info and Receipt of Info	
• Consent to Photograph	
• Hospice Primary Care Person Agreement	
• Oxygen Safety and Information Sheet	
• Emergency Phone Numbers, Guidance and Instruction	
Resource Guidebook – Includes the following information:	**Acknowledgment**
• Bill of Rights and Responsibilities	
• Medicare Benefits Summary	
• Financial Agreement	
• Oxygen Safety Information	
• Primary Care Person Agreement for Pt Without a Live-in Caregiver	
• Authorization for Use and Disclosure of Protected Health Information	
• Elder Abuse	
• Drug Free Workplace	
• Hospice Medication Policies / Drug Disposal Policy	
• Hospice Comfort Kit	
• Proposition 65 Statement / Notification in Accordance with Prop 65	
• Home Environment Safety Evaluation	
• Basic Home Safety	
• Emergency Preparedness	
• Patient Email and Text Message Informed Consent	
• Universal Pain Assessment Tool	
• Notice of Nondiscrimination and Accessibility	
• Grievances/How to File a Complaint	
• Ethical Issues	
• Military History Checklist	

_____ _____

Patient/Representative Name and Signature Date

_____ _____

Hospice Representative Name and Signature Date

CONSENT TO PHOTOGRAPH AND NOTICE OF NON-DISCRIMINATI0N AND ACCESSIBILITY

CONSENT TO PHOTOGRAPH: I hereby consent ***Amavi Home Health and Hospice Care Services, Inc.*** to take a photograph of me (or person for whom I am a represent legally). I understand that the information may be used in my medical record, for purposes of medical assessment, evaluation, treatment, and medical record. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact my RN Case Manager, or by immediately calling the office at (925) 684-7979. By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

- I consent for these photographs to be used for medical assessment, evaluation, treatment, and medical record.
- I understand that the image may be seen by members of the Interdisciplinary Team.
- Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.
- The photograph(s) will be used for internal purposes such as quality reviews, education, and treatment to supplement written documentation about my medical condition, and/or for the payer of my services (Medicare, Medical or other insurances) to assist with coverage /payment decisions.
- I understand that any photograph taken will be placed in my clinical record and may be forwarded to the payer(s) of my services and/or my physician as determined by the agency.

NOTICE OF NONDISCRMINATION AND ACCESSIBILITY: Amavi Hospice complies with applicable Federal civil right laws and does not discriminate based on race, color, national origin, age, disability, or sex. Amavi Hospice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Amavi Hospice:

- Provides free aids and services to people with disabilities to communicate effectively with us: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats and other formats)
- Provides free language services to people whose primary language is not English, such as: qualified interpreters, information written in other languages.

If you need these services, please contact Amavi office at 925-684-7979. If you believe that Amavi Hospice has failed to provide services or discriminated in another way based on race, color, national origin, age, disability, or sex: you may file a grievance with: **COMPLIANCE OFFICER**

131 Sand Creek Road Suite K
Brentwood, CA 94513

_____ _____
Patient/Representative Name and Signature Date

_____ _____
Hospice Representative Name and Signature Date

PATIENT NAME	DOB	MR#

Home Health and Hospice Care Services, Inc.

HOSPICE PRIMARY CARE PERSON AGREEMENT

I, _____ (Caregiver Name) hereby agree to accept the role of primary care person for _____ (Patient Name) during the period of time that hospice care was provided. I understand this involves the obligations and responsibilities listed below. I also understand that during this period, I will have the assistance and support of the interdisciplinary staff at Amavi Home Health and Hospice Care Services, Inc. I am committed to have the patient remain in his/her home during the terminal illness for as long as possible.

I understand that the goal of Amavi Home Health and Hospice Care Services, Inc. is to provide palliative (comfort) care and symptom management.

I understand that my obligation and responsibilities are as follows:

1. I will be the primary care person for _____.
   I understand that in this role I will be the person taking the responsibility of caring for the patient while he/she remains in the home setting, and if needed to arrange for others to participate in this care.
2. I understand that if the hospice staff, the patient, or I feel that it is no longer safe for the patient to remain in the home setting, that alternative arrangements for care will be made. This may include hiring of privately paid caregivers, admission to a facility, etc.

I understand that the goal of Amavi Home Health and Hospice Care Services, Inc., obligations, and responsibilities are as follows:

1. The hospice staff will provide the instructions I need to successfully care for the patient.
2. Emotional and spiritual support will be available from the hospice staff when I need it.
3. The hospice staff will provide skilled care and personal care on a regularly scheduled basis to meet the needs of the patient.
4. The hospice staff will be available to me and the patient 24 hours a day.

I understand that the patient/family/caregiver is cared for as a unit. The hospice medical record may contain information about me. Amavi Home Health and Hospice Care Services, Inc. commits to keeping this information confidential.

_____ _____

Printed Name and Signature of Primary Care Person Date

_____ _____

Printed Name and Signature of Agency Witness Date

PATIENT NAME	DOB	MR#

OXYGEN SAFETY ACKNOWLEDGMENT

DOCTOR'S INSTRUCTIONS/ORDERS

Your doctor has prescribed the use of oxygen to help your heart and lungs function better.

Oxygen is a drug that is **only effective and safe for use in a prescribed dosage**. Your doctor has carefully selected this dosage and you should follow the ordered dosage carefully. The safety guidelines below should be followed.

FIRE HAZARD

DO NOT SMOKE within 15 feet of oxygen tank use or a patient using oxygen.

- Oxygen supports combustion. This means that some things will burn hotter and faster when oxygen is present.
- If you smoke or light a fire in the vicinity of the oxygen set up could explode and cause fire, leading to severe injuries and even death.
- Oxygen will build up around the user and immediate area.
- **Flammable materials should NOT be present.**
- **Do NOT operate your oxygen tank or concentrator in a small or confined area.**
- **Do NOT** use petroleum-based products in and around your nose. (Vaseline, A&D ointment, etc.) Use of these products when using oxygen, can cause burns.
- Avoid open flames, matches, stoves, fireplaces, grills, space heaters.
- Caution should be used with electrical devices or toys that produce sparks.

HANDLING AND STORAGE

- The tank should always be kept in the stand or cart provided to avoid tipping.
- You should only move tanks as instructed by your home care representative or the DME company representative.
- Tanks should **NOT** be stored in confined or unventilated areas.
- Tanks should **NOT** be stored near flammable substances or heat/ignition sources.
- Tanks should **NOT** be stored in the trunk of a car.
- Always secure tanks in moving vehicles to avoid falling or tipping.

CONCENTRATOR SAFETY

- Some oxygen is delivered by an electrical concentrator enricher.
- Concentrator should only be plugged into a properly grounded outlet.
- Extension cords should **NOT** be used.
- Concentrator should be placed as close to the outlet as possible.
- Electrical devices that create heat or sparks should be avoided or used with extreme caution.
- Power sources should meet or exceed electrical/amperage requirement of the equipment.

I acknowledge that I have read and understand all components related to oxygen use and safety.
I understand that smoking with oxygen is a safety hazard to myself and others.
and I understand that continuing to smoke with oxygen is a reason for discharge from services.

_____ _____

Representative/DPOA Name and Signature Date

_____ _____

Hospice Representative Name and Signature Date

PATIENT NAME	DOB	MR#

Home Health and Hospice Care Services, Inc.

EMERGENCY PHONE NUMBERS AND INSTRUCTIONS

EMERGENCY PHONE NUMBERS		
DESCRIPTION	NAME	PHONE NUMBER
Hospital of Choice		
Medical Director	Dr. Anthony Allen	9256847979
Medical Director	Dr. Andrew Ng	9256847979
Pt Choice Attending Physician		
RN Case Manager		9256847979
Home Health Aide		9256847979
Medical Social Worker		9256847979
Spiritual Counselor		9256847979
Primary Contact/DPOA		
Secondary Contact		
LOCAL EMERGENCY PHONE NUMBERS		
AMBULANCE		911
FIRE		911
POLICE		911
GAS/ELECTRIC	PG & E	8007435000
WATER		
OTHER	AMERICAN RED CROSS	7074387060
DME	Superior Health Care Equipment	9259699699
Pharmacy	City Center Pharmacy	9252409777
Local Church		

EMERGENCY GUIDELINES / INSTRUCTIONS

GUIDELINES: The patient and family/caregiver will be assessed and instructed regarding the components of an emergency preparedness/natural disaster plan that includes: emergency phone access, including ambulance, police, fire, gas, electric, water; emergency supplies including food, water, heat, light, day-to-day necessities, and medical supplies; disaster follow-up including battery-powered access to local radio stations, procedures to follow if care is disrupted by a natural disaster; actions to take in preparation and during natural disasters, such as flood, storms, earthquakes, or pandemic; actions to take in case of fire; evaluation plans for the home.

INSTRUCTIONS: In the event that that you go to a shelter or are forced to evacuate your home, please bring a copy of this form and our home folder with you and call the Amavi Hotline: (925) 684-7979

Initial _____ Home Environment Safety Evaluation completed: date _____/_____/_____.

SIGNED:

_____ _____

Patient/Representative Name and Signature Date

_____ _____

Hospice Representative Name and Signature Date

Nursing Assistance is Available 24/7 by Calling (925) 684-7979

PATIENT NAME	DOB	MR#