MEADOWLARK HOSPICE
709 Liberty, Clay Center KS 67432
Phone: (785) 632-2225 Fax: (785) 632-3557

Informed Consent

Patient Name: _____ Patient #: _____

I REQUEST ADMISSION TO HOSPICE AND UNDERSTAND AND AGREE TO THE FOLLOWING CONDITIONS:

PROGRAM PURPOSE: The Hospice program is palliative (comfort oriented), not curative, in its goals. The program emphasizes the relief of symptoms such as pain and physical discomfort, and addresses the spiritual needs and emotional stress, which may accompany a life-threatening illness.

CAREGIVER: Hospice services are not intended to take the place of care by my family members, my physician, or others who are important to me, but rather to support them in my care. I ask that my family member/significant other, respect my choice of Hospice care and that they, insofar as they are able, fulfill the role of primary caregiver for me.

As the family member/significant other, I/we understand the role of primary caregiver and pledge to undertake that role with the training and support of the Hospice team.

HOME CARE: The Hospice program is primarily services delivered in my place of residence (home or residential facility) by the Hospice team consisting of nursing, social work, pastoral care, volunteer staff, and may consist of homemaker, home health aide and therapist if covered under insurance benefits. These services are available both on a scheduled basis and as needed 24 hours a day, seven days a week.

Continuous Home Care -- Continuous care is to be provided only during periods of crisis to maintain the individual at home. A period of crisis is a period of time when the patient requires continuous care to achieve palliation or management of acute medical symptoms, or there is a breakdown in the family caregiving system, which necessitates this level of care. Primarily, nursing care is to be used during continuous home care.

INPATIENT CARE: Short-term acute (hospital) care may be provided if covered under insurance and deemed necessary for symptom control by the Hospice team and my physician.

RESPITE: Short-term inpatient care may be provided if necessary for respite for the caregiver and covered by insurance.

FOLLOW-UP CARE: The caregiver, companions and others who are important to me may choose to participate in the bereavement program. Services include individual and group counseling seminars and workshops, help with practical matters and social activities.

CARE PLAN: I have the opportunity to join the Hospice team in making decisions about the variety, frequency, intensity of services and techniques the Hospice team will use to help me. I have access to my Hospice Care Plan and I am invited to attend Hospice Team Meetings to hear and participate in discussions about the services and techniques being used to assist me.

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FINANCIAL RESPONSIBILITY: The estimated cost and expected reimbursement of Hospice care has been explained to me. I have read the Election / Assignment of Benefits form and understand the benefits and scope of the services offered to us. I understand that I am responsible for payment of those services not covered by insurance (i.e. deductibles, co-payments and shift work) unless other arrangements have been made. I have been given the opportunity to discuss my financial needs with a representative of Hospice and I understand that I will be informed in writing of any financial obligations. I understand that I will not be denied admission to the program because of inability to pay.

WITHDRAWAL / DISCHARGE: I accept the conditions of Hospice as described. I may choose to remain in the program and/or have Hospice discharge me from the program if Hospice care is no longer appropriate. This means there will be not further liability to Hospice or me. I may request to be re-admitted at a later date.

ACKNOWLEDGEMENTS:

- I HAVE BEEN ABLE TO DISCUSS THE ABOVE CONDITIONS WITH A MEMBER OF THE MEADOWLARK HOSPICE STAFF AND HAVE HAD MY QUESTIONS ANSWERED TO MY SATISFACTION.

X _____ _____
Patient Signature Date signed

_____
Caregiver / Responsible Party (Person identified by patient as being family/significant other or legally responsible person for this patient)

- I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE MEADOWLARK HOSPICE NOTICE OF PRIVACY PRACTICES.

X _____ _____
Patient Signature Date signed

_____
Caregiver / Responsible Party (Person identified by patient as being family/significant other or legally responsible person for this patient)

_____
Reason if patient is unable to sign

_____ _____
Witness Date