Home Health & Hospice of Montana

Hospice Election Statement

Hospice Philosophy

I acknowledge that I have been given a full explanation and have an understanding of 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 caregivers.

Effects of 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 waiving (give up) all rights to Medicare payments for services related to my terminal illness and related conditions and I understand while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected. I understand that services not related to my terminal illness or related conditions will continue to be eligible for coverage by Medicare; however, I also understand that services unrelated to my terminal illness and related conditions are exceptional and unusual and hospice should cover all care related to my terminal illness and related conditions needed under the hospice election.

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 copayment and inpatient respite care). 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 through the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) if I disagree with any of the hospice's determination and I have been provided with the contact information for the BFCC-QIO that services my area.

☐ I elect to receive the "Patient Notification of Hospice Non-Covered Items, Services and Drugs."
Initials _____ Date _____
(**Hospice:** Please provide the beneficiary with the addendum. Must be signed and dated accompanying the election statement.)

☐ I decline to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs."
Initials _____ Date _____

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 that the date of the election statement. An individual may not designate an effective date that is retroactive.

_____ _____
Signature of Beneficiary/Representative (Date Signed)

☐Beneficiary is unable to sign-Reason: _____

_____ _____
Witness Signature (Date Signed)

NPI: 1790295046

Montana Medicaid
Notice of Election Statement

I, _____ choose to elect the Medicaid hospice benefit and Hospice services from
Beneficiary Name

_____. (Hospice Agency Name)

Beneficiary Medicaid ID #:_____ (required)

Hospice Philosophy
I acknowledge that I have been given a full explanation and have an understanding of 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 a cure. The focus of hospice is to provide comfort and support to both me and my family/caregivers.

Effects of a Medicaid Hospice Election
I understand that by electing hospice care under the Medicaid Hospice Benefit, I am waiving (giving up) all rights to Medicaid payments for services related to my terminal illness and related conditions. I understand that while this election is in force, Medicaid will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected. I understand that services not related to my terminal illness or related conditions will continue to be eligible for cover age by Medicaid.

Right to Choose an Attending Physician
I understand that I have a 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.

I acknowledge that my choice of an attending physician is:

Physician's Full Name_____ NPI (if known)_____

Office Address_____

I acknowledge and understand the above, and authorize Medicaid hospice coverage to be provided by:

_____ to begin on_____
(Hospice Agency) (Effective Date of Election)

Note: The effective date of the election, which may be the first day of hospice care or 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.

_____ _____
Signature of Beneficiary/Representative Date

____Beneficiary unable to sign Reason_____

_____ _____
Witness's Signature Date

Home Health & Hospice of Montana

INFORMED CONSENT AND NOTICE OF PATIENT RIGHTS
ELECTION OF BENEFIT (Page 1 of 2)

Patient Name_____ **MR#**_____ **DOB**_____

I/we, the patient and/or caregiver (hereinafter "I refers to I/we), request admission to Home Health & Hospice of Montana program of care and understand and agree to the following conditions:

Introduction: I have chosen (insert full name)_____ to be my attending physician. I have been informed of my physical condition and understand that hospice care is not designed to cure my disease. The program emphasizes the relief of symptoms such as pain and physical discomfort and addresses the spiritual and emotional needs which may accompany a life-threatening illness. Support for the family/significant others is an integral part of this care.

FOR OFFICE USE ONLY: Attending Physician NPI Number_____

Caregiver Role, Responsibility and Arrangements: I understand that hospice services are not intended to take the place of care by family members/significant others, but rather to guide and support them in the care of the patient. I understand the role and responsibility of a primary caregiver to provide quality care and to ensure patient safety. I, the patient, understand that when my quality of care and/or personal safety is jeopardized by the lack of a primary caregiver, I will make arrangements to ensure my safety and quality of care or allow such arrangements to be made for me.

Services: I understand that home care is a main goal of the hospice program. Emergency telephone and visit support is available 24 hours/day, 7 days/week. Services that may be provided during the course of the illness may include: physician, skilled nurse, social worker, home health aide, homemaker, chaplain, volunteers, medications, supplies, oxygen, medical equipment, acute inpatient care, respite care, continuous care, dietary, physical therapy, occupational therapy, speech therapy and bereavement.

Choice of Care: I understand that I have a choice of hospice providers. I further understand that I can be involved in the planning of my care; including the right to review the plan of care that guides hospice services, may set goals, make suggestions, and may refuse a particular treatment or service offered.

Advance Directives: I understand that the hospice philosophy DOES NOT endorse the use of life sustaining interventions as a result of the natural progression of the disease process. I understand that the absence of a Do Not Resuscitate order does not disqualify me from hospice services and that a social worker is available to discuss advance directives, such as a living will, Allow Natural Death, or durable power of attorney with me. I have received verbal and written information about my legal rights to have an advance directive.

_____I have discussed the issue of life support with my physician and I DO NOT want the use of life sustaining interventions such as CPR, resuscitation or mechanical ventilation.

Inpatient Care: I understand that, if it is determined necessary by the hospice and attending physician, the patient can receive short-term inpatient care when pain and symptom management becomes impossible in the patient's home. I understand that admissions ***must*** be preauthorized and arranged by the hospice, and I will assume financial responsibility for admissions not preauthorized by the hospice or inconsistent with the plan of care.

Financial Responsibility: Financial responsibility for the services provided is determined by my health/hospice benefit plan. The benefits, provisions, scope of service to be offered, and the expected reimbursement for hospice care have been explained to me. I have received this information in verbal and written form. I have been given a chance to discuss our financial situation with a representative of the hospice. I have been admitted to the hospice under the following financial classification:

INFORMED CONSENT AND NOTICE OF PATIENT RIGHTS
ELECTION OF BENEFIT (Page 2 of 2)

Patient Name_____**MR#**_____ **DOB**_____

_____Medicare/Medicaid Election of Services (*circle appropriate elections*). I elect my hospice benefit and understand that as long as I choose to receive care from the hospice, I will be eligible for Medicare/Medicaid benefits related to my life-limiting condition, as they are arranged by the hospice. I understand that hospice Medicare/Medicaid benefits are for palliative care and treatment only (rather than curative), and I waive my rights to other Medicare/Medicaid benefits for my life-limiting condition. I have been informed that I will continue to be eligible for regular Medicare/Medicaid benefits for treatment of conditions not directly related to my life-limiting illness.

_____Commercial Insurance: I authorize payment of insurance benefits directly to the hospice.

_____Special Concerns: I understand that I will not be denied admission to the program based solely on inability to pay.

Notice of Privacy Practices, Bill of Rights and Policy and Procedure for Filing a Complaint: I have received a verbal explanation of my rights, and a written copy of the hospice's *Notice of Privacy Practices* and *Hospice Bill of Rights*, and have had the opportunity to discuss them to my satisfaction. I understand my rights to have effective pain and symptom management, to choose my own attending physician, have a confidential medical record and be free from mistreatment, neglect, abuse (physical, verbal, mental or sexual), exploitation and misappropriation of my property.

Records: I give consent and approval for the release of necessary information and medical records to or from any medical facility, hospital, home health agency, health organization, coroner, medical examiner, or private physician. I also give consent for release of information to the following agencies for the purpose of coordinating benefits for which I may be eligible. These agencies include, but are not limited to, Division of Family Services, Division of Aging, Social Security, Department of Veterans Affairs, and State Veteran's Commission. I further consent to allow medical review and/or survey by state, federal or Joint Commission personnel to conduct a home visit to assess the quality of care provided, as requested.

Withdrawal/Discharge/Transfer: I understand that I may choose to discontinue hospice care at any time by signing a revocation statement, and that I may re-elect hospice care at a future time, as long as I remain eligible for hospice services. I understand that I may choose to receive hospice care from another hospice provider at any time during the benefit periods by informing the hospice and arranging a transfer.

I have been able to discuss the conditions of the informed consent, patient rights and election of hospice benefit with a member of the hospice staff and have had all questions answered satisfactorily. I accept the conditions of hospice as described above. I understand that services are provided without regard to age, race, color, gender, national origin, disability, religion or financial resources.

Reason Patient is unable to sign (or other special provisions)_____

Patient's Signature _____ Date_____

Patient's Representative's Signature_____ Date _____

Relationship to Patient _____ Start Date of Care_____

Hospice Representative's Signature _____ Date_____

____Medicare _____Medicaid Election Begins_____ Time_____

Home Health & Hospice of Montana

INFORMED CONSENT AND NOTICE OF PATIENT RIGHTS
ELECTION OF BENEFIT (Page 2 of 2)

Patient Name_____**MR#**_____ **DOB**_____

_____Medicare/Medicaid Election of Services (*circle appropriate elections*). I elect my hospice benefit and understand that as long as I choose to receive care from the hospice, I will be eligible for Medicare/Medicaid benefits related to my life-limiting condition, as they are arranged by the hospice. I understand that hospice Medicare/Medicaid benefits are for palliative care and treatment only (rather than curative), and I waive my rights to other Medicare/Medicaid benefits for my life-limiting condition. I have been informed that I will continue to be eligible for regular Medicare/Medicaid benefits for treatment of conditions not directly related to my life-limiting illness.

_____Commercial Insurance: I authorize payment of insurance benefits directly to the hospice.

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Notice of Privacy Practices, Bill of Rights and Policy and Procedure for Filing a Complaint: I have received a verbal explanation of my rights, and a written copy of the hospice's *Notice of Privacy Practices* and *Hospice Bill of Rights*, and have had the opportunity to discuss them to my satisfaction. I understand my rights to have effective pain and symptom management, to choose my own attending physician, have a confidential medical record and be free from mistreatment, neglect, abuse (physical, verbal, mental or sexual), exploitation and misappropriation of my property.

Records: I give consent and approval for the release of necessary information and medical records to or from any medical facility, hospital, home health agency, health organization, coroner, medical examiner, or private physician. I also give consent for release of information to the following agencies for the purpose of coordinating benefits for which I may be eligible. These agencies include, but are not limited to, Division of Family Services, Division of Aging, Social Security, Department of Veterans Affairs, and State Veteran's Commission. I further consent to allow medical review and/or survey by state, federal or Joint Commission personnel to conduct a home visit to assess the quality of care provided, as requested.

Withdrawal/Discharge/Transfer: I understand that I may choose to discontinue hospice care at any time by signing a revocation statement, and that I may re-elect hospice care at a future time, as long as I remain eligible for hospice services. I understand that I may choose to receive hospice care from another hospice provider at any time during the benefit periods by informing the hospice and arranging a transfer.

I have been able to discuss the conditions of the informed consent, patient rights and election of hospice benefit with a member of the hospice staff and have had all questions answered satisfactorily. I accept the conditions of hospice as described above. I understand that services are provided without regard to age, race, color, gender, national origin, disability, religion or financial resources.

Reason Patient is unable to sign (or other special provisions)_____

Patient's Signature _____ Date_____

Patient's Representative's Signature_____ Date _____

Relationship to Patient _____ Start Date of Care_____

Hospice Representative's Signature _____ Date_____

____Medicare ____Medicaid Election Begins_____ Time_____

Distribution: White – Patient Chart Yellow – Patient

Home Health & Hospice of Montana

EXPLANATION OF PAYMENT FOR MEDICAL SERVICES

Patient Name (print)_____ **MR#**_____

MEDICARE/MEDICAID BENEFITS

Hospice is reimbursed on a per diem basis, and is responsible for the following services, based on need as determined and directed by the hospice interdisciplinary team.

1. **Visits by the hospice interdisciplinary team** – medical director or identified hospice physician, skilled nurse, medical social worker, chaplain, home health aide, homemaker, dietary counselor, and other support staff, including volunteers.
2. **Medications** – *Approved* by the interdisciplinary team, as necessary for the treatment of pain or symptoms associated with life-limiting diagnosis, and filled through the hospice-contracted pharmacy.
3. **Medical equipment** – *Approved* by the interdisciplinary team, as necessary to maintain the patient's independence and comfort, and provided through a hospice-contracted company.
4. **Medical supplies** – *Approved* by the interdisciplinary team, as necessary for the care of conditions directly related to the life-limiting diagnosis.
5. **Ambulance transportation** – *Approved* by the interdisciplinary team, as needed for transportation to an inpatient facility or emergency room for the control of pain or symptoms of the life-limiting diagnosis.
6. **Inpatient acute care** – *Approved and arranged* by the hospice and the attending physician, in a hospice-contracted facility, for the treatment of pain or symptoms that fail to yield to home care management. Inpatient stays are intended to b brief, with the goal of the patient returning to routine home care when pain or symptoms are controlled.
7. **Inpatient respite care** – *Approved and arranged* by the hospice, in a hospice-contracted facility, for the purpose of providing caregiver relief. Respite is provided for no more than five (5) continuous days and cannot be provided in the home.
8. **Continuous care** – *Approved and arranged* by the interdisciplinary team when the patient is in a medical crisis that requires additional skilled care to maintain control of signs and symptoms in the home environment. Medicare only approves continuous care if the medical crisis would otherwise require hospitalization. Continuous care is intended to be brief and must end when the medical crisis is controlled.
9. **Ancillary Therapies** – *Approved and arranged* by the interdisciplinary team, and provided for the relief of pain or other symptoms associated with the life-limiting illness. Such therapies may include physical therapy, speech therapy, respiratory therapy, and/or occupational therapy.
10. **Outpatient procedures and consulting physicians** – *Approved* by the hospice interdisciplinary team and provided by hospice-contracted physicians or facilities.
11. Bereavement care – Provided to the family for one year (by hospice but not reimbursed by Medicare).

HOSPICE DOES NOT PAY FOR:

1. CPR or other resuscitative measures.
2. Unapproved hospitalizations and/or emergency room visits. A hospice nurse is available 24 hours a day, 365 days a year by telephone for prior coordination of admissions to hospitals. If a patient chooses to ender a non-contracted facility, or any facility without preauthorization of the hospice, he/she may choose to
   a. Assume financial responsibility for the admission (if it is related to the terminal diagnosis); or
   b. Revoke the hospice Medicare/Medicaid benefit and allow regular Medicare/Medicaid to pay for the admission.
3. Acute admission to the coronary care unit or any intensive care unit.
4. Medications not directly related to the terminal diagnosis and/or not filled in the hospice-contracted pharmacy.
5. Unauthorized supplies, equipment, testing or treatment (such as labs, MRIs, CT scans, x-rays, apheresis products, chemotherapy, radiation therapy, strontium, bi-pap, and/or tube feeding).
6. Unauthorized ambulance or medical transportation.
7. Consulting physician visits made without prior approval, or visits with physicians who are not contracted with the hospice, or visits unrelated to terminal diagnosis.
8. Consultation or care obtained outside the service area.
9. Curative or artificially-life-prolonging treatment; dobutamine treatment, experimental studies, gamma knife procedures, therapeutic apheresis procedures; TPN, Iressa treatment, or dialysis.
10. Treatment of any and all medical problems that are not related to the terminal illness.

The patient/family will be financially responsible for services not preapproved or supplied by the hospice.

Patient/Caregiver (signature)_____ Date_____

Witness (signature)_____ Date_____

Distribution: White – Patient Yellow – Chart

Home Health & Hospice of Montana

EXPLANATION OF PAYMENT FOR MEDICAL SERVICES (Page 2)

Patient Name_____ MR#_____

HOSPITALS/NURSING FACILITIES contracted with Senior Solutions Hospice

Saint Patrick's Hospital Skilled Nursing Facility_____

PHARMACIES

Granite Pharmacy

A patient may choose to use a pharmacy not listed with the understanding that emergent medications may not be available 24 hours a day.

Alternate pharmacy chosen_____

If a patient chooses to enter a hospital other than a contracted facility, or without preauthorization of the hospice, he/she may choose to:

1. Assume financial responsibility for the admission (if it is related to the terminal diagnosis).
2. Revoke the Hospice Medicare/Medicaid be_nefit and allow regular Medicare/Medicaid to pay for the admission.

The patient's Family will be financially responsible for services not preapproved or supplied by the hospice.

Patient/Caregiver (signature)_____ Date_____

Witness (signature)_____ Date_____

Distribution: While - Patient Yellow - Chart

Home Health & Hospice of Montana

Medicare Secondary Payor/Insurance Questionnaire

Patient Name_____ MR#_____

1. Are you covered under an employee's group health plan? ___Yes ___No
2. Are you covered under any other large group health plan? ___Yes ___No
3. Is your disease/illness related to an auto accident? ___Yes ___No
4. Is your illness due to an injury? ___Yes ___No
5. If auto accident or injury, describe briefly

_____

_____

_____

6. Has patient filed or is there an intention to file a liability suit? __Yes __No
7. If a liability suit is to be filed, please provide the name and address of the attorney

_____

8. Do you have a Medicare supplemental policy? __Yes __No
9. Please check if the illness is covered under

___ the black lung program ___end-stage renal disease

10. Are you covered under the Veteran's Administration benefits? ___ Yes ___No
11. If you answered yes to questions 1 or 2, please complete the following:

Insured's Name_____ Insured's SS#_____

Name, address, and phone number of employer_____

_____

Insurance Company_____

Address _____ Phone No._____

Policy No._____ Group No._____

Group Name _____

Patient/Caregiver Signature_____ Date_____

Hospice Staff Witness_____ Date _____

Distribution: White – Patient Yellow – Chart

Home Health & Hospice of Montana

CONSENT TO SHARE HEALTH INFORMATION WITH DESIGNATED INDIVIDUALS

Patient Name_____ Date of Birth_____

I give consent to Home Health & Hospice of Montana to share information about my medical condition with the following people:

_____ All family members

_____ All family members except _____

_____

_____

_____

_____ Friends listed here _____

_____

_____

_____ Others listed here _____

_____

_____

_____ I absolutely do NOT want information given to the following people

_____

_____

_____

Other instructions:

Patient's Signature_____ Date _____

Caregiver/Authorized Representative's Signature (if patient is unable to sign)

_____ Date _____

Reason that Patient is Unable to Sign:

Witness's Signature_____ Date _____

Home Health & Hospice of Montana

Advanced Directives Policies Statement

Patient's Name_____ MR#_____

Home Health & Hospice of Montana respects your rights to make your own medical treatment decisions. In order to help you exercise this right, we advise you that:

- Montana recognizes the legal right of any adult to sign a written directive (Living Will) instructing his/her physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition. In addition, Montana has passed a law authorizing an adult to designate an individual to make health care decisions when the patient is no longer able to make those decisions.
- The Durable Power of Attorney for Health Care Decisions form, which must be in the format provided by the statute, enables you to appoint someone to make any and all health care decisions for you in the event that your are unable to do so. Instructions and information are available from our Social Services Department upon request.
- Whether or not you choose to execute an Advance Medical Directive is a personal matter and will never be a condition for providing care or a basis for discrimination for or against you.
- Home Health & Hospice of Montana provides or participates in providing education for our staff and community on issues relating to advance medical directives.
- Medical treatment decisions sometimes raise difficult issues for patients, family members, and the health care team. We are committed to discussing and resolving these questions as they arise.
- Please let us know how we can help you legally document your wishes regarding your end-of-life care.

_____ _____

Patient or Patient's Representative Signature Date

_____ _____

Hospice Staff's Signature Date

White – Patient Chart Yellow – Patient

2445 South 3rd Street West Suite B Missoula, Montana 59801 406.541.1800

This form is ONLY necessary if hospice start of care or Medicare/Medicaid benefit start date is later than date informed consent signed, or patient not admitted to hospice services.

NOTIFICATION OF START DATE

Patient Name _____ MR#_____

On_____, the patient or his/her legal representative signed a hospice informed consent, requesting services from Home Health and Hospice of Montana that requested that hospice start of care and/or Medicare/Medicaid hospice benefit become effective as follows:

Hospice start of care to become effective upon:

_____ Determination of medical eligibility
_____ Other _____

Medicare/Medicaid hospice benefit to become effective upon:

_____ Determination of medical eligibility
_____ Other _____

The Attending Physician on election:

_____ _____ None

In keeping with that agreement, Home Health & Hospice of Montana is notifying the patient or his/her legal representative of the start of care and/or start of Medicare/Medicaid Hospice election, as provided by this hospice. The information above may have been missing, incomplete or inaccurate in the previously signed agreement due to pending eligibility criteria, change in insurance, postponed discharge from facility, etc. This document and the information in bold below serves as confirmation of and attestation to the information contained in the patient Informed Consent and Notice of Patient Rights Election of Benefit. Please sign and return this document for confirmation purposes.

Hospice care is intended to provide comfort and palliation (relief) of symptoms related to the terminal illness, rather than curative care. The patient remains eligible for regular Medicare/Medicaid benefit only for treatment of conditions not related to the terminal illness, as long as his/her Medicare/Medicaid eligibility is in effect.

Date Hospice Start of Care Effective_____

Date Medicare/Medicaid Hospice Election Effective Date_____

Attending Physician of Patient's Choice _____

FOR OFFICE USE ONLY: Attending Physician NPI number

Patient Not Admitted to Hospice Services due to:

____Patient not medically eligible ____ Care requested/needed outside scope of services provided by hospice

____Patient/legal representative requested non-admission ____ Other (specify) _____

Patient Signature_____ Date_____

Patient Representative Signature _____ Date _____

Relationship to Patient_____

Hospice Representative Signature _____ Date_____

Distribution: White – Patient Yellow – Chart

Patient & Caregiver Resources for Disposal of Prescription Medications

So, what can you do with the drugs you have sitting in your medicine cabinet? The first step is to keep prescription drugs locked, if possible, and out of reach of children. Maintain a medications log to track the number of pills you have and regularly check that none are missing. Be mindful of guests and strangers who enter your home and keep medications and bottles out of sight.

Properly dispose of unwanted or unused prescriptions one of three ways:

Drop your unwanted drugs at a permanent prescription drop location (listed below), participate in a drug take-back in your community, or ask your hospice nurse for assistance in disposing of prescription medication in your home.

PERMANENT PRESCRIPTION DRUG DROP LOCATIONS FOR MISSOULA

Missoula Police Department	435 Ryman Rd.	406-652-6300
St. Patrick's Hospital	500 West Broadway	406-543-7271

If a drug take-back event is not accessible in your community, follow these Office Of National Drug Control Policy recommendations:

- Take your prescription drugs out of their original containers.
- Mix drugs with undesirable substance, such as cat litter or used coffee grounds.
- Put the mixture in a disposable container with a lid, such as an empty margarine tub, or in a sealable bag.
- Conceal or remove any personal information, including the prescription number on the empty containers by covering it with black permanent marker or duct tape, or by scratching it off.
- Place the sealed container with the mixture and the empty drug containers in the trash.

Additional Resources

Additional prescription drug drop locations can be found at
dojmt.gov/consumer/prescriptiondrugabuse/rx-dropbox-locations
How to Dispose of Unused Medicines
http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm

HPNA Recommendations for Safe Drug Disposal in the Home Setting
http://www.hpna.org/DisplayPage.aspx?Title=Drug%20Disposal%20Guidelines

NHPCO Drug Disposal Laws and Regulations by State
https://www.nhpco.org/?s=Drug+Disposal

_____ I have received "Home Health & Hospice of Montana Medication Disposal Practices" and other resources available for medication destruction/disposal. I have reviewed both articles and been given opportunity to ask questions regarding disposal of medications. I am aware that if in the future questions arise in regard to disposal of medications, I can contact Senior Solutions for assistance or utilize any of the resources provided.

Patient/Caregiver Signature: _____ Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____

Hospice Drug Destruction/Disposal Record

Patient Name: _____ **MR#:** _____

Reason for medication destruction/disposal: (check one)

☐ Medication has been discontinued (DC'd) by the hospice physician (controlled substances only)

☐ Patient deceased, hospice staff assist caregiver/ultimate user in destruction/disposal

☐ Per the patient/family/caregiver/ultimate user request

Medication (Drug name, Dosage, Dosage form)	Qty (volume/ea)

Check One

☐ Nurse assisted patient/caregiver/ultimate user dispose/destroy medication(s) in home.

☐ Patient/caregiver/ultimate user refused assistance in medication destruction/disposal and the following was provided:

- Montana Department of Justice protocol for disposing drugs in the state of Montana.
- In-home medication destruction/disposal supplies (DisposeRX packets).

☐ Medication(s) destroyed/disposed in home with nurse and witnessed by coroner or law enforcement officer.

☐ Medication(s) removed by coroner or law enforcement officer for offsite destruction/disposal.

Nurse Signature: _____ **Printed Name:** _____

Date & Time : _____

Witness Signature: _____ **Printed Name:** _____

Date & Time: _____

FACILITY NOTIFICATION OF ADMISSION

Resident Name _____

Date of Hospice Admission_____

Facility Staff Member Receiving Notification _____

Your resident was admitted to our service for the following hospice diagnosis _____

_____

To comply with State and Federal Regulations, we are required to schedule a Care Plan meeting as soon as possible with appropriate facility staff members. The assigned case manager will contact you within seven days or you may call us at 406-299-3777.

Please make the appropriate changes to the resident's billing:

_____ Bill family for room and board (private pay/Medicare/insurance)

_____ Bill Home Health and Hospice of Montana for room and board at 100% of the Medicaid rate.
Note: Home Health and Hospice of Montana will be responsible for case managing DME. supplies, pharmaceuticals and other items RELATED to the hospice diagnosis.

_____ If no Medicaid number at this time but application is in progress, please notify Home Health and Hospice of Montana at the time of Medicaid authorization receipt.

_____ Continue billing Medicare Part A (skilled bed, unrelated).

_____ General Inpatient Care (GIP) based on contracted rate.
Note: Facility will be responsible for DME, supplies and pharmaceuticals related to the GIP stay which is included in the contract rate.

_____ Respite Care based on contracted rate.

We look forward to working with you and your team to provide the highest quality end-of-life care for your resident.

Hospice Representative's Signature _____ Date _____

Distribution: White – Patient Yellow – Chart