Doctor's Hospice of Idaho

Hospice and Part D

Medicare requires that Doctor's Hospice of Idaho provide you with all medications and other treatments necessary for the palliation and management of symptoms related to your principal hospice diagnosis and related conditions. Medicare also requires that Doctor's Hospice of Idaho Hospice arrange for and provide you these necessary medications.

As part of this process **Doctor's Hospice of Idaho will review all your medications to determine if they should be covered by:**

- Doctor's Hospice of Idaho under your Medicare hospice benefit
- by a Medicare Part D plan
- or by you, the beneficiary.

As explained during the admission process, Doctor's Hospice of Idaho is responsible for providing and paying for all medications that are **related** to your principal hospice diagnosis and any related conditions. The drugs must also be **reasonable and necessary** for treating this diagnosis and any related conditions.

Any medications that are **unrelated** to this diagnosis and related conditions are paid for under:

- Medicare Part D if you are a Medicare Part D enrollee
- or through other insurance coverage you have
- or out-of-pocket by you

If there are medications that are related to the principal hospice diagnosis or any related conditions buy are **not reasonable and necessary** for treating this diagnosis or any related conditions, CMS requires that you, the beneficiary, pay for the medication. You may use non-Medicare insurance to cover the drug if you have this type of coverage.

The hospice physician, with input from your attending physician (if any), and the hospice team determines if a medication is related to the principal diagnosis and related conditions as well as if the medication is reasonable and necessary in your hospice plan of care.

If the hospice physician determines that the medication is related and reasonable and necessary, Doctor's Hospice of Idaho will provide and pay for this medication in reasonable fill amounts.

Should you choose to continue or being taking a medication that is determined to be related to the principal diagnosis and related conditions buy not reasonable and necessary in your hospice plan of care, Medicare

prohibits Doctor's Hospice of Idaho and your Medicare Part D plan from paying for this medication. In these cases, Medicare requires you, the beneficiary, to pay for the medication.

This is also the care if there is medication you would like to take that is not part of the Doctor's Hospice of Idaho formulary. For an off-formulary medication to be covered by Doctor's Hospice of Idaho under your Medicare hospice benefit, there must be a clinical reason why you cannot take the equivalent medication that is on the Doctor's Hospice of Idaho formulary. If there is no such clinical reason, you will need to pay for the medication out-of-pocket.

It is important for you, the beneficiary, to know who is responsible for paying for your medication. Doctor's Hospice of Idaho will inform you of which medications will be covered by the hospice.

For those medications not covered by the hospice, Medicare has implemented a Prior Authorization (PA) process to determine payment responsibility. Therefore, if the pharmacy notifies you that it has not/is not planning to get the information necessary to determine payment responsibility from the person who prescribed the medication (the prescriber) or Doctor's Hospice of Idaho, we **encourage you to initiate this PA process**. You will not be able to receive the medication, unless you pay for it out-of-pocket, until this PA process is completed.

You can initiate this process by telling your pharmacy that you are requesting a PA for the medication. We ask **that you also contact Doctor's Hospice of Idaho to notify us you have initiated the PA.**

We can help speed up the decision by providing the Part D plan with information. We also suggest that you tell the pharmacy that you are requesting an expedited review. With an expedited review, a payment decision is usually made within 24 hours.

If you feel that Medicare Part D should be paying for medication that it is not covering, you have the right to appeal this decision to Medicare. Information on how to make an appeal can be provided by your pharmacy and/or Part D plan.

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Idaho Physician Orders for Scope of Treatment (POST)

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

- This form must be signed by an authorized practitioner in **Section E** to be valid
- **If any section is NOT COMPLETE provide the most comprehensive treatment in that section**
- **EMS:** If questions arise contact on-line **Medical Control**

Last name_____

First name_____

Date of birth____/____/_____

Last four digits of SS # __ __ __ __

☐ Male ☐ Female

Section A — Select 1 OR 2

Cardiopulmonary Resuscitation: Patient is not breathing and/or does not have a pulse

☐ **1. Do Not Resuscitate:** Allow Natural Death (No Code/DNR/DNAR): No CPR or advanced cardiac life support interventions

☐ **2. Resuscitate (Full Code):** Provide CPR (artificial respirations and cardiac compressions, defibrillation, and emergency medications as indicated by the medical condition)

Additional resuscitation instructions: _____

Section B — Select only ONE box

Medical interventions: Patient has a pulse and is breathing

☐ **Comfort measures only:** Use medications by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suctioning and manual treatment of airway obstruction. Reasonable measures are to be made to offer food and fluids by mouth. **Transfer to higher level of care only if comfort needs cannot be met in current location.**

☐ **Limited additional interventions:** In addition to the care described above, you may include cardiac monitoring and oral/IV medications. Transfer to higher level of care (e.g. from home to hospital) and provide treatment as indicated in Section A. Do not admit to Intensive Care.

☐ **Aggressive interventions:** In addition to the care described above and in Section A, you may include other interventions (e.g. dialysis, ventricular support)

Section C

Artificial Fluids and Nutrition:

☐ Yes ☐ No Feeding tube

☐ Yes ☐ No IV fluids

Other instructions:_____

Antibiotics and blood products:

☐ Yes ☐ No Antibiotics

☐ Yes ☐ No Blood products

Other instructions: _____

Section D

Advance Directives: The following documents also exist:

☐ Living Will ☐ DPAHC ☐ Other _____

Section E

☐ **I request that this document be submitted to the Idaho Health Care Directive Registry**

Patient/Surrogate Signature: X _____

Print Patient/Surrogate name | Relationship (Self, Spouse, etc.) | Date

Physician/APRN/PA Signature: X _____ Phone #____-____-____

Print Physician/APRN/PA name | ID license number | Date

Discussed with: ☐ Patient ☐ Spouse ☐ DPAHC ☐ Other _____

The basis for these orders is: ☐ Patient's request ☐ Patient's known preference

*****ORIGINAL OR COPY TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED*****

*****PROVIDER SUBMISSION OF COPY TO REGISTRY RECOMMENDED*****

*****COPY OF ORIGINAL LEGALLY VALID*****

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Orig 7/2007; Rev 7/2012

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Doctor's Hospice of Idaho

Welcome to Doctor's Hospice of Idaho

The Doctor's Hospice of Idaho team welcomes you. It is our hope that the care and services we offer will be helpful to you and your family. Please feel free to call us at any time with questions and concerns. It is our desire to provide you with high quality, compassionate, and knowledgeable care. All hospice team members can be reached through our main telephone number at (208) 985-2260.

We understand and support your desire to aid your loved one and provide care in familiar surroundings. Realizing that the dying process can create anxiety and concern for caregivers, Doctor's Hospice of Idaho has compiled the information in this folder to help you prepare for, anticipate, and understand what your loved one may experience in the final stages of life. We hope that providing you with this information will calm your fears and anxiety. We suggest you read through this information soon and refer to it often.

In addition, this folder contains a handbook with information about your rights as a caregiver, our Privacy Practices, and lots of information regarding questions you may have about hospice care. If at any time you need more information, feel free to call our office.

Respectfully,

Cody Freston

Cody Freston
Chief Operating Officer


Doctor's Hospice of Idaho

At Doctor's Hospice of Idaho our number one priority is to provide the highest quality of care, education and support that our patients, caregivers and family members need. It is a commitment that we take very seriously.

We work with an independent agency that rates our care by gathering information via telephone survey. Several questions are asked about the services provided while on hospice. Our hope is that we rate as having provided the best care and would ask that you complete the survey when contacted. The survey is completely confidential.

As the Director of Quality Assurance I am here to address any questions or concerns that you may have. Please feel to reach me at 208-985-2260.

Sincerely,

Marlys Bailey
Director of Quality Assurance
Doctor's Hospice of Idaho
208-985-2260

Doctor's Hospice of Idaho

REQUEST FOR MEDICAL RECORDS RELEASE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

Hospital _____

Physician _____

SNF, ECF _____

Other _____

Dates from: _____ to _____ .

PHI to be release and/or faxed to as soon as possible:

Doctors Hospice of Idaho
1552 Crestmont Drive Suite B
Meridian, Idaho 83642
Bus (208) 985-2260
Fax (208) 985-2261

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 authorization is good for 60 days after the date signed.

Patient Name:

Signature: _____ Date: _____
Patient/Personal Representative

Date of Birth: _____ Social Security Number: _____

Documents Requested: Discharge Summary
History and Physical
_____
_____
_____
_____

Doctor's Hospice of Idaho

Admission Service Agreement

Patient Name — Last, First, Middle Initial _____

CONSENT FOR CARE/SERVICE: I consent to and authorize the Agency, its agents and associates to provide care and treatment to me in my home or place of residence as prescribed by my attending physician or hospice Medical Director and per program policy for the duration of this agreement. I understand that I have the right to choose my attending physician and I appoint _____ as such. I have received an explanation of the services to be provided (including disciplines, proposed frequency of visits and goals for my care), my involvement with the plan of care, and how changes will be made as needed. I understand that I am required to have an appointed "primary caregiver" to assist with my personal care needs not covered by the hospice benefit. I understand that the Agency reserves the right to refuse to admit a patient or to continue providing care for a patient on service if I do not have or continue to have a primary caregiver. My primary caregiver Is:_____ mailing address _____

RELEASE OF INFORMATION: I consent to and authorize the Agency to release and receive information for the purposes of treatment, payment and health care operations. The exchange of information may occur between, but is not limited to physicians, third party payors, other health care providers and regulatory and/or accrediting reviewers.

CONSENT TO PHOTOGRAPH: I authorize the Agency to photograph me while I am receiving hospice services when the Agency deems it appropriate for treatment purposes, including but not limited to: documentation of care given, of progress or lack thereof and reports to care providers or payors.

ACKNOWLEDGEMENTS:

- Advance Directives: I understand that the Agency's policy is to respect individual choice and not to discriminate based on whether or not I have an Advance Directive or a Do Not Resuscitate (DNR) order.
- Patient Rights and Responsibilities: I've received information on my rights and responsibilities and how to use the organization's complaint process and the state's toll free hotline.
- Patient Handbook: I have received a copy of the Agency's Patient Handbook which includes information on Home Safety, Emergency Disaster Planning, Infection Control and Proper Disposal of Controlled Substances.
- Notice of Privacy: I have received a copy of the Notice of Privacy Practices/HIPAA
- Authorized Hospice Services: I understand that in order for services, medications, equipment, medical supplies, emergency treatment or admission to a facility to be covered under my payor's Hospice Benefit, the Agency must approve/authorize these in advance.
- Hiring Restriction. I understand that the Agency has incurred expenses in hiring and maintaining its staff. I agree not to hire the Agency's employees.

INSURANCE INFORMATION: (circle all that apply)

Medicare # _____ **Medicaid #**_____

Insurance # _____ **Name of Insurance** _____

Annual Deductible $ _____ **met/not met OOP $**_____ **Co-Pay$** _____ **Coverage %**_____

Self Pay (indicate responsible party if not the patient): _____

ASSIGNMENT OF BENEFITS: I request that payment of authorized benefits be made on my behalf directly to the Agency

Discipline	Rate	Discipline	Rate
RN/LPN	$165/visit	Speech Therapist	$240/visit
Aide	$ 95/visit	Massage/Music Therapist	$240/visit
MSW	$230/visit	Spiritual Care	
Physical Therapist	$210/visit	Per Diem/Routine Day	$165/day
Occupational Therapist	$215/visit	Other	

FINANCIAL RESPONSIBILITY: I certify that all the information given by me to the Agency is correct for requesting and applying for payment. I understand and agree to pay deductibles, co-payments, spend downs and any amount due after payment of benefits on my behalf. The Agency may bill my insurance company as a courtesy, but by doing so shall not be construed as a waiver of Agency right to seek payment from me and/or another responsible party. I further understand that if there is a change to my insurance coverage or third party it is my responsibility to notify the Agency of this change. I acknowledge and agree that my failure to notify the Agency of any change may result in my being responsible for payment of all charges incurred which are not reimbursed by the new payor source. I understand if I have no insurance coverage and do not have the financial resources to pay privately, the Agency will arrange for a Social Worker to meet with me to review my financial circumstances to determine if I qualify for discounted or charity care.

This admission agreement is applicable to this admission to the Agency. I understand what I have read and what was explained to me and agree to the terms and conditions as above. Additionally, I understand that either party may terminate this agreement for any reason and/or at any time.

SIGNATURES:

_____ _____

Admitting Clinician Date Patient or Authorized Representative Date

Doctor's Hospice
of Idaho

Hospice Election Statement

I, _____ choose to elect the Medicare hospice benefit and receive
(Beneficiary Name)
Hospice services from Doctors Hospice of Idaho, LLC.

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 a Medicare Hospice Election

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 that 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.

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 for an attending physician is:
Physician Full name: _____ NPI (if known) _____

Office Address: _____

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

DOCTOR'S HOSPICE OF IDAHO, LLC , services 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.

_____ _____
Signature of Beneficiary/Representative (Date)

☐ Beneficiary is unable to sign -
Reason: _____

_____ _____
Witness signature (Date)

PATIENT NAME_____

Doctor's Hospice of Idaho

Informed Consent, Patient's Rights and Responsibilities
Election of Benefit, Consent for Treatment & Advance Directives

INFORMED CONSENT

Hospice is palliative as opposed to curative in its goals. It emphasizes the relief of symptoms and/or emotional/spiritual distress that may accompany the illness. It is designed to provide care and services to the patient experiencing a life limiting illness and their family. Nursing and physician services, qualifying drugs and medical equipment are available on a 24-hour basis. Hospice care will not be discontinued because of an inability to pay for that care. All services are given under the direction of a physician. If the patient is unable to perform his/her own activities of daily living, a caregiver must be available 24 hours a day.

Services Provided:

- Physician provides palliation and management of the terminal illness.
- Nurses will assist the patient to be free from pain and other uncomfortable physical symptoms. These services are provided by an RN or under the supervision of an RN.
- Social Workers provide emotional support to the patient and family as they address end-of-life issues. The service includes advocacy, referral, problem-solving and intervention related to personal, family, business and financial issues.
- Counseling (dietary, spiritual, bereavement): Dietary counseling is provided as needed. Spiritual counseling is consistent with the patient's customs, religious preferences, cultural background and ethnicity. Bereavement counseling is provided to surviving family members, as needed, for at least one year after the death of the patient.
- Physical Therapy, Occupational Therapy, and Speech-Language Pathology are utilized to assist in the relief of pain and provide other comfort measures.
- Home health aide and homemaker services are available to meet the personal care and home cleanliness needs of the patient if a family member is unable to provide them.
- Volunteer(s) assist by sitting/and or reading with the patient, grocery shopping, errands, etc.
- Medical supplies include pharmaceutical services, medications, equipment and supplies related to the terminal illness. The patient/family is responsible for the items that are **not** related to the terminal condition or those that are not approved by the interdisciplinary team.

LEVELS OF CARE AND FINANCIAL RESPONSIBILITY:

1. Routine care is provided at the residence of the patient. Medicare pays 100% of hospice care. The patient/family is responsible for board and room charges if the patient resides in an assisted living center or nursing home. Medicaid pays for board and room and hospice care if the patient qualifies for Medicaid.

2. Continuous care can be provided in the home or assisted living center if the patient's symptoms exacerbate and require the services of an RN, aide, or homemaker for at least 8 hours in a 24-hour day. At least one half of the service hours need to be provided by an RN. Hospice assumes financial responsibility for this service.

3. Respite care is provided in a skilled nursing facility (SNF), up to five (5) days, to provide relief from caregiver responsibilities. All hospice services are continued in the SNF, under the direction of Hospice. Hospice assumes financial responsibility for this service. If the patient/family chooses to stay in the facility longer than 5 days, the additional days will be the financial responsibility of the patient/family.

4. General inpatient care is provided in a skilled nursing facility (SNF) for pain control and/or symptom management that cannot be provided in the home. All hospice services are continued in the SNF, under the direction of Hospice. Hospice assumes financial responsibility for this service. As soon as symptoms are controlled this service will revert back to "routine care."

PATIENT NAME_____

THE PATIENT HAS THE RIGHT:

1. Be informed of patient rights under state law to formulate Advance Directives
2. Receive effective pain management and symptom control for conditions related to terminal illness(s)
3. Have one's property and person treated with respect, consideration, and recognition of patient dignity and individuality
4. Be able to identify visiting personnel members through proper identification
5. Recommend changes in policies and procedures, personnel or care/service
6. Not be subject to discrimination or reprisal for the exercising of one's rights and be fully informed of one's responsibilities.
7. Choose a health care provider, including choosing an attending physician
8. Receive appropriate care without discrimination in accordance with physician orders
9. Be fully informed of one's responsibilities
10. Be informed of anticipated outcomes of care and of any barriers in outcome achievement
11. Hospice patients and their caregivers have a right to mutual respect and dignity. The Hospice staff are prohibited from accepting personal gifts and borrowing from patients/families.
12. Be informed of your rights at the time of admission and before the initiation of care, and on an ongoing basis as necessary.
13. Elect and revoke Hospice care according to law and regulation.
14. Receive information in writing and in a manner that you understand.
15. Be treated with consideration, respect and full recognition of your dignity and individuality by trained professional staff.
16. Receive considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
17. Have your cultural, psychosocial, spiritual and personal values, beliefs and preferences respected. To assure these preferences are identified and communicated to staff, a discussion of these issues, including the availability of spiritual and counseling services, will be included during the initial nursing admission assessment.
18. Have relationships with hospice staff that are based on honesty and ethical standards of conduct.
19. Participate in your healthcare decisions.
20. Exercise your rights, or your family or guardian may exercise your rights if you have been judged incompetent.
21. Be informed of the procedure to follow to voice concerns regarding care or lack of respect for property without being subject to discrimination or reprisal.
22. Be informed in advance of the extent to which payment may be expected from Medicare, Medicaid or other third party payer and any costs for which you may be responsible.
23. Be informed by knowledgeable staff about your medical condition, to the extent known and be given an opportunity to participate in designing a care plan that addresses your needs and preferences, and updating it as your condition changes.
24. Be informed about the outcomes of care, treatment and services that have been provided, including unanticipated outcomes.
25. Be advised of any change in the plan of care before the change is made.
26. Be advised in advance of the discipline of staff who will provide care and the proposed frequency of visits.
27. Be informed about the nature and purpose of any technical procedure that will be performed as well as who will perform the procedure.
28. Expect confidentiality of all information related to your care, within applicable laws and regulations.
29. Refuse care and/or treatment after being fully informed, and to be told the consequences of your action.
30. Be informed within a reasonable amount of time of anticipated termination of service or transfer to another organization.
31. Report any complaints or grievances with respect to care that is furnished (without interference, coercion, discrimination or reprisal)
32. Have access to, request an amendment to, and obtain information on disclosures of his/her health information in accordance with law and regulation.
33. Unlimited private contact with visitors, if inpatient unit.
34. Not be subjected to discrimination or reprisal for exercising his/her rights.

PATIENT NAME_____

PATIENT RESPONSIBILITIES:

As a Patient, you have the responsibility to:

1. Remain under a physician's care while receiving Hospice services.
2. Provide Hospice with a complete and accurate health history in order to plan and carry out care.
3. Inform Hospice staff about any changes in your health status, condition or treatment.
4. Provide Hospice with all requested insurance and financial information/records.
5. Sign or have your legal representative sign the required consents and releases for insurance billing.
6. Allow the Hospice to act on your behalf in filing appeals of denied payment of service by third-party payers and to cooperate to the fullest extent possible in such appeals.
7. Notify the Hospice of any changes in treatment made by the physician.
8. Participate in your plan of care including, if appropriate, a pain management plan.
9. Ask your nurse/therapist what to expect regarding pain and pain management.
10. Discuss pain relief options with your nurse/therapist.
11. Provide your nurse/therapist with as comprehensive information as possible about your pain and any concerns you may have about pain medications and/or management.
12. Be available to the Hospice staff for home visits at reasonable times.
13. Notify the Hospice if you are going to be unavailable for a visit.
14. Treat the Hospice staff with respect and dignity without discrimination as to color, religion, sex or national or ethnic origin.
15. Accept the consequences for any refusal of treatment or choice of noncompliance.
16. Provide the Hospice staff with a safe home environment in which your care can be provided.
17. Cooperate with your physician, Hospice staff and other caregivers.

ASSIGNMENT OF BENEFITS: I assign direct payment of Medicare, Medicaid, or insurance benefits to the Company for services received. I authorize the release of any and all records required to act on this request so that payment of authorized benefits can be made on my behalf.

MEDICAL RECORD REVIEW: I authorize the review of my medical records for internal and external audits. Medical record review will be done to determine the quality of care rendered, appropriateness of utilization and services rendered, and to determine if Medicare, Medicaid, insurance, and accrediting bodies criteria are being met.

RELEASE OF MEDICAL RECORDS: I authorize the release of medical information and/or records if transferred to another facility or agency.

ADVANCE DIRECTIVES: Do you have a Special Power of Attorney, a Living Will or Medical Treatment Plan explaining the measures you want given or withheld if you are unable to express your wishes?

☐ **YES:** Copy Obtained: Yes ☐ No ☐ Copy unavailable, patient wishes to redraft: Yes ☐ No ☐

☐ **NO**, I do not have a special power of attorney, a living will, or medical plan of treatment plan explaining the measures I want given or withheld if I am unable to express my wishes.

I am satisfied with the explanation and have read and understand the Patient Rights/Responsibilities as written above. I understand my right to make decisions about my medical care, and that Hospice will make every attempt to comply with any Advance Directives or DNR I have executed. It will be my responsibility to notify my physician and Hospice if such directives are changed **or withdrawn**.

CONSENT FOR TREATMENT: I voluntarily give consent to receive care, treatment and services as ordered by my physician or the Hospice Medical Director. I understand the purpose and potential risk of treatment, as well as the risks of declining the recommended care/treatment or services, will be explained to me.

PATIENT NAME_____

ELECTION OF BENEFIT:

☐ **I understand the following explanation of the Medicare hospice benefit:**

1. Hospice will receive payment for my care, relating to my terminal illness.
    a. Medicare will continue to make payment to my attending physician for services if my physician is not a hospice employee or receiving payments from Hospice. If my physician is a hospice employee, Hospice will bill Medicare for visits to my physician.
    b. I waive my rights to Medicare benefits related to my life-limiting illness while enrolled in the Medicare hospice program.
2. The Medicare hospice program is divided into benefit periods consisting of two (2) 90-day periods, followed by an unlimited number of 60-day periods.

☐ **I understand the following explanation of the Non-Medicare hospice benefit:**

1. The hospice benefit package that my insurance company covers has been explained to me, along with the financial limitations and deductibles/co-pays for which I am responsible. I understand that I will be billed for the expenses not covered by my insurance company unless other arrangements have been made.
2. I understand that should I choose to reside in a nursing facility, I accept responsibility for payment of room and board. Should I choose to hire additional caregiver services, I understand that I would be financially responsible for payment of such services.
3. It is understood that the provider will bill insurers directly and that my assignment of benefits is ongoing and continuous unless and until canceled by me in writing to the insurer(s) providing coverage with a copy to provider.

I understand that all hospice services, considered to be reasonable and necessary by the hospice team, will be provided or arranged by Hospice.

I understand I have the right to seek treatment or therapy for any condition unrelated to my terminal illness. Any such services are not reimbursed by Hospice.

I may discontinue hospice care at any time by completing a revocation statement. If I revoke during a benefit period, I lose the remaining days in that benefit period. (Example: If I revoke care on the tenth day of the 1st 90-day period, I give up that day and the remaining 80 days of coverage.) I may, however, re-elect at any time the next benefit period for which I am eligible.

All care, related to my life limiting illness, must be **PREAUTHORIZED** BY Hospice. I understand that if I choose to seek care for treatment related to my life-limiting illness from other than my primary physician, or decide to be admitted to the hospital, or call 911 without authorization from Hospice, I will be responsible for payment for these services or Hospice will assume that I have chosen to revoke my Medicare Hospice Benefit.

Acknowledging and understanding the above, I authorize hospice care from Doctor's Hospice of Idaho:

(Benefit Period Elected) ☐1st 90 days ☐2nd 90 days ☐60 days

PATIENT NAME_____

Hospice care to begin on _____ (date)

My signature acknowledges I have reviewed the following:

- Copy of the Informed Consent, Patient's Rights & Responsibilities, Consent for Treatment, Election of Benefit and Advance Directives.
- Notice of Privacy Practices for Use and Disclosure of Protected Health Information (HIPAA)
- Information on Advance Directive
- Information on Disposal of Medications
- Patient and Family Handbook
- Preauthorizing treatment with Hospice and calling 911
- Home Safety Information
- Financial Responsibility
- Making a Complaint

_____

Print Patient Name

_____

Patient or Legal Representative Signature Date Relationship to Patient

Reason Patient is unable to sign: _____

_____

Witness Signature Date

You may voice grievances regarding any issue without being subject to discrimination or reprisal by calling our office, (208) 985-2260, and/or the State Department of Public Health Licensing and Certification Division or the Accreditation Commission for Health Care at:

(208) 334-6626 State Survey Agency
(855) 937-2242 Accreditation Commission for Health Care (ACHC)

After hours, on weekends or holidays contact your local office at the following number:

Doctor's Hospice of Idaho
(208) 985-2260

Doctor's Hospice of Idaho

Admission Service Agreement

Patient Name — Last, First, Middle Initial _____

CONSENT FOR CARE/SERVICE: I consent to and authorize the Agency, its agents and associates to provide care and treatment to me in my home or place of residence as prescribed by my attending physician or hospice Medical Director and per program policy for the duration of this agreement. I understand that I have the right to choose my attending physician and I appoint _____ as such. I have received an explanation of the services to be provided (including disciplines, proposed frequency of visits and goals for my care), my involvement with the plan of care, and how changes will be made as needed. I understand that I am required to have an appointed "primary caregiver" to assist with my personal care needs not covered by the hospice benefit. I understand that the Agency reserves the right to refuse to admit a patient or to continue providing care for a patient on service if I do not have or continue to have a primary caregiver. My primary caregiver is: _____ mailing address _____

RELEASE OF INFORMATION: I consent to and authorize the Agency to release and receive information for the purposes of treatment, payment and health care operations. The exchange of information may occur between, but is not limited to physicians, third party payors, other health care providers and regulatory and/or accrediting reviewers.

CONSENT TO PHOTOGRAPH: I authorize the Agency to photograph me while I am receiving hospice services when the Agency deems it appropriate for treatment purposes, including but not limited to: documentation of care given, of progress or lack thereof and reports to care providers or payors.

ACKNOWLEDGEMENTS:

- Advance Directives: I understand that the Agency's policy is to respect individual choice and not to discriminate based on whether or not I have an Advance Directive or a Do Not Resuscitate (DNR) order.
- Patient Rights and Responsibilities: I've received information on my rights and responsibilities and how to use the organization's complaint process and the state's toll free hotline.
- Patient Handbook: I have received a copy of the Agency's Patient Handbook which includes information on Home Safety, Emergency Disaster Planning, Infection Control and Proper Disposal of Controlled Substances.
- Notice of Privacy: I have received a copy of the Notice of Privacy Practices/HIPAA.
- Authorized Hospice Services: I understand that in order for services, medications, equipment, medical supplies, emergency treatment or admission to a facility to be covered under my payor's Hospice Benefit, the Agency must approve/authorize these in advance.
- Hiring Restriction: I understand that the Agency has incurred expenses in hiring and maintaining its staff. I agree not to hire the Agency's employees.

INSURANCE INFORMATION: (circle all that apply)

Medicare # _____ **Medicaid #**_____

Insurance # _____ **Name of Insurance** _____

Annual Deductible $ _____ **met/not met OOP $**_____ **Co-Pay$** _____ **Coverage %**_____

Self Pay (indicate responsible party if not the patient): _____

ASSIGNMENT OF BENEFITS: I request that payment of authorized benefits be made on my behalf directly to the Agency

Discipline	Rate	Discipline	Rate
RN/LPN	$165/visit	Speech Therapist	$240/visit
Aide	$ 95/visit	Massage/Music Therapist	$240/visit
MSW	$230/visit	Spiritual Care	
Physical Therapist	$210/visit	Per Diem/Routine Day	$165/day
Occupational Therapist	$215/visit	Other	

FINANCIAL RESPONSIBILITY: I certify that all the information given by me to the Agency is correct for requesting and applying for payment. I understand and agree to pay deductibles, co-payments, spend downs and any amount due after payment of benefits on my behalf. The Agency may bill my insurance company as a courtesy, but by doing so shall not be construed as a waiver of Agency right to seek payment from me and/or another responsible party. I further understand that if there is a change to my insurance coverage or third party it is my responsibility to notify the Agency of this change. I acknowledge and agree that my failure to notify the Agency of any change may result in my being responsible for payment of all charges incurred which are not reimbursed by the new payor source. I understand if I have no insurance coverage and do not have the financial resources to pay privately, the Agency will arrange for a Social Worker to meet with me to review my financial circumstances to determine if I qualify for discounted or charity care.

This admission agreement is applicable to this admission to the Agency. I understand what I have read and what was explained to me and agree to the terms and conditions as above. Additionally, I understand that either party may terminate this agreement for any reason and/or at any time.

SIGNATURES:

_____ _____

Admitting Clinician Date Patient or Authorized Representative Date

Doctor's Hospice of Idaho

Hospice Election Statement

I, _____ choose to elect the Medicare hospice benefit and receive
(Beneficiary Name)
Hospice services from Doctors Hospice of Idaho, LLC.

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 a Medicare Hospice Election

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 that 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.

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 for an attending physician is:
Physician Full name: _____ NPI (if known) _____

Office Address: _____

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

DOCTOR'S HOSPICE OF IDAHO, LLC , services 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.

_____ _____
Signature of Beneficiary/Representative (Date)

☐ Beneficiary is unable to sign -
Reason: _____

_____ _____
Witness signature (Date)

PATIENT NAME _____

Doctor's Hospice of Idaho

Informed Consent, Patient's Rights and Responsibilities
Election of Benefit, Consent for Treatment & Advance Directives

INFORMED CONSENT

Hospice is palliative as opposed to curative in its goals. It emphasizes the relief of symptoms and/or emotional/spiritual distress that may accompany the illness. It is designed to provide care and services to the patient experiencing a life limiting illness and their family. Nursing and physician services, qualifying drugs and medical equipment are available on a 24-hour basis. Hospice care will not be discontinued because of an inability to pay for that care. All services are given under the direction of a physician. If the patient is unable to perform his/her own activities of daily living, a caregiver must be available 24 hours a day.

Services Provided:

- Physician provides palliation and management of the terminal illness.
- Nurses will assist the patient to be free from pain and other uncomfortable physical symptoms. These services are provided by an RN or under the supervision of an RN.
- Social Workers provide emotional support to the patient and family as they address end-of-life issues. The service includes advocacy, referral, problem-solving and intervention related to personal, family, business and financial issues.
- Counseling (dietary, spiritual, bereavement): Dietary counseling is provided as needed. Spiritual counseling is consistent with the patient's customs, religious preferences, cultural background and ethnicity. Bereavement counseling is provided to surviving family members, as needed, for at least one year after the death of the patient.
- Physical Therapy, Occupational Therapy, and Speech-Language Pathology are utilized to assist in the relief of pain and provide other comfort measures.
- Home health aide and homemaker services are available to meet the personal care and home cleanliness needs of the patient if a family member is unable to provide them.
- Volunteer(s) assist by sitting/and or reading with the patient, grocery shopping, errands, etc.
- Medical supplies include pharmaceutical services, medications, equipment and supplies related to the terminal illness. The patient/family is responsible for the items that are **not** related to the terminal condition or those that are not approved by the interdisciplinary team.

LEVELS OF CARE AND FINANCIAL RESPONSIBILITY:

1. Routine care is provided at the residence of the patient. Medicare pays 100% of hospice care. The patient/family is responsible for board and room charges if the patient resides in an assisted living center or nursing home. Medicaid pays for board and room and hospice care if the patient qualifies for Medicaid.

2. Continuous care can be provided in the home or assisted living center if the patient's symptoms exacerbate and require the services of an RN, aide, or homemaker for at least 8 hours in a 24-hour day. At least one half of the service hours need to be provided by an RN. Hospice assumes financial responsibility for this service.

3. Respite care is provided in a skilled nursing facility (SNF), up to five (5) days, to provide relief from caregiver responsibilities. All hospice services are continued in the SNF, under the direction of Hospice. Hospice assumes financial responsibility for this service. If the patient/family chooses to stay in the facility longer than 5 days, the additional days will be the financial responsibility of the patient/family.

4. General inpatient care is provided in a skilled nursing facility (SNF) for pain control and/or symptom management that cannot be provided in the home. All hospice services are continued in the SNF, under the direction of Hospice Hospice assumes financial responsibility for this service. As soon as symptoms are controlled this service will revert back to "routine care."

PATIENT NAME_____

THE PATIENT HAS THE RIGHT:

1. Be informed of patient rights under state law to formulate Advance Directives
2. Receive effective pain management and symptom control for conditions related to terminal illness(s)
3. Have one's property and person treated with respect, consideration, and recognition of patient dignity and individuality
4. Be able to identify visiting personnel members through proper identification
5. Recommend changes in policies and procedures, personnel or care/service
6. Not be subject to discrimination or reprisal for the exercising of one's rights and be fully informed of one's responsibilities.
7. Choose a health care provider, including choosing an attending physician
8. Receive appropriate care without discrimination in accordance with physician orders
9. Be fully informed of one's responsibilities
10. Be informed of anticipated outcomes of care and of any barriers in outcome achievement
11. Hospice patients and their caregivers have a right to mutual respect and dignity. The Hospice staff are prohibited from accepting personal gifts and borrowing from patients/families.
12. Be informed of your rights at the time of admission and before the initiation of care, and on an ongoing basis as necessary.
13. Elect and revoke Hospice care according to law and regulation.
14. Receive information in writing and in a manner that you understand.
15. Be treated with consideration, respect and full recognition of your dignity and individuality by trained professional staff.
16. Receive considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
17. Have your cultural, psychosocial, spiritual and personal values, beliefs and preferences respected. To assure these preferences are identified and communicated to staff, a discussion of these issues, including the availability of spiritual and counseling services, will be included during the initial nursing admission assessment.
18. Have relationships with hospice staff that are based on honesty and ethical standards of conduct.
19. Participate in your healthcare decisions.
20. Exercise your rights, or your family or guardian may exercise your rights if you have been judged incompetent.
21. Be informed of the procedure to follow to voice concerns regarding care or lack of respect for property without being subject to discrimination or reprisal.
22. Be informed in advance of the extent to which payment may be expected from Medicare, Medicaid or other third party payer and any costs for which you may be responsible.
23. Be informed by knowledgeable staff about your medical condition, to the extent known and be given an opportunity to participate in designing a care plan that addresses your needs and preferences, and updating it as your condition changes.
24. Be informed about the outcomes of care, treatment and services that have been provided, including unanticipated outcomes.
25. Be advised of any change in the plan of care before the change is made.
26. Be advised in advance of the discipline of staff who will provide care and the proposed frequency of visits.
27. Be informed about the nature and purpose of any technical procedure that will be performed as well as who will perform the procedure.
28. Expect confidentiality of all information related to your care, within applicable laws and regulations.
29. Refuse care and/or treatment after being fully informed, and to be told the consequences of your action.
30. Be informed within a reasonable amount of time of anticipated termination of service or transfer to another organization.
31. Report any complaints or grievances with respect to care that is furnished (without interference, coercion, discrimination or reprisal)
32. Have access to, request an amendment to, and obtain information on disclosures of his/her health information in accordance with law and regulation.
33. Unlimited private contact with visitors, if inpatient unit.
34. Not be subjected to discrimination or reprisal for exercising his/her rights.

PATIENT NAME_____

PATIENT RESPONSIBILITIES:

As a Patient, you have the responsibility to:

1. Remain under a physician's care while receiving Hospice services.
2. Provide Hospice with a complete and accurate health history in order to plan and carry out care.
3. Inform Hospice staff about any changes in your health status, condition or treatment.
4. Provide Hospice with all requested insurance and financial information/records.
5. Sign or have your legal representative sign the required consents and releases for insurance billing.
6. Allow the Hospice to act on your behalf in filing appeals of denied payment of service by third-party payers and to cooperate to the fullest extent possible in such appeals.
7. Notify the Hospice of any changes in treatment made by the physician.
8. Participate in your plan of care including, if appropriate, a pain management plan.
9. Ask your nurse/therapist what to expect regarding pain and pain management.
10. Discuss pain relief options with your nurse/therapist.
11. Provide your nurse/therapist with as comprehensive information as possible about your pain and any concerns you may have about pain medications and/or management.
12. Be available to the Hospice staff for home visits at reasonable times.
13. Notify the Hospice if you are going to be unavailable for a visit.
14. Treat the Hospice staff with respect and dignity without discrimination as to color, religion, sex or national or ethnic origin.
15. Accept the consequences for any refusal of treatment or choice of noncompliance.
16. Provide the Hospice staff with a safe home environment in which your care can be provided.
17. Cooperate with your physician, Hospice staff and other caregivers.

ASSIGNMENT OF BENEFITS: I assign direct payment of Medicare, Medicaid, or insurance benefits to the Company for services received. I authorize the release of any and all records required to act on this request so that payment of authorized benefits can be made on my behalf.

MEDICAL RECORD REVIEW: I authorize the review of my medical records for internal and external audits. Medical record review will be done to determine the quality of care rendered, appropriateness of utilization and services rendered, and to determine if Medicare, Medicaid, insurance, and accrediting bodies criteria are being met.

RELEASE OF MEDICAL RECORDS: I authorize the release of medical information and/or records if transferred to another facility or agency.

ADVANCE DIRECTIVES: Do you have a Special Power of Attorney, a Living Will or Medical Treatment Plan explaining the measures you want given or withheld if you are unable to express your wishes?

☐ **YES:** Copy Obtained: Yes ☐ No ☐ Copy unavailable, patient wishes to redraft: Yes ☐ No ☐

☐ **NO,** I do not have a special power of attorney, a living will, or medical plan of treatment plan explaining the measures I want given or withheld if I am unable to express my wishes.

I am satisfied with the explanation and have read and understand the Patient Rights/Responsibilities as written above. I understand my right to make decisions about my medical care, and that Hospice will make every attempt to comply with any Advance Directives or DNR I have executed. It will be my responsibility to notify my physician and Hospice if such directives are changed **or withdrawn.**

CONSENT FOR TREATMENT: I voluntarily give consent to receive care, treatment and services as ordered by my physician or the Hospice Medical Director. I understand the purpose and potential risk of treatment, as well as the risks of declining the recommended care/treatment or services, will be explained to me.

PATIENT NAME _____

ELECTION OF BENEFIT:

☐ **I understand the following explanation of the Medicare hospice benefit:**

1. Hospice will receive payment for my care, relating to my terminal illness.
    a. Medicare will continue to make payment to my attending physician for services if my physician is not a hospice employee or receiving payments from Hospice. If my physician is a hospice employee, Hospice will bill Medicare for visits to my physician.
    b. I waive my rights to Medicare benefits related to my life-limiting illness while enrolled in the Medicare hospice program.
2. The Medicare hospice program is divided into benefit periods consisting of two (2) 90-day periods, followed by an unlimited number of 60-day periods.

☐ **I understand the following explanation of the Non-Medicare hospice benefit:**

1. The hospice benefit package that my insurance company covers has been explained to me, along with the financial limitations and deductibles/co-pays for which I am responsible. I understand that I will be billed for the expenses not covered by my insurance company unless other arrangements have been made.
2. I understand that should I choose to reside in a nursing facility, I accept responsibility for payment of room and board. Should I choose to hire additional caregiver services, I understand that I would be financially responsible for payment of such services.
3. It is understood that the provider will bill insurers directly and that my assignment of benefits is ongoing and continuous unless and until canceled by me in writing to the insurer(s) providing coverage with a copy to provider.

I understand that all hospice services, considered to be reasonable and necessary by the hospice team, will be provided or arranged by Hospice.

I understand I have the right to seek treatment or therapy for any condition unrelated to my terminal illness. Any such services are not reimbursed by Hospice.

I may discontinue hospice care at any time by completing a revocation statement. If I revoke during a benefit period, I lose the remaining days in that benefit period. (Example: If I revoke care on the tenth day of the 1st 90-day period, I give up that day and the remaining 80 days of coverage.) I may, however, re-elect at any time the next benefit period for which I am eligible.

All care, related to my life limiting illness, must be **PREAUTHORIZED** BY Hospice. I understand that if I choose to seek care for treatment related to my life-limiting illness from other than my primary physician, or decide to be admitted to the hospital, or call 911 without authorization from Hospice, I will be responsible for payment for these services or Hospice will assume that I have chosen to revoke my Medicare Hospice Benefit.

Acknowledging and understanding the above, I authorize hospice care from Doctor's Hospice of Idaho:

(Benefit Period Elected) ☐ 1st 90 days ☐ 2nd 90 days ☐ 60 days

PATIENT NAME _____

Hospice care to begin on _____ (date)

My signature acknowledges I have reviewed the following:

- Copy of the Informed Consent, Patient's Rights & Responsibilities, Consent for Treatment, Election of Benefit and Advance Directives.
- Notice of Privacy Practices for Use and Disclosure of Protected Health Information (HIPAA)
- Information on Advance Directive
- Information on Disposal of Medications
- Patient and Family Handbook
- Preauthorizing treatment with Hospice and calling 911
- Home Safety Information
- Financial Responsibility
- Making a Complaint

_____

Print Patient Name

_____

Patient or Legal Representative Signature Date Relationship to Patient

Reason Patient is unable to sign: _____

_____

Witness Signature Date

You may voice grievances regarding any issue without being subject to discrimination or reprisal by calling our office, (208) 985-2260, and/or the State Department of Public Health Licensing and Certification Division or the Accreditation Commission for Health Care at:

(208) 334-6626 State Survey Agency
(855) 937-2242 Accreditation Commission for Health Care (ACHC)

After hours, on weekends or holidays contact your local office at the following number:
Doctor's Hospice of Idaho
(208) 985-2260

Doctor's Hospice
of Idaho

Family Disclosure Form

Name_____ Disclose Medical information?	Address and Phone Number:
Name_____ Disclose Medical information?	Address and Phone Number:
Name_____ Disclose Medical information?	Address and Phone Number:
Name_____ Disclose Medical information?	Address and Phone Number:
Name_____ Disclose Medical information?	Address and Phone Number:
Name_____ Disclose Medical information?	Address and Phone Number:

Signature of Patient: Date:

Doctor's Hospice
of Idaho

Emergency Preparedness Training Signature Page

(DHI Patient Name)

Name: _____

And Doctors Hospice of Idaho

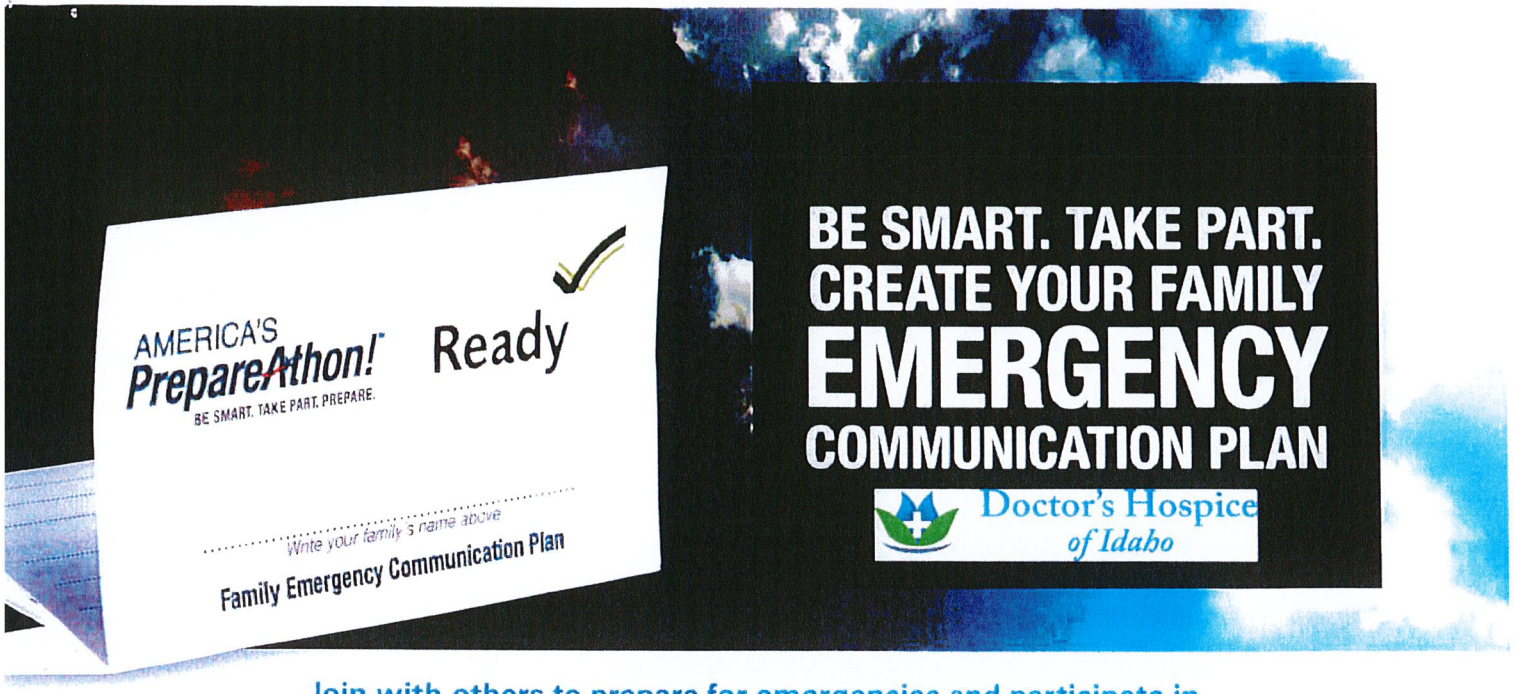
ACHC, The Centers for Medicare require that Doctors Hospice of Idaho have documented education and educational handouts for emergency preparedness and evacuation planning. I have received these handouts /training and understand them.

_____

Patient or Caregiver Signature

_____

Date



BE SMART. TAKE PART. CREATE YOUR FAMILY EMERGENCY COMMUNICATION PLAN

Doctor's Hospice of Idaho

Join with others to prepare for emergencies and participate in America's PrepareAthon! | ready.gov/prepare

Creating your *Family Emergency Communication Plan* starts with one simple question: "What if?"

"What if something happens and I'm not with my family?" "Will I be able to reach them?" "How will I know they are safe?" "How can I let them know I'm OK?" During a disaster, you will need to send and receive information from your family.

Communication networks, such as mobile phones and computers, could be unreliable during disasters, and electricity could be disrupted. Planning in advance will help ensure that all the members of your household—including children and people with disabilities and others with access and functional needs, as well as outside caregivers—know how to reach each other and where to meet up in an emergency. Planning starts with three easy steps.

1. COLLECT.

Create a paper copy of the contact information for your family and other important people/offices, such as medical facilities, doctors, schools, or service providers.

2. SHARE.

Make sure everyone carries a copy in his or her backpack, purse, or wallet. If you complete your *Family Emergency Communication Plan* online at ready.gov/make-a-plan, you can print it onto a wallet-sized card. You should also post a copy in a central location in your home, such as your refrigerator or family bulletin board.

3. PRACTICE.

Have regular household meetings to review and practice your plan.

TEXT IS BEST!

If you are using a mobile phone, a text message may get through when a phone call will not. This is because a text message requires far less bandwidth than a phone call. Text messages may also save and then send automatically as soon as capacity becomes available.

The following sections will guide you through the process to create and practice your *Family Emergency Communication Plan.*

COLLECT INFORMATION

HOUSEHOLD INFORMATION

Write down phone numbers and email addresses for everyone in your household. Having this important information written down will help you reconnect with others in case you don't have your mobile device or computer with you or if the battery runs down. If you have a household member(s) who is Deaf or hard of hearing, or who has a speech disability and uses traditional or video relay service (VRS), include information on how to connect through relay services on a landline phone, mobile device, or computer.

SCHOOL, CHILDCARE, CAREGIVER, AND WORKPLACE EMERGENCY PLANS

Because a disaster can strike during school or work hours, you need to know their emergency response plans and how to stay informed. Discuss these plans with children, and let them know who could pick them up in an emergency. Make sure your household members with phones are signed up for alerts and warnings from their school, workplace, and/or local government. To find out more about how to sign up, see *Be Smart. Know Your Alerts and Warnings* at http://1.usa.gov/1BDloze. For children without mobile phones, make sure they know to follow instructions from a responsible adult, such as a teacher or principal.

OUT-OF-TOWN CONTACT

It is also important to identify someone outside of your community or State who can act as a central point of contact to help your household reconnect. In a disaster, it may be easier to make a long distance phone call than to call across town because local phone lines can be jammed.

EMERGENCY MEETING PLACES

Decide on safe, familiar places where your family can go for protection or to reunite. Make sure these locations are accessible for household members with disabilities or access and functional needs. If you have pets or service animals, think about animal-friendly locations. Identify the following places:

___ *Indoor.* If you live in an area where tornadoes, hurricanes, or other high-wind storms can happen, make sure everyone knows where to go for protection. This could be a small, interior, windowless room, such as a closet or bathroom on the lowest level of a sturdy building, or a formal safe room or storm shelter.

___ *In your neighborhood.* This is a place in your neighborhood where your household members will meet if there is a fire or other emergency and you need to leave your home. The meeting place could be a big tree, a mailbox at the end of the driveway, or a neighbor's house.

___ *Outside of your neighborhood.* This is a place where your family will meet if a disaster happens when you're not at home and you can't get back to your home. This could be a library, community center, house of worship, or family friend's home.

- [ ] *Outside of your town or city.* Having an out-of-town meeting place can help you reunite if a disaster happens and:
  - You cannot get home or to your out-of-neighborhood meeting place, or
  - Your family is not together and your community is instructed to evacuate the area.

  This meeting place could be the home of a relative or family friend. Make sure everyone knows the address of the meeting place and discuss ways you would get there.

OTHER IMPORTANT NUMBERS AND INFORMATION

You should also write down phone numbers for emergency services, utilities, service providers, medical providers, veterinarians, insurance companies, and other services.

SHARE

MAKE SURE EVERYONE HAS THE INFORMATION

- [ ] Make copies of your *Family Emergency Communication Plan* for each member of the household to carry in his or her wallet, backpack, or purse. Post a copy in a central place at home. Regularly check to make sure your household members are carrying their plan with them.
- [ ] Enter household and emergency contact information into all household members' mobile phones or devices.
- [ ] Store at least one emergency contact under the name "In Case of Emergency" or "ICE" for all mobile phones and devices. This will help someone identify your emergency contact if needed. Inform your emergency contact of any medical issues or other requirements you may have.
- [ ] Create a group list on all mobile phones and devices of the people you would need to communicate with if there was an emergency or disaster.
- [ ] Make sure all household members and your out-of-town contact know how to text if they have a mobile phone or device, or know alternative ways to communicate if they are unable to text.
- [ ] Read *Be Smart: Know Your Alerts and Warnings* at http://1.usa.gov/1BDloze and sign up to receive emergency information.

NOW IT'S TIME TO PRACTICE!

Once you have completed your *Family Emergency Communication Plan*, made copies for all the members of your household, and discussed it, it's time to practice!

Here are some ideas for practicing your plan:

- [ ] Practice texting and calling. Have each person practice sending a text message or calling your out-of-town contact and sending a group text to your mobile phone group list.
- [ ] Discuss what information you should send by text. You will want to let others know you are safe and where you are. Short messages like "I'm Ok." or "At library" are good.

- [ ] Talk about who will be the lead person to send out information about the designated meeting place for the household.
- [ ] Practice gathering all household members at your indoor and neighborhood emergency meeting places. Talk about how each person would get to the identified out-of-neighborhood and out-of-town meeting places. Discuss all modes of transportation, such as public transportation, rail, and para-transit for all family members, including people with disabilities and others with access and functional needs.
- [ ] Regularly have conversations with household members and friends about the plan, such as whom and how to text or call, and where to go.
- [ ] To show why it's important to keep phone numbers written down, challenge your household members to recite important phone numbers from memory—now ask them to think about doing this in the event of an emergency.
- [ ] Make sure everyone, including children, knows how and when to call 911 for help. You should only call 911 when there is a life-threatening emergency.
- [ ] Review, update, and practice your *Family Emergency Communication Plan* at least once a year, or whenever any of your information changes.

To help start the conversation or remind your family why you are taking steps to prepare and practice, you may want to watch the 4-minute video *It Started Like Any Other Day*, about families who have experienced disaster, at www.youtube.com/watch?v=w_omgt3MEBs. Click on the closed captioning (CC) icon on the lower right to turn on the captioning.

After you practice, talk about how it went. What worked well? What can be improved? What information, if any, needs to be updated? If you make updates, remember to print new copies of the plan for everyone.

OTHER IMPORTANT TIPS FOR COMMUNICATING IN DISASTERS

- [ ] Text is best when using a mobile phone, but if you make a phone call, keep it brief and convey only vital information to emergency personnel and/or family or household members. This will minimize network congestion, free up space on the network for emergency communications, and conserve battery power. Wait 10 seconds before redialing a number. If you redial too quickly, the data from the handset to the cell sites do not have enough time to clear before you've re-sent the same data. This contributes to a clogged network.
- [ ] Conserve your mobile phone battery by reducing the brightness of your screen, placing your phone in airplane mode, and closing apps you do not need. Limit watching videos and playing video games to help reduce network congestion.
- [ ] Keep charged batteries, a car phone charger, and a solar charger available for backup power for your mobile phone, teletypewriters (TTYs), amplified phones, and caption phones. If you charge your phone in your car, be sure the car is in a well-ventilated area (e.g., not in a closed garage) to avoid life-threatening carbon monoxide poisoning.

- [ ] If driving, do not text, read texts, or make a call without a hands-free device.
- [ ] Maintain a household landline and analog phone (with battery backup if it has a cordless receiver) that can be used when mobile phone service is unavailable. Those who are Deaf or hard of hearing, or who have speech disabilities and use devices and services that depend on digital technology (e.g., VRS, Internet Protocol (IP) Relay, or captioning) should have an analog phone (e.g., TTY, amplified phone, or caption phone) with battery backup in case Internet or mobile service is down.
- [ ] If you evacuate and have a call-forwarding feature on your home phone, forward your home phone number to your mobile phone number.
- [ ] Use the Internet to communicate by email, Twitter, Facebook, and other social media networks. These communication channels allow you to share information quickly with a widespread audience or to find out if loved ones are OK. The Internet can also be used for telephone calls through Voice over Internet Protocol. For those who are Deaf or hard of hearing, or who have speech disabilities, you can make calls through your IP Relay provider.
- [ ] If you do not have a mobile phone, keep a prepaid phone card to use if needed during or after a disaster.
- [ ] Use a pay phone if available. It may have less congestion because these phones don't rely on electricity or mobile networks. In some public places, you may be able to find a TTY that can be used by those who are Deaf or hard of hearing, or who have speech disabilities.

America's PrepareAthon! is a grassroots campaign for action to get more people prepared for emergencies. Make your actions count at **ready.gov/prepare**

10 WAYS TO PARTICIPATE IN AMERICA'S PrepareAthon!

- **Access Alerts and Warnings**
- **Test Communication Plans**
- **Assemble or Update Supplies**
- **Drill or Practice Emergency Response**
- **Participate in a Class, Training, or Discussion**
- **Plan with Neighbors**
- **Conduct an Exercise**
- **Make Property Safer**
- **Document and Insure Property**
- **Safeguard Documents**

FAMILY EMERGENCY COMMUNICATION PLAN

HOUSEHOLD INFORMATION

Home #: .....
Address: .....

Name: ..... Mobile #: .....
Other # or social media: .....
Email: .....
Important medical or other information: .....
.....

Name: ..... Mobile #: .....
Other # or social media: .....
Email: .....
Important medical or other information: .....
.....

Name: ..... Mobile #: .....
Other # or social media: .....
Email: .....
Important medical or other information: .....
.....

Name: ..... Mobile #: .....
Other # or social media: .....
Email: .....
Important medical or other information: .....
.....

SCHOOL, CHILDCARE, CAREGIVER, AND WORKPLACE EMERGENCY PLANS

Name: .....
Address: .....
Emergency/Hotline #: .....
Website: .....
Emergency Plan/Pick-Up: .....

SCHOOL, CHILDCARE, CAREGIVER, AND WORKPLACE EMERGENCY PLANS

Name: .....
Address: .....
Emergency/Hotline #: .....
Website: .....
Emergency Plan/Pick-Up: .....

Name: .....
Address: .....
Emergency/Hotline #: .....
Website: .....
Emergency Plan/Pick-Up: .....

Name: .....
Address: .....
Emergency/Hotline #: .....
Website: .....
Emergency Plan/Pick-Up: .....

IN CASE OF EMERGENCY (ICE) CONTACT

Name: ..... Mobile #: .....
Home #: ..... Email: .....
Address: .....

OUT-OF-TOWN CONTACT

Name: ..... Mobile #: .....
Home #: ..... Email: .....
Address: .....

EMERGENCY MEETING PLACES

Indoor: .....
Instructions: .....
Neighborhood: .....
Instructions: .....

Out-of-Neighborhood: .....
Address: .....
Instructions: .....

Out-of-Town: .....
Address: .....
Instructions: .....

IMPORTANT NUMBERS OR INFORMATION

Police: ..... Dial 911 or #: .....
Fire: ..... Dial 911 or #: .....
Poison Control: .....#: .....
Doctor: .....#: .....
Doctor: .....#: .....
Pediatrician: .....#: .....
Dentist: .....#: .....
Hospital/Clinic: .....#: .....
Pharmacy: .....#: .....
Medical Insurance: .....#: .....
Policy #: .....
Medical Insurance: .....#: .....
Policy #: .....
Homeowner/Rental Insurance: .....
#: .....
Policy #: .....
Flood Insurance: .....#: .....
Policy #: .....
Veterinarian: .....#: .....
Kennel: .....#: .....
Electric Company: .....#: .....
Gas Company: .....#: .....
Water Company: .....#: .....
Alternate/Accessible Transportation: .....
#: .....
Other: .....#: .....
Other: .....#: .....
Other: .....#: .....

ATTENTION!!!!!

THIS PATIENT IS ENROLLED IN HOSPICE

Doctor's Hospice
of Idaho

Call Hospice immediately for any changes in condition, symptoms, or management issues, falls, etc. Do not order any labs or tests without calling hospice first.

(208) 985-2260

This patient's hospice team members are:

Nurse:_____

HHA:_____

MSW:_____

Spiritual Coordinator:_____

Volunteer:_____

Private Duty Caregiver:_____

If you are unable to reach
Doctors at main number,
contact our Answering service
directly 1-888-883-1430