



Hospice of Warren County

2 Crescent Park West, P.O. Box 68, Warren PA 16365
Phone: (814) 723-2455 Fax: (814) 723-6259

I, _____, request admission to Hospice of Warren County. I have read the patient/family rights and responsibilities statement, and voluntarily acknowledge, consent and agree to the following:

I understand that I am suffering from (disease description) _____

_____ and that further attempts to achieve a cure or attain a significant remission are not likely to be successful.

I understand that the care provided by Hospice of Warren County is palliative, not curative in its goals and techniques, and that the financial benefits of the Hospice program extend only to medications, treatments, hospitalizations and equipment that are **pre-certified** by Hospice of Warren County. Unauthorized services are not covered.

I understand that the Hospice staff will also provide emotional support and spiritual support (when requested) to me and my family or primary care person (PCP) and that every attempt will be made to preserve my personal dignity.

I understand that Hospice program policies related to the use of resuscitation or extraordinary heartbeat and breathing measures such as cardio-pulmonary resuscitation and mechanical breathing assistance with the help of a respirator will be made explicit to me and my family.

I understand that my family or PCP (when applicable) will also be cared for by the Hospice program and will receive training and support when it is needed to carry out the management of my care.*

I agree to identify a PCP who will be available around the clock. This PCP may be a family member, friend, or other person of my choosing.*

I understand that (name) _____ will be considered my to be my PCP. This means that he/she will be the person mainly responsible for meeting my needs at home.*

I understand that as long as I am enrolled in the Hospice program my care will take place mainly at home.

I understand that Hospice care will be provided by a Hospice team of caregivers, which includes physicians, nurses, social worker, spiritual counselor, nutritionist and volunteers. Volunteer services may be of a professional or non-professional nature, but volunteers will all be trained in the basic principles and practices of Hospice care and have adequate supervision.

I understand that the Hospice services are primarily provided on a prearranged schedule, but they are also available as needed twenty-four hours a day, seven days a week. The Hospice program's phone number is 723-2455 (8:00-4:30 Monday thru Friday); evenings and weekends call 723-3300 and ask for the Hospice Nurse on call.

I understand that the Hospice program will assist with arranging inpatient services in an appropriate facility if it is deemed necessary by the physician. The Hospice team will continue to follow my care in whatever setting (within the geographic confines of the program) I may temporarily be.

I understand the explanation of the costs and reimbursement methods of payment for Hospice care that have been presented to me.

I understand that I am free to change my mind about this method of care and withdraw from the Hospice program at any time.

I understand the Hospice medical record, which will be shared with my family, will contain information about me and my family or other PCP and that every effort will be made to keep this information confidential.

I authorize the Hospice to release any information acquired by my participation in the program to medical insurers.

I understand that if I am to receive the full benefits of Hospice care it is important for me and my PCP to make my needs and concerns known to the Hospice staff. I (we) will actively participate in plans for my care.

*If Nursing Home Placement becomes necessary for skilled care, I understand Hospice of Warren County will continue to provide supportive services to me/my family.

At this time I believe I understand both the nature of my disease and Hospice care. My questions about this program have been answered to my satisfaction by

(name of person responsible for gaining the consent)

SIGNATURE OF PATIENT/ LEGAL REPRESENTATIVE

DATE

WITNESS

DATE

WITNESS

DATE