(To be completed by OCFS)
LOG #:

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

FAMILY-TYPE HOME FOR ADULTS (FTHA)

APPLICATION FOR HOSPICE SERVICES

Instructions: FTHA operators must complete this form to secure approval prior to allowing hospice services to be provided to a resident who resides in their FTHA. Minimum requirements for approval include residence in the FTHA for at least six months prior to the date of admission to a hospice program and meeting the FTHA retention requirements on the date of this request.

FTHA operators/substitute caregivers are not authorized to provide medical or nursing care to residents and cannot dispense, store, or administer controlled substances. Therefore, this request must include

- a written care plan or preliminary care plan completed by hospice on their letterhead,
- a written plan of who (other than the FTHA operator or substitute caregivers) will provide hospice-related services and a backup coverage plan, and
- a written staffing plan of who will provide care and supervision to maintain the safety and well-being of the non-hospice residents in the FTHA.

This form and the required care plan must be submitted to the local department of social services (LDSS) or Human Resources Administration (HRA) FTHA coordinator for review and recommendation. The final decision is provided by the New York State Office of Children and Family Services' (OCFS) Bureau of Adult Services. Requests will be reviewed on a case-by-case basis. The impact of the provision of hospice services in the FTHA and all the residents will be considered in the final determination.

SECTION 1A: To be completed by the operator
FTHA Name: _____
Operator Name: _____
Address: _____
_____
Telephone Number: _____
Name of resident for whom the operator is requesting hospice plan approval: _____.
Resident admission date: / /
Does the resident currently meet admission and retention criteria?: ☐ Yes ☐ No
Anticipated date of hospice admission: / /
Type, frequency, and expected duration of hospice services:
Preliminary hospice care plan attached: ☐ Yes ☐ No

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SECTION 1B: To be completed by Operator

List the names and roles of non-FTHA caregivers who will be responsible for providing hospice care and the activities outlined in the hospice care plan. These activities may include medication administration, 24-hour care, and evacuation assistance in the event of an emergency.

Additional duties may include the following:

- Total assistance with feeding
- One- or two-person transfers
- Storage and/or administration of controlled substances
- Any nursing tasks

List the names and roles of non-FTHA caregivers who will serve as backup for the non-FTHA caregivers listed above.

Outline the FTHA staffing plan that provides continual support of the needs of the non-hospice residents in the home, including the ability to safely evacuate all residents.

My signature below confirms my understanding that the approval of this request must not interfere with or impact the supervision or care of any residents in the home and has been developed in partnership with the above-named resident, the resident's family/representative and hospice staff, and I agree to the plan of care while the resident remains in the FTHA.

Operator Signature: Date: / /

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SECTION 2: To be completed by the LDSS/HRA

LDSS/HRA confirmed resident meets six-month admission minimum: ☐ Yes ☐ No

LDSS/HRA confirmed resident meets FTHA retention standards: ☐ Yes ☐ No

LDSS/HRA recommendation: ☐ Approve ☐ Deny

Reason for denial

LDSS/HRA Staff Name and Title:

LDSS/HRA Signature: Date: / /

SECTION 3: To be completed by the OCFS Bureau of Adult Services

Bureau of Adult Services decision: ☐ Approve ☐ Deny

Reason for denial:

Bureau of Adult Services /Designee Name and Title

Bureau of Adult Services Staff Signature: Date: / /