

CHHA/HOSPICE AGREEMENT

This Agreement made and entered into this _____ day
of _____, 1992 by and between the _____
Certified Home Health Agency (hereinafter referred to as "CHHA") and the
_____ Hospice (hereinafter referred to as "Hospice")
is for the purpose of ensuring the timely transfer of patients to the
service most appropriate to the patient's needs. This Agreement shall be in
effect upon its proper execution by both parties and will remain in effect
until revised or terminated by both parties.

TERMS OF AGREEMENT

1. The CHHA will assess patients for eligibility for admission to the Hospice.
2. For patients who appear to be eligible for Hospice, the CHHA will contact the patient's primary physician and, if the physician is in agreement, will obtain a verbal order to refer to Hospice. The verbal order will be written and sent to the physician for signature.
3. The CHHA will discuss Hospice with the patient and, if the patient is in agreement, will obtain the patient's verbal consent to make a referral to Hospice. The CHHA may not refer the patient to Hospice if either the patient or the patient's physician is not in agreement with the plan.
4. When the patient is to be referred to Hospice, the CHHA will contact the Hospice with all pertinent information necessary to ensure a smooth transition.
5. The Hospice will discuss the Hospice program with the patient and, if the patient is in agreement and admission criteria are met, Hospice will proceed to admit the patient.
6. The Hospice will notify the CHHA of the date of the patient's evaluation and acceptance into Hospice.

7. The CHHA will continue to provide home health care services to the patient until notified by Hospice that the patient has been admitted to the Hospice.

CERTIFIED HOME HEALTH AGENCY

By: _____

Title: _____

Date: _____

HOSPICE

By: _____

Title: _____

Date: _____

Part III: If either section A. or B. has not been completed, this form will be returned to the physician.

Section A.

++ I do not believe that the patient's ability to perform ADLs would diminish as a result of the patients placement in a RHCf

Section B.

++ I do believe the patient's ability to perform the following ADLs would diminish as a result of his/her placement in a RHCf

	ACTIVITY OF DAILY LIVING (ADL)	DESCRIPTION OF THE IMPACT OF PLACEMENT ON EACH ACTIVITY OF DAILY LIVING (ADL)
++	EATING/DRINKING	
++	TOILETING	
++	TURNING/POSITIONING	
++	MOBILITY	
++	TRANSFERRING	
++	BATHING	
++	GROOMING	
++	DRESSING	

Note: (If additional space is needed to describe the impact of RHCf placement on the patient's ADLs, please submit as an attachment.)

Physician's Certification Statement:

I certify that in my professional judgment, the information provided above is an accurate description of the impact of residential health care facility placement on this patient's ability to perform the activities of daily living. I understand that this certification statement is subject to the New York State Department of Social Services Regulations at Parts 515, 516, 517 and 518 of Title 18 NYCRR, which permit the Department to impose monetary penalties on, or sanction and recover overpayments from providers or prescribers of medical care, services or supplies, when medical care, services or supplies that are unnecessary, improper or exceed the patient's documented medical condition are provided or ordered.

Signed: _____ Date: _____

Residential Health Care Facility Review Form
of the Impact of Institutionalization on the Patient's Ability
to Perform the Activities of Daily Living (ADL)

_____ has been determined by
the _____ Certified Home Health Agency to be
inappropriate for home care services and in need of placement in a
residential health care facility (RHCF).

The patient's physician has indicated on the attached Physician's
Certification Form that this patient's ability to perform the activities of
daily living (ADL) would diminish if the patient were institutionalized.

Please review Section III., B. of the Physician's Certification Form in
conjunction with the attached physician's order for Home Health Services,
complete either Section A or Section B of this form, and return this
document in the enclosed self-addressed envelope. Thank you.

| Section A:
|
|++ I have reviewed the Physician's order and the Physicians Certification
|++ Form and agree with the patient's physician that this individual's
ability to perform ADLs would diminish because of RHCF placement
Section B:
I have reviewed the Physician's order and the Physicians Certification
++ Form and disagree with the patient's physician that placement in a
++ RHCF would cause the diminishment of the patient's ability to perform
the activities of daily living.
Comments:
(Additional comments may be submitted as an attachment to this form.)

Signed: _____ Date: _____
Position: _____
Facility Name: _____
Address: _____
