Haven Health

PATIENT ACKNOWLEDGMENT

Patient's Name: _____ Date: _____

IMPORTANT INFORMATION EXPLAINED TO PATIENT/FAMILY/CAREGIVER:	
1. Patient's freedom of choice in selecting a hospice agency.	
2. Patient's condition/plan of care/goals and how related to his/her condition.	
3. Patient's right to participate in the Plan of Care/treatment, and informed of change.	
4. Patient/Caregiver is expected to learn and participate in care consistent with capabilities.	
5. Disease process, medication regime, and diet.	
6. Written notice of Pt. Rights & Responsibilities, Consent, Assignment of Benefits, Patient Grievance Procedure, Guidelines for Pt. Care, Emergency Care and non-discrimination policy.	
7. Advance Directives. Has Patient executed an Advance Directive? ☐ YES ☐ NO • Given written materials about right to accept or refuse medical treatment. • Been informed of rights to formulate Advance Directives. • That patient is not required to execute an Advance Directive to receive medical treatment from this health care facility. • That the terms of any Advance Directive executed will be followed by the agency and caregivers to the extent permitted by law.	
8. Visit Plan to include disciplines & frequencies.	
9. Confidentiality & Disclosure of Clinical Records.	
10. Basic Home Safety, Infection Control, Disaster Plan.	
11. Patient liability for payment and right to be informed of any changes.	
12. Toll-free State Hospice Hot Line number and purpose.	
13. How to register a complaint with the agency and their right to voice grievance without fear of reprisal.	
14. Patient and family understand that equipment will be provided by hospice. Patient/Family understands and agrees to return all equipment at the end of hospice services. Any unreturned equipment will be billed to family.	
15. Discharge Planning.	
16. Emergency Disaster Plan Priority Code:	*(Check Category)*
Support systems unreliable and inconsistent and/or on O2, Infusion, or ventilator therapy (Priority 1)	☐ *1*
Support systems in place requiring frequent agency interventions (Priority 2)	☐ *2*
Good support system, efficient caregivers in place (Priority 3)	☐ *3*

I have received the following information and have been given the opportunity to ask questions.

Patient/Caregiver Signature: _____

My signature certifies that I have explained and left a copy of the above items in the home.

Staff Signature/Title: _____

Haven Health

Release of Information & Consent for Treatment

Patient name: (Last, M.I., First) _____ SSN: _____

1. PATIENT SELF DETERMINATION ACT AND BILL OF RIGHTS
   I have received a written statement of my rights as a patient of Haven Health. I understand my rights because they have been explained to me and my questions have been answered. I have received written and verbal information about advance directives, company policy, applicable state law, my rights under state law, the state hot line #, and other information necessary to make decisions about advance directives and my care in accordance with the Patient Self Determination Act of 1990.
2. RELEASE OF INFORMATION
   I consent to the release of information by my Physician, Licensed Health Care Professionals, or Facility, and to allow the disclosure of medical records kept by the above to Haven Health. I consent to the release of information by Haven Health or their representative to representatives of other health providers involved in my care, those being Federal, State, and JCAHO representatives. I also authorize the release of information to third party payers in order to assure continuity of treatment, proper communication of information to my physician(s) and referral source, and proper reimbursement of services.
3. CONSENT FOR TREATMENT
   I voluntarily consent to receive treatment from Haven Health consistent with a medical treatment plan authorized by my physician. I understand that if I am in such condition as to need services not provided by Haven Health, then my legal representative, my Physician, or I must arrange such services. Haven Health shall assist in locating such services, but shall no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that I am not provided with such additional care. In the event a health care worker sustains exposure to my blood or body fluids. I give permission for my blood to be tested for infectious diseases such as HIV and Hepatitis. I understand that the exposed employee will be informed of the results of the test. I understand that I will not be billed for any lab fees incurred should an employee sustain exposure to my blood.
4. PAYMENT AUTHORIZED AND ASSIGNMENT OF BENEFITS.
   I hereby authorize my insurance company to make payments directly to Haven Health for any and all authorized services provided. In consideration of Haven Health's agreement to forego collection of my account for a reasonable period of time, I hereby assign to Haven Health or its legal representative all of my rights, including the right to the use of my name on my behalf, under policy # (Insurance #) _____, issued by (name of insurance) _____ to recover charges for services rendered by Haven Health. This assignment shall not extinguish or diminish my obligation to pay the full fee to Haven Health for services rendered, but I shall receive credit for all sums collected pursuant to this agreement. If I enroll in another insurance plan it is my responsibility to notify Haven Health, otherwise I will be responsible for payment. I understand that my insurance has agreed to pay _____% of allowable charges and that my secondary insurance (if applicable) will be billed for _____%. I understand that I am responsible for _____% of allowable charges after my deductible has been met.
5. MEDICARE (PART A & B)
   I certify that the information given by me in applying for payment under Title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical, or other information about me, to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or related Medicare claim. I request that payment of authorized benefits be made to Haven Health on my behalf. Services under Medicare part A and Medicaid Medical Assistance are covered at 100%, therefore no co-payment is necessary. I will be notified of any changes in the amount of charges for items and services as soon as possible, but no later than thirty (30) days from the date that Haven Health becomes aware of the change.

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

Please explain if someone other than patient signs: _____

HAVEN HEALTH

Informed Consent and Medicare Benefit Election Form

Patient Name: _____

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

1) 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.
2) 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.
3) 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.
4) I understand that I am responsible for the cost of care for my terminal illness if I seek care beyond what is considered medically necessary by the hospice interdisciplinary team and documented on my plan of care.

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 understand that 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 determinations and I have been provided with the contact information for the BFCC-QIO that services my area.

BFCC-QIO Name: **Commence Health**

BFCC-QIO Phone Number: (877) 588-1123 TTY (877) 577-1123 Dial 711

☐ I elect to receive the "**Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**

Initials_____ Date__

☐ I decline to receive the "**Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**

Initials_____ Date__

Other Hospice Information

1. Routine hospice care may involve skilled nursing care, volunteer companions and caregivers, emotional and spiritual care, physical or other therapies, social workers and inpatient care. More intense levels of care may be provided for symptom management or during crisis and short-term respite care may be provided occasionally.

a) The Medicare hospice program consists of two 90-day periods, and unlimited 60-day periods if no revocations or discharges occur.

HAVEN HEALTH

Informed Consent and Medicare Benefit Election Form

b) I may discontinue hospice care at any time by completing a revocation statement. If I revoke hospice are during a benefit period, I lose the remaining days in that benefit period. I may, however, re-elect hospice care at any time when I am eligible.
c) I can change from one hospice to another, if I wish to do so. To change programs, I will confirm that I may be admitted to another hospice, and then I will inform Haven Health of my wishes so arrangements for transfer can be made. I will specify a date to discontinue care from Haven Health, the name of the hospice from which I wish to receive care, and the date care will start. In changing to another hospice program, I will not lose any benefit days. I may change hospices only once during each benefit period.
d) Hospice patients may be discharged when they move out of the hospice's service area, are no longer terminally ill, or in extraordinary circumstances such as patient or hospice staff safety.

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:
(Please provide any information that will uniquely identify your attending physician choice.)

Physician Full name: _____

_____

I,_____(Patient Name) choose to elect the Medicare hospice benefit

and receive Hospice services from Haven Health to begin on _____ (Start of Care Date).

Signature of Beneficiary: _____

Date Signed: _____
☐ Beneficiary is unable to sign

Signature of Representative: _____

Date Signed: _____

Medi-Cal Hospice Program Election Notice

Email to: HospiceProviderHelp@dhcs.ca.gov **Questions, call: (800) 541-5555**

Section 1			
Recipient Name:			
Email:	Phone Number:	Medi-Cal ID:	Date of Birth:
Address:	City:	State:	Zip Code:

Section 2	
I and/or the Legal Representative/Agent of the Medi-Cal recipient identified above understand the following:	
I have a terminal illness with a life expectancy of six months or less if the illness were to run its normal course.	Initials:
Hospice care services alleviate pain and suffering and are intended to treat symptoms rather than to cure illness. Recipients younger than 21 years of age may concurrently receive both hospice care and curative treatments of the hospice-related diagnosis. The Medi-Cal Hospice Services and benefits have been explained to me and/or my legal representative. I understand that only recipients younger than 21 years of age may receive both hospice services and curative treatment concurrently.	Initials:
By choosing hospice, I waive my right to payment for all Medi-Cal services, except for: 1) services provided by my designated hospice, 2) services provided by another hospice through an arrangement made by my designated hospice, and 3) services provided by my attending physician if that physician is not employed by my designated hospice or receiving any compensation from the hospice for those services. 4) services that are unrelated to my terminal diagnosis.	Initials:
I understand that for recipients ages 21 and over: 1) All my care will be provided by my elected hospice provider for my terminal diagnosis and related conditions. 2) I am not eligible to receive services for my terminal diagnosis and related conditions from providers other than a hospice provider or attending physician. 3) I am still eligible for services needed for conditions not related to my terminal diagnosis, and related conditions, such as provider examinations, drugs, or other medical care.	Initials:
I and/or the Legal Representative/Agent of the Medi-Cal recipient identified above, understand that I may revoke the hospice benefit at any time by signing a statement to that effect, and that both I and/or the Legal Representative/Agent and the hospice provider must inform DHCS by submitting the hospice revocation form signed by me. I understand my rights to other Medi-Cal services will resume on that date, if I continue to be Medi-Cal eligible. (This revocation is not to be pre-dated or post-dated).	Initials:
I understand that if I reach a point of stability and can no longer be certified as terminally ill, I will return to the traditional Medi-Cal benefits as long as I am eligible for Medi-Cal.	Initials:

I understand that the Hospice provider is responsible for any Home Health, Private Duty Nursing, or Personal Care Services, if related to my terminal diagnosis, and related conditions. Medi-Cal benefits will cover care for treatments not related to the terminal diagnosis and related conditions.	Initials:

Section 3

Admitting Terminal Diagnosis and related conditions ICD-10 Code(s):	
Recipient is currently being admitted from a medical facility or home. ☐ Yes ☐ No	
Facility:	NPI Number:
Recipient is transferring from another Hospice Agency. ☐ Yes ☐ No	
Agency:	NPI Number:
Recipient is transferring from Home Hospice. ☐ Yes ☐ No	
Address:	NPI Number:
Recipient and/or the Legal Representative/Agent choice of attending physician.	
Attending Physician:	NPI Number:
I and/or the Legal Representative/Agent of the recipient identified above, certify that the recipient DOES NOT have an attending physician separate from the hospice physician. Therefore, the hospice physician is my choice for attending physician.	Initials:

Section 4

Services currently being provided to recipient by other Agencies:

Home Health Services	☐ Yes ☐ No	Name of Agency:
Private Duty Nursing Services	☐ Yes ☐ No	Name of Agency:
Personal Care Services	☐ Yes ☐ No	Name of Agency:

Elected Hospice Provider: AB Safe Haven Palliative & Hospice Care, Inc.	NPI Number: 1669764726

Recipient and/or Legal Representative/Agent Statement
I, (Recipient's Name) _____, have read and understand the statements in this document. Recipient Signature: _____ Date: _____
I, (Legal Representative/Agent Name) _____, as the Legal Representative/Agent for (Recipient's Name) _____, have read and understand the statements in this document. Relationship to Recipient: _____ Legal Representative/Agent Signature: _____ Date: _____
Hospice Provider Statement
I, (Hospice Representative Name) _____, Hospice Representative for (Hospice Provider's Name) AB Safe Haven Palliative & Hospice Care, Inc., understand that the Hospice provider is responsible for the coordination of services to ensure there is no duplication of services. Hospice Representative Title: _____ Signature: _____ Date: _____

☐ I elect to receive the "**Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**

Initials_____ Date__

☐ I decline to receive the "**Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**

Initials_____ Date__

Patient Name:_____

Patient's Bill of Rights and Responsibilities

As a Hospice patient you have the right to:

- Be informed of your rights and responsibilities on admission and any time thereafter as needed.
- Receive these rights in a manner that you understand, written and oral.
- Exercise your rights as a patient of the hospice, through yourself or your legal representative.
- Voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice
- Be protected from discrimination or reprisal for exercising your rights.
- Have your property and person treated with Respect and Dignity.
- Have relationships with our staff members based on honest and ethical standards.
- Participate in all healthcare decisions that will affect you and be involved in developing the care plan
- Formulate Advance Directives.
- Choose your attending physician.
- Expect confidentiality of all medical information as the law requires, and have access to or release of clinical records in accordance with State and Federal Guidelines. A copy of our policy regarding the release of medical records will be made available upon request.
- Receive effective pain management and symptom control for conditions related to the terminal illness.
- Be informed of your medical condition and be educated about it.
- Receive education about medications, treatments, procedures, etc. and have your questions answered.
- Refuse any medication, treatment, or procedure, and fully know the consequences of the refusal.
- Be free from mistreatment, neglect or verbal, mental, sexual, and physical abuse, including injuries of unknown source and misappropriation of patient property.
- Receive information about the services covered under the hospice benefit.
- Receive information about the scope of services that the hospice will provide and specific limitations
- Be informed of discharge from hospice within a reasonable timeframe as part of the Plan of Care.
- All information and education to be provided in a language or through an interpreter you understand.

Patients have the responsibility to:

- Remain under a physician's care while in our hospice program.
- Render as complete as possible all healthcare information requested to aid in your care.
- Tell us of any changes in your condition, pain, or any other symptoms, including changes in your Advance Directive.
- Provide financial and insurance information as needed by the hospice for billing, as well as notify hospice of any changes in financial or insurance information.
- Sign or have the legal representative sign all consents needed for medical and billing purposes.
- Allow us to bill and file appeals with Medicare or any insurance you are using to cover hospice.
- Notify Haven Health of any changes in medication, treatment, or procedures ordered by your doctor.
- Obtain medications, supplies and equipment ordered by the patient's physician if they cannot be obtained or supplied by the program.
- Participate as much as possible in creating the Plan of Care.
- Ask questions about any, and all concerns, medications, treatments, and or procedures.
- Advise the program of any problems or dissatisfaction with patient care or personnel.
- Let us know when you are available for visits by the care team.
- Please call if you are not going to be available for a scheduled visit.
- Treat us with the same respect and dignity that we extend to you.
- Accept the consequences of any/all refused medications, treatments, and or procedures.
- Provide Haven Health team members with a safe environment to work in.
- Lastly, please cooperate with the caregivers, staff, and physicians in your care.

If you have any concerns about the quality or safety of our services, please contact us directly at:

(562) 426-7500 ask for the Administrator

If you are not satisfied with our response to your concerns you have the right to bring your complaints to the following regulatory agencies:

THE JOINT COMMISSION AT: (800) 994-6610

OR

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES AT (800) 228-1019

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

Hospice Durable Medical Equipment Rental Agreement

This Rental Agreement ("Agreement") is made and entered into on this ___ day of _____, ***2026***, by and between Haven Health/Bella Vida Hospice ("Hospice") and _____ ("Patient") and/or _____ ("Responsible Party").

1. Equipment Provided: The Hospice agrees to provide all rented durable medical equipment ("Equipment") to the Patient for use during hospice care. Medicare will reimburse hospice for equipment. Hospice will pay rental fees to ASAP Pharmacy as long as the patient remains on hospice.

2. Ownership: The Equipment is and shall remain the property of ASAP Pharmacy. Neither the hospice nor the Patient shall have any ownership rights to the Equipment.

3. Rental Period: The rental period shall commence on the date the Equipment is delivered to the Patient and shall continue until the Patient is discharged from hospice care.

4. Return of Equipment: Upon discharge from hospice care, the Patient and/or Responsible Party agrees to return the Equipment to ASAP Pharmacy in good working condition, normal wear and tear excepted, within _5_ days of discharge.

5. Billing for Unreturned Equipment: If the Equipment is not returned within the specified period, the Patient and/or Responsible Party will be billed for the full replacement cost of the Equipment. The amount due will be determined based on the current market value of the Equipment.

6. Maintenance and Care: The Patient and/or Responsible Party agrees to take reasonable care of the Equipment and to use it only for its intended purpose. Any damage beyond normal wear and tear will be the responsibility of the Patient and/or Responsible Party.

7. Liability: The Hospice nor ASAP Pharmacy shall not be liable for any injury or damage caused by the use of the Equipment. The Patient and/or Responsible Party assumes all risks associated with the use of the Equipment.

8. Governing Law: This Agreement shall be governed by and construed in accordance with the laws of the state of California.

9. Entire Agreement: This Agreement constitutes the entire agreement between the parties and supersedes all prior agreements or understandings, whether written or oral, relating to the subject matter hereof.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

Patient/Responsible Party Name: _____

Patient/Responsible Party Signature: _____

Hospice Representative Name: _____

Hospice Representative Signature: _____

Haven Health

2855 Temple Avenue, Suite B, Signal Hill, CA 90755

Level of Care Notification

Facility Name: _____

Attention: _____

Patient Name: _____

Please bill as of the following date(s):

Routine _____

Inpatient _____

Respite _____

Facility will bill hospice at the contracted rate.

** MediCal GIP is subject to TAR approval.*

Delivered by (hospice employee name): _____

Date delivered: _____

Please contact our office with any questions or concerns at (562) 426-7500

For Hospice Staff only:	Please leave copy of this form with the SNF Business Office. Then scan and email form to Accounts Payable@havenhealth.org

Policy Section: Administrative Patient Practices

Effective Date: 08/02/2024
Revision Date: 08/02/2024

Subject: Mortuary

Policy:
It is the expectation of the hospice that all patients and families be offered assistance with identifying the mortuary they wish to be contacted upon death. Assessment of final wishes will be conducted to determine any requests for burial, cremation, whole body donation, or transfer out of state/county. Education and referrals will be provided accordingly.

All patients admitted to a skilled nursing facility for any reason, must notify hospice of their preferred mortuary, which will be documented in the attributes section of patient's chart.

In the event a patient or family does not wish to decide upon and inform Hospice of their chosen mortuary, Hospice staff will inform patient and family of the agency's Mortuary Protocol and document it in the Skilled Nursing Facility and hospice medical record.

1. Deaths in Skilled Nursing Facility (SNF)
    a. Should a SNF patient die without identifying a chosen mortuary, attempts will be made to reach the family/DPOA/NOK for up to 1 hour post death. This is to be communicated to the SNF personnel.
    b. In the event family/DPOA/NOK cannot be reached, hospice will contact SNF default mortuary or Optima Funeral Home (213) 820-2798 to arrange pickup of deceased.
    c. Further attempts will be made to contact family/NOK/DPOA to inform them of contacting Optima Funeral Home (213) 820-2798 for mortuary pick up
2. No Next of Kin (NOK)
3. In the event there is no next of kin, and patient does not have/cannot make mortuary arrangements for themselves for whatever reason, currently established protocols for contacting the County Morgue will be utilized.
        i. Orange County—Orange County has rotating mortuaries who are responsible for responding to SNF deaths where the County Morgue will be utilized. Hospice staff to ask the Skilled Nursing Facility for the name of this mortuary at the time of death
        ii. Los Angeles County—there are no rotating mortuaries in LA County. Deaths without a Next of Kin must go to the morgue.
            0. If patient with no NOK lives in a skilled nursing facility, care plan meeting to be scheduled upon patient's admission to SNF/hospice.
                a. Hospice team to discuss "Time of Death" instructions, including SNF's responsibility to contact the morgue at the appropriate time (per LA County Morgue protocol). SNF Director of Nursing to be informed of this plan. All to be documented in "Time of Death" instructions in patient's medical record (call log/quick note)
                b. Hospice team to review SNF medical record with SNF personnel to identify any/all NOK listed. Incorrect or out of date information must be removed. Hospice team to follow up weekly to confirm removal.

1. If death occurs Monday-Friday between 8:00AM PST-5:00PM PST, the LA County Public Administrator will be contacted—(213) 974-0460.
    a. Hospice will fax a completed Initial Decedent Referral Report to the LA County Public Administrator (213) 633-1944—Intake Unit
    b. Hospice will follow up every 15 minutes of faxing document to obtain the "EA Number" and continue to follow up every 15 minutes until EA # is assigned.
    c. Once EA # is assigned, HOSPICE to contact Morgue (323) 409-7062, report death, provide EA #, and request pick up.
    d. HOSPICE TO CALL LA COUNTY MORGUE.
2. If death occurs after 5:00pm PST and/or outside of regular business hours (Monday-Friday), or during a government observed holiday, HOSPICE to contact LA County Morgue (323) 409-7062 directly to report death and request pickup.

☐ Form not applicable

Patient/Caregiver Signature: _____

TELEHEALTH CONSENT FORM

By signing this form, I understand and agree with the following:

Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists and/or subspecialists, nurse practitioners, registered nurses, medical assistants and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate on the telehealth/telemedicine service, and I agree to share my personal information with such family members, caregivers, legal representatives or guardians. The information may be used for diagnosis, therapy, follow-up and/or education.

Telehealth/Telemedicine requires transmission, via Internet or tele-communication device, of health information, which may include:

- Progress reports, assessments, or other intervention-related documents
- Bio-physiological data transmitted electronically
- Videos, pictures, text messages, audio and any digital form of data

The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. Information obtained during telehealth/telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing and healthcare operations. By agreeing to use the telehealth/telemedicine services, I am consenting to Haven Health sharing of my protected health information with certain third parties as more fully described in Haven Health's Privacy Policy. I understand, agree, and expressly consent to Haven Health obtaining, using, storing, and disseminating to necessary third parties, information about me, including my image, as necessary to provide the telehealth/telemedicine services.

As with any Internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Individuals other than my clinical care team or consulting providers may also be present and have access to my information for the telehealth/telemedicine session. This is so they can operate or repair the video or audio equipment used. These persons will adhere to applicable privacy and security policies.

Telehealth/telemedicine sessions may not always be possible. Disruptions of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, audio interference) that prevent effective interaction between consulting clinician(s), participant, patient or care team.

I hereby release and hold harmless Haven Health and all members of my care team from any loss of data or information due to technical failures associated with the telehealth/telemedicine service.
I understand and agree that the health information I provide at the time of my telehealth/telemedicine service may be the only source of health information used by the medical professionals during the

course of my evaluation and treatment at the time of my telehealth/telemedicine visit, and that such professionals may not have access to my full medical record or information held at Haven Health.

I understand that I will be given information about test(s), treatments(s) and procedures(s), as applicable, including the benefits, risks, possible problems or complications, and alternate choices for my medical care through the telehealth/telemedicine visit.

I have the right to withhold or withdraw consent to the use of telehealth/telemedicine services at any time and revert back to traditional in-person services. I understand that if I withdraw my consent for telehealth/telemedicine, it will not affect any future services or care benefits to which I am entitled.

All my questions have been answered to my satisfaction.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions.

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____ _____

Printed Name of Patient or Patient's Legal Representative Relationship to Patient

INTERPRETER'S ATTESTATION (if applicable):
I certify that I am fluent in the language of the person providing consent. I certify that I have accurately and completely interpreted the contents of this form, and that the person giving consent has indicated their understanding of the contents.

_____ _____

Signature of Interpreter /Printed Name Date

Patient Name: _____

RELEASE WITH AUTHORIZATION TO RECORD AND PHOTOGRAPH

State of California

I, the undersigned, do hereby authorized Haven Health and any of its business partners to photograph me while under the care of Haven Health, Haven Home Health, Haven Palliative Care, or any other line of service. I agree that they may use or permit other persons to use the negatives, prints, or digital versions of said images prepared there from in such a manner as may be deemed necessary.

Photographs will be used for internal medical purposes only. Photographs will not be shared on social media, marketing materials or any other external media. All photographs will be securely stored in patient's electronic medical record.

I also hold Haven Health and any of its business partners free and harmless from any and all liability from the photography and its subsequent use. I understand the photography is being carried out with my consent, and so assume full responsibility for the photographs, negatives, prints or digital versions of said images.

I hereby release the Company, and any associates, as well as any assignees, from any and all claims for damages for libel, slander, invasion of privacy or any other claim based on use of the above-described material(s).

_____ _____

Signature (Releaser) Date

_____ _____

Print name Relation (if not Releaser)

_____ _____

Haven Health Staff Signature Date

_____ _____

Witness Signature Date

Comfort Medications

You will be provided a combination of medications also known as your "Comfort Pack". Comfort medications are intended to be "just in case" medications to have in your home for comfort and symptom management. You may use a combination of medications at the same time in order to provide relief. Your hospice nurse will review the medications with you, along with instructions on how and when to take medications. Please contact hospice if you should experience discomfort from these medications, so that we can help you manage your symptoms. * If patient is confused or forgetful, must store out of reach.

By signing, I acknowledge that I understand the teaching provided to me regarding use, safety, and storage.

Patient/caregiver: _____

SYMPTOMS	MEDICATIONS	HOW IT HELPS
PAIN OR TROUBLE BREATHING	**Morphine concentrate (Roxanol) solution** Use orally and under the tongue as needed per orders. Measure with oral syringe provided. Possible side effects: Lightheadedness, dizzy/drowsiness, constipation This medicine is a strong pain drug Misuse or abuse of Roxanol (morphine oral concentrate (20 mg/mL)) **can lead to overdose and death**	**Trouble breathing**: dilates blood vessels in the lungs, reduces respiratory rate within normal limits, and increase depth of breathing. **Pain:** liquid morphine is an immediate release form, the onset is rapid and allows for pain to be managed more quickly in a crisis ****Doses can be repeated, as needed**
TROUBLE BREATHING	**DuoNeb (Iprotropium/Albuterol Sulfate)** as needed for shortness of breath per order	Used to help relax the muscles around the airways in the lungs causing them to open up and facilitate breathing and breaks up mucus.
NAUSEA AND VOMITING	**Prochlorperazine/promethazine rectal suppository** Lay on side, unwrap and insert one suppository in rectum as needed per order	Used to treat severe nausea/vomiting in patients who may not be able to tolerate oral anti-emetics.
TROUBLE BREATHING OR INCREASED SECRETIONS	**Hyoscyamine sublingual tablets** Dissolve 1 tablet under the tongue as needed.	Used to reduce excess saliva production and may also help with the wet lung sounds or saliva build up at the back of the throat (gurgling).
FEVER	**Acetaminophen rectal suppository** Lay on side, unwrap and insert one suppository every 4 hrs as needed. Do not exceed 6doses/24hrs	Used to reduce elevated body temperatures of 100.4 and may alleviate mild to moderate pain. ****Remain laying down and avoid having a bowel movement for an hour or longer so the medication can properly be absorbed.**
ANXIETY AND SLEEP DISTURBANCE	**Lorazepam sublingual tablets** Place under tongue, chew or crush and mix with water Possible side effects: Drowsiness/dizziness	Used to help a patient relax during either emotional or physical anxiety. If a patient is experiencing restlessness, Lorazepam is also used to help alleviate sleep disturbances.
CONSTIPATION	**Senna tab or Dulcolax suppository** as needed for constipation	Stimulant laxative that is used to help a patient feeling the discomfort of constipation. ****Remain laying down and avoid having a bowel movement for an hour or longer so the medication can properly be absorbed.**

Medicamentos de Comodidad

Se le proporcionará una combinación de medicamentos también conocida como su "paquete de confort". Estos medicamentos están destinados a estar en su hogar para la comodidad y el manejo de los síntomas. Puede usar una combinación de medicamentos al mismo tiempo para dar alivio. La enfermera de hospice revisará los medicamentos con usted, junto con las instrucciones sobre cómo y cuándo tomar estos medicamentos. Comuníquese con el hospicio si experimenta alguna molestia con estos medicamentos para que podamos ayudarlo a controlar sus síntomas. *Si el paciente presenta con confución o es olvidadizo, debe guardar lejos de su alcance.

Al firmar, reconozco que entiendo la ensenanza que se me ha proporcionado con respect al uso, la seguridad y el almacenamiento.

Paciente/cuidador: _____

SINTOMAS	MEDICACION	COMO AYUDA
DOLOR O DIFICULTAD PARA RESPIRAR	**Morphine concentrate (Roxanol) solution** Use por vía oral y debajo de la lengua si es necesario. Para medir, use jeringa oral suministrada. Posibles effectos secundarios: Aturdimiento, mareos / somnolencia, estreñimiento Este medicamento es un analgésico potente. El uso indebido o abuso de Roxanol (concentrado oral de morfina (20 mg / ml)) **puede provocar una sobredosis y la muerte**	**Dificultad para respirar:** Dilata las venulas sanguíneas en los pulmones, reduce la frecuencia respiratoria dentro de los límites normales y aumenta la profundidad de la respiración **Pain:** La morfina líquida es una forma de liberación inmediata, el inicio es rápido y permite que el dolor se maneje más rápidamente en una crisis **** Las dosis pueden repetirse según lo ordene el médico.**
DIFICULTAD PARA RESPIRAR	**DuoNeb (Iprotropium/Albuterol Sulfate)** Si es necesario para la falta de aire	Se usa para ayudar a relajar los músculos alrededor de las vías respiratorias en los pulmones, hace que se abran y faciliten la respiración y rompan la mucosidad.
NÁUSEA Y VOMITO	**Prochlorperazine/promethazine rectal suppository** Acueste de lado, desenvuelva y inserte un supositorio en el recto según sea necesario	Se usa para tratar náuseas / vómitos graves en pacientes que no pueden tolerar las medicaciones orales.
DIFICULTAD PARA RESPIRAR O AUMENTO DE LAS SECRECIONES	**Hyoscyamine sublingual tablets** Disuelva 1 tableta debajo de la lengua según sea necesario.	Se utiliza para reducir la producción excesa de saliva. También puede ayudar con los sonidos húmedos de los pulmones o la acumulación de saliva en la parte posterior de la garganta (gorgoteo).
FIEBRE	**Acetaminophen rectal suppository** Acueste de lado, desenvuelva y inserte un supositorio en el recto según sea necesario cada 4 horas. No exceda de 6 dosis/24 hrs	Se utiliza para reducir la temperatura corporal elevada de 100.4 y puede aliviar el dolor leve a moderado. **** Permanezca acostado y evitar usar el baño durante una hora o más para que el medicamento pueda ser absorbido adecuadamente.**
ANSIEDAD Y INQUIETUD	**Lorazepam sublingual tablets** Poner debajo de la lengua, masticar o deshacer y mezclar con agua. Posibles effectos secundarios: mareos / somnolencia	Se utiliza para ayudar al paciente a relajarse durante la ansiedad emocional o física. Si un paciente experimenta inquietud, el lorazepam también se usa para ayudar a aliviar los trastornos del sueño.
ESTREÑIMIENTO	**Senna tab or Dulcolax supposition** según sea necesario para el estreñimiento	Estimulante laxante que se usa para ayudar al paciente a sentir la incomodidad del estreñimiento. **** Permanezca acostado y evitar usar el baño durante una hora o más para que el medicamento pueda ser absorbido adecuadamente.**

HavenHealth™

Emergency Preparedness Plan

Patient Name:	
Date of Birth:	
Emergency Contact Information	
Primary Contact:	
Relationship:	
Phone Number:	
Alternate Contact:	
Relationship:	
Phone Number:	
Plan for Common Emergencies	
Power Outage:	Prepare flashlights and backup oxygen source (if applicable) in advance. Notify Agency for assistance.
Earthquake:	Prepare Earthquake Emergency Bag in advance (7 day supply of meds, backup oxygen source (if applicable), supplies, perishable food, flashlight, copies of medical docs, and others). Notify Agency and initiate evacuation plan if needed. Take essentials with you if able to safely (meds, phone, charger, DNR POLST, others).
Fire:	Call 911/evacuate immediately if in immediate danger. Notify Agency and initiate evacuation plan if needed. Take essentials with you if able to safely (meds, phone, charger, DNR POLST, others).
Severe Weather:	Monitor news, shelter in place, and Notify Agency if Emergency Evacuation plan needs to be initiated.
Other Emergencies:	Notify Agency
Priority Code (check box)	
☐	**Priority Code 1:** Support system is unreliable or inconsistent and requiring frequenty agency interventions. Oxygen, ventilator, other life sustaining equipment dependent. Patient must be seen within 24hrs.
☐	**Priority Code 2:** Support system may be adequate but requires frequent agency interventions. Patient must be seen within 48hrs.
☐	**Priority Code 3:** Good support system with efficient caregivers and resources. Patient must be seen within 72hrs.
Emergency Evacuation Plan	
Emergency Equipment/Supplies:	
Oxygen in use(YES/NO):	
Oxygen Order (if applicable)	
Transportation:	
Evacuation Location:	
POLST and Advance Directives	
DNR-POLST in place (YES/NO):	
Advance Directives in place: (YES /NO)	
Location of POLST/Adv Directive:	
Caregiver Responsibilities	
Prepare Emergency Bag, Supplies, and Equipment	
Know how to operate emergency medical equipment, medications, and supplies	
Notify Agency of any emergencies and assistance needed with emergency plan	
Agency Responsibilities	
Prepare and Review Emergency Preparedness Plan	
Provide education for when to contact Agency and how to initiate emergency plan	
Provide support when emergency plan is initiated (evacuation, equipment, medication, transportation, other services)	