

N. C. Little Hospice Admission Agreement

1. PARTIES TO THE AGREEMENT

The N. C. Little Memorial Hospice, Inc. Hereby enters into this agreement with _____ the “Resident” and _____, the Resident’s legal guardian, conservator, attorney in fact or responsible party acting on the Resident’s behalf for the care of the Resident. Except as provided in this agreement, any reference to the resident under this agreement also applies to the legal guardian, conservator, attorney in fact, responsible party or any other person signing this agreement. This agreement shall also bind heirs, executors, administrators and assigns of the Resident. Any provision in this agreement found to be invalid will be severable and the remainder of this agreement will remain effective.

2. SERVICES PROVIDED

The Little Hospice agrees to furnish the Resident with basic care services included in the daily rate, i.e., patient room, three meals per day, if appropriate, also snacks and a variety of beverages. NCLMH employs a varying number of qualified staff that are on duty 24 hours/day, seven days/week, and at all times provides sufficient staff to meet the needs of our patients, including but not limited to registered nurses, licensed practical nurses, certified nursing assistants, home health aides and trained medical administrators. At no time are there fewer than two staff members on duty. In addition, we have trained volunteers that are scheduled for duty from 9:00 a.m. until 9:00 p.m. each day of the week.

The Little Hospice also provides basic equipment and supplies, i.e., bed linens; also maintenance of an appropriate personal hygiene program, i.e., Resident shall be offered a bath at least daily. Assistance is offered in brushing of teeth, hair combing, brushing and shampooing, hand washing, shaving, caring for toe and fingernails. All incontinent patients are immediately cleaned. An interdisciplinary team consisting of physician medical director, nurses, social worker, volunteer coordinator, bereavement coordinator are available to meet with Resident and/or responsible persons. All prescription medications are administered by Little Hospice staff. Telephones are provided in each room, as are televisions and radios. Housekeeping and laundry services are also provided.

The N. C. Little Memorial Hospice does not include in its daily charge for services special or extra services including but not limited to the following: personal clothing, specialized or adaptive equipment and supplies, beauty and barber services, therapies by licensed therapists, prescription drugs and medications, transportation, non-emergency oxygen, laboratory fees (tests), physician, dental, podiatry and psychiatric care.

When a patient requires one-on-one care, the family may be asked to assist in such care. After death, personal belongings will be held for family for four weeks. After that time the belongings will be donated.

CONTINGENCY ACTION:

I. In the event the above services cannot be provided for any reason by the Little Hospice and if the service or services unable to be offered is of such a nature, duration and extent to compromise the safety and well-being of Resident, immediate action will be taken by the Little Hospice to find an appropriate hospice, hospital or nursing home setting for Resident, Little Hospice staff will reschedule non-essential services at the Resident's convenience, whenever necessary.

II. The Resident or responsible person may contact the administration at any time by telephoning (952) 928-9394 or coming to the Little Hospice located at 7019 Lynmar Lane, Edina, MN to meet and/or speak with the administration.

III. The name of the person to contact in case of emergency or in the event of an adverse change in the Resident's condition:

IV. The name of the responsible person/persons to contact and the method by which they can be reached:

(same as above) _____

V. Circumstances in which emergency medical services are not to be summoned:

Patients are required to have a DNR/DNI (Do Not Resuscitate / Do Not Intubate), code status before admission.

3. DECLARATIONS

I understand that the Hospice program is palliative, not curative, in its goals. The program emphasizes the relief of symptoms such as pain and physical discomfort and addresses the spiritual need and the emotional stress, which may accompany a terminal illness.

I understand that I have a choice about the care provided to me. I may review the plan of care that guides the Hospice services, and if I desire, may refuse a particular treatment or service offered.

I understand that some medical services or procedures are not provided by Hospice. The subject of resuscitation has been discussed with my physician and I have signed the DNI/DNR required prior to admission into Hospice.

I authorize the N. C. Little Memorial Hospice to obtain copies of medical records and to keep records which include necessary personal information about my medical condition, family and finances during the time I reside at said Hospice.

I agree to immediately provide a copy of any advance directive/living will declaration that exists for Resident.

I understand I am responsible for payment to the N. C. Little Memorial Hospice at a cost of \$425.00 per day; \$2,975.00 per week, payable the day of admission for one week in advance. That the next payment of \$2,975.00 will be paid at the end of the 7th day for the next week and in the same manner for each succeeding week. (That a three (3) day minimum charge of \$1,275.00 is applied to all patients). I further understand that I am responsible for any payment not covered by insurance.

I accept the conditions of the N. C. Little Memorial Hospice as described, understanding that I may choose to leave said Hospice, if so desired, and that the N. C. Little Memorial Hospice may discharge me if Hospice care is no longer appropriate. I understand, however, that I may request to be admitted at a later date.

I hereby acknowledge by my signature the following:

- A. That I have been able to discuss the above conditions with a member of the "Little" Hospice staff and have had my questions answered to my satisfaction.
- B. That I have been supplied with a written copy of the Minnesota Home Care Bill of Rights.
- C. That I have been supplied with a Patient's Bill of Rights.
- D. That I have been supplied with a copy of the NCLMH Complaint Procedure.

E. That I have been supplied with a copy of the NCLMH Plan of Care.

Signature of Patient or Responsible Person

_____ Date: _____

Name of Patient: (Printed)

Signature of NCLMH Representative:

_____ Date: _____