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: _____

Attachment 11

Physician's Certification Form:
Request for an Exception to Receive Home Health Services
Based on the Impact of Institutionalization on the Patient's Functioning

Part I: Patient Information

Patient Name:_____ D.O.B._____
Address:_____
(Street/Apt. #) Sex:_____
_____
(City, State, Zip Code)
CIN/M.A. I.D.#:_ _ _ _ _ _ _ _

Part II: Physician Information

Physician Name:_____Phone:_____
(Print or Type)
Clinic/Hospital (if applicable):_____

Bus. Address:_____
(Street)
_____
(City, State, Zip Code)
License #:_____ MMIS Billing #:_____

Instructions to the Physician:

The patient named above in Part I, Patient Information, has been determined by the _____Certified Home Health Agency as being inappropriate for home care services and requiring placement in a residential health care facility placement (RHCF). Placement proceedings will be initiated unless the patient's physician certifies that the patient's ability to perform the activities of daily living would diminish, if RHCF placement occurs.

If you believe the above named patient's placement in an RHCF would result in the diminishment of the patient's ability to perform the activities of daily living (ADLs), complete the Physician Information Section above and Part III.,B. on the back-side of this form. You must check each ADL in III., B. that would be diminished AND indicate the impact of the RHCF placement on each ADL checked in order for your opinion to be considered. If you do not believe RHCF placement would diminish the patient's ability to perform the activities of daily living, check the statement in Part III.,A. that is located on the back of this form.

After completing Parts II. and III., sign the certification statement located on the back side of this form, and return to the Certified Home Health Agency in the enclosed envelope. If you have indicated that the patient's ability to perform ADLs would diminish as a result of RHCF placement, this form will be forwarded to the RHCF for their review.

Attachment 11

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:_____

Attachment 12

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 physican has indicated on the attached Physician's Certification Form that this patient's ability to perform the activities of daily living (ADL) would diminsh 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:_____

_____