

(MODEL)

AGREEMENT FOR HOSPICE REFERRAL

BETWEEN

_____COUNTY DEPARTMENT OF SOCIAL SERVICES

AND

This agreement is between the _____ County Department of Social Services having its principal office at _____ and _____, a hospice established under Article 40 of the Public Health Law, having its principal office at _____.

WITNESSETH

WHEREAS, according to Social Services Law 367-k and 505.14, each social services district must have a written agreement with every hospice which is available in the district and,

WHEREAS, such agreement must contain procedures for notifying and referring Medical Assistance (MA) recipients to any such hospice,

NOW, THEREFORE, the _____ County Department of Social Services, (the "DISTRICT"), and _____, (the "HOSPICE"), agree that:

FIRST: The DISTRICT must designate a DISTRICT representative to function as liaison between the DISTRICT and the HOSPICE named in this Agreement.

SECOND: The DISTRICT must identify those MA recipients it reasonably expects are appropriate for hospice services. Such identification shall be based on the recipient's medical diagnosis and prognosis as determined and verified by the recipient's primary physician on forms utilized in the DISTRICT's personal care services program.

THIRD: The DISTRICT must, unless medically contraindicated by the recipient's physician, notify the recipient, and/or the recipient's primary caregiver when appropriate, of the availability of hospice services.

FOURTH: When the recipient, or the recipient's primary caregiver, agrees to a referral to the HOSPICE, the DISTRICT will initiate the referral.

FIFTH: The referral must contain:

A. The name and address of the recipient and the recipient's primary caregiver, if any, and;

B. A copy of the physician's order.

SIXTH: The HOSPICE must conduct an assessment based on the rules and regulations of its governing body and in accordance with Department of Health regulations.

SEVENTH: The HOSPICE must, following the assessment, inform the DISTRICT of the results of the assessment.

EIGHTH: The responsibility for case management of any recipients eligible for and accepted into the hospice program must be assumed and retained by the HOSPICE.

NINTH: If, following acceptance into the hospice program, the recipient's needs are such that supplemental services may be provided under the MA program, the HOSPICE and the DISTRICT will complete a joint assessment. Should such supplemental services be appropriate, the HOSPICE must continue to retain case management responsibility.

IN WITNESS WHEREOF, the parties have executed this Agreement.

COUNTY
DEPARTMENT OF SOCIAL SERVICES

DATE: _____

BY: _____

DATE: _____

BY: _____

Physician's Certification Form:

Request for an Exception to Receive Personal Care Services
Based on the Impact of Institutionalization on the Patient's Functioning

Part I: Patient Information

Patient Name: _____ D.O.B. _____

Address: _____

(Street/Apt. #)

(City, State, Zip Code)

CIN/M.A. I.D.#: _ _ _ _ _

Sex: M or F

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 _____ County Department of Social 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 because of RHCF placement.

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 reverse-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 social services district 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.

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 patient's placement in an 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 an 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:_____

Please review Section III., B. of the Physician's Certification Form in conjunction with the attached DSS-4359, Physician's Order for Personal Care Services, complete either Section A or Section B of this form, and return this document in the enclosed self-addressed envelope. Thank you.

