



Coming Home Hospice

115 Diamond Street, San Francisco, CA 94114
(415) 861-1110 FAX: (415) 861-5763

Dear Referral Source,

Please review and complete the following application for admission to Coming Home Hospice. If we are at full capacity at time of referral, the applicant will be placed on a waiting list and the referral source notified.

Please fax or mail application to the intake coordinator at CHH. Our website is www.cpmc.org.

FAX: (415) 861-5763

**Coming Home Hospice
115 Diamond Street
San Francisco, CA 94114
ATTN: CHH Intake Coordinator**

Attached please find a copy of our current criteria for admissions. Feel free to call if you have any questions or concerns regarding the application, criteria, or program. We look forward to serving you.

ACCREDITATION

Coming Home Hospice works with many of the Medicare and Medi-Cal Certified Hospice Agencies in the San Francisco area, and is surveyed by agencies of the state and federal governments, and by the Joint Commission on Accreditation of Healthcare Organizations.

COMING HOME HOSPICE

www.cpmc.org (look under services)

GENERAL INFORMATION

Coming Home Hospice (CHH) is a residential setting where clients with terminal illnesses can receive hospice care and 24-hour attendant care.

CHH is a program of California Pacific Medical Center (CPMC). The VNA or other hospice service provides hospice care and nursing case management in consultation with the client's personal physician and the Hospice Medical Director. Multidisciplinary services, including registered nursing, social worker and other professional services, are provided on an intermittent basis, and may include spiritual counseling, bereavement support, and rehabilitation therapy. 24-hour care is provided by LVNs and/or home care aides with RN and physician services are available on-call 24-hours a day.

CHH is designed to provide 24-hour care in a home-like setting. CHH is not a hospital facility, and patients requiring hospital level of care are not appropriate. Clients are appropriate and eligible for residential hospice placement when they have a prognosis of less than 6 months and have decided in collaboration with their physician to pursue palliative/comfort care only. Admission criteria includes a negative TB skin test, or a chest x-ray that is negative for pulmonary TB. All clients are requested to have legally executed a Durable Power of Attorney for Health Care.

CHH has a multiple fee structure. The client will be charged separately for: (1) room and board; and (2) hospice care, including nursing, social worker and attendant/home care aide. **Charges for room and board are billed directly to the client. Medicare, Medi-Cal and most private insurances will not reimburse for these charges.** Fees for hospice services will be billed to the client's third party payer, or to the client separately. The client is responsible to pay for any portion of the bill not covered by the third party payer.

COMING HOME HOSPICE/VISITING NURSES AND HOSPICE

Coming Home Hospice (CHH) is a beautiful, home-like hospice residence located in the renovated convent of the Most Holy Redeemer Parish in San Francisco's Castro district. The beautiful deck and multiple indoor common areas adorned with stained glass and original art are the result of the dedicated and loving work of the community. During 1985-86, volunteers contributed thousands of hours to the development, fund-raising and renovation that produced CHH. It opened its doors on March 2, 1987 as part of the Hospice Program of Visiting Nurses and Hospice of San Francisco (VN&H). The facility was remodeled in 1998.

CHH provides personalized 24-hour hospice care to clients with AIDS, cancer or other terminal illness. The focus of care is palliative. IV infusions are not provided. CHH is a 15 bed facility with 13 private rooms and one semi-private room. All resident rooms are wheelchair accessible. Meals are served in the dining room or in residents' rooms and our culinary staff will try to accommodate patient requests. There is cable TV, a DVD, and telephone. Other services include laundry services. No smoking is permitted indoors. Friends and family are welcome and encouraged to participate in care of the residents.

Charges for room and board are \$200 per day. Those unable to afford \$200 per day may negotiate another fee prior to admission at Coming Home Hospice. CHH provides a supportive, beautiful and homelike alternative for clients who can no longer remain at home due to progressive illness and need for 24-hour care.

COMING HOME HOSPICE

ELIGIBILITY CRITERIA

Coming Home Hospice is a program of California Pacific Medical Center (CPMC). Only persons who are eligible for admission into a Certified Hospice Program and who meet the following admission criteria will be considered. Persons being followed by any Certified Hospice program will be eligible for admission.

1. **Terminal Illness.** The person must have a diagnosis of AIDS/HIV disease, cancer or other terminal disease. The adult (18 years or above) must be in the terminal phase of his/her illness and have a prognosis of six months or less. The patient and his/her physician must agree that the focus of care is palliative only. The prognosis and focus on palliative care must be confirmed in writing by the primary physician.
2. **Intravenous Medications.** The person will not have requirements for intravenous therapy.
3. **Continuous Care.** The person will not have requirements for continuous 24-hour one-to-one supervision. Should this be necessary, the patient will be financially responsible to hire a sitter or family members may provide this care.
4. **Negative TB Status.** The person must have been certified by an MD to be non-contagious with pulmonary TB within 3 months of admission.
5. **Decubitis.** No person may be admitted with a Stage III or greater decubitis ulcer.
6. **Financial Status.** The resident will be responsible to pay for room and board on a monthly basis. Financial assessment will be completed and reviewed to determine room and board rates.
7. **Other Family Members.** Family members, such as spouses, partners, parents, siblings, children, or friends may not live with the patient at Coming Home Hospice.
8. **Durable Power of Attorney for Finances.** Prior to admission, identification of a durable power of attorney for finances or another responsible party is required to make decisions and to handle pertinent financial matters after admission.
9. **Durable Power of Attorney for Health Care.** Prior to admission, identification of a Durable Power of Attorney for Health Care or another responsible party is requested in order to make critical medical decisions after admission for the resident if he/she is no longer competent to make such decisions.
10. **Illegal Substances.** The person may not have or use illegal drugs while a resident at Coming Home Hospice.
11. **Admission Agreement.** The person, a close family member, Durable Power of Attorney or the identified responsible person must sign the Admission Agreement to Coming Home Hospice.
12. **A Completed Application** must be submitted to CHH to establish status on the waiting list.

COMING HOME HOSPICE

POLICIES FOR RESIDENTS AND VISITORS

Our goal is to provide a safe, supportive and homelike setting for the residents. We also endeavor to promote an atmosphere whereby residents, staff and caretakers alike will be treated with dignity and with respect by one another. You can help accomplish these goals by following the protocols outlined below:

1. VISITING

Please respect the privacy of all residents. You are in their home. The person you are visiting is one of a number of people who live here. A person that you are not visiting may be sleeping, so keep noise to a minimum.

Visitors will be limited to close friends and family. The number of visitors at one time may be limited upon the request of the resident, or at the discretion of the staff. The staff may also use their discretion in requesting that visitors leave if they become disruptive and/or disturb other residents.

Visitors may not stay on the premises unless the resident they are visiting is on the premises as well.

Overnight stay requests are generally approved only if a client is approaching death. These requests, and any other exceptions to the “no overnight” policy, are subject to the approval of House Manager or the Team Leader on site.

Coming Home Hospice is not liable for the loss of personal effects belonging to visitors.

We recommend that personal valuables be maintained in secured areas.

VISITING HOURS ARE: 9:00 a.m. to 9:00 p.m. Other hours can be accommodated as needed.

2. MEALS

All meals are prepared by the staff at CHH. Arrangements may be made on occasion for special food needs.

3. ERRANDS

Shopping and pickup of medications and other personal items are carried out by volunteers when they are available to do so.

4. ALCOHOL AND DRUGS

Alcohol in moderation as directed by resident’s physician is permitted. The residence is illicit drug-free. No drugs of any kind, other than those prescribed by a physician will be allowed in the house. Visitors who do not comply with this policy will be told to leave the house and may not be allowed to make further visits. Abusive use of alcohol or use of illicit drugs by residents may result in eviction from Coming Home Hospice.

All prescribed and over-the-counter medications will be locked up in a separate medication cabinet. The resident will receive medications from the LVN charge nurse on duty.

COMING HOME HOSPICE

5. SAFETY

Some residents may be experiencing dementia or confusion and/or are on medications affecting motor coordination and awareness. Care must be taken to ensure their safety and the safety of other residents. **No smoking is allowed indoors.** Some residents may also require supervised outdoor smoking. When residents leave the house they must be accompanied by a responsible other person.

6. LAUNDRY

While residents are welcome to bring personal linens and towels, both are provided by the facility. Laundry is done on-site by the CHH staff.

7. KEYS AND LOCKING ROOMS

Under no circumstances should anyone go into a resident's room when the resident is not on the premises. In the event of a resident's hospitalization or prolonged absence, CHH staff will only authorize certain individuals (e.g., significant others, family members) to access the resident's room when deemed absolutely necessary. This decision will be done with the resident's express authorization whenever possible. This provision is made for the protection of all residents' belongings in their absence.

Because of personal safety and health care service delivery considerations, residents cannot install their own personal locks on either the outside or the inside of their bedroom doors.

8. IF A RESIDENT DIES

After a resident's death and removal of the body, the resident's room will be closed. No one but the executor, next of kin, or CHH/Hospice nurse or aide should enter. Only those responsible parties, as designated by the resident, will be permitted to enter the resident's room for the purpose of packing and removing personal belongings. It is expected that belongings are removed from the facility after the resident is discharged.

9. CONDITIONS FOR DISCHARGE FROM CHH

- a) Psychiatric emergency.
- b) Failure of progression of illness after evaluation of the Hospice team and adhering to the hospice benefit.
- c) Behavioral management issues.

10. PERSONAL SPENDING MONEY

Residents may keep no more than \$30.00 cash on hand for incidental personal expenses. Personal money, cash or travelers checks, should be locked in the nurse's office and be obtained from the Team Leader.

Name: _____

COMING HOME HOSPICE

ADMISSION PROCEDURE CHECKLIST

Please check as completed:

1. Patient has met all eligibility criteria.
2. The following information **must be complete** in order to place the patient on the waiting list and consider him/her for admission:
 - Formal referral with a doctor's order to start care. Please call the Coming Home Hospice Intake Coordinator at (415) 861-1110.
 - Admission Application, Pages 12&13; H & P with current medication list; related consults; related Nursing Progress Notes; behavior issues of concern; and any specific social concerns.
 - Written confirmation of the name, address and phone number of an immediate family member or durable power of attorney for health care, and/or for finances, whenever possible; including a copy of the forms appointing the power(s) of attorney.
 - The Adjusted Net Income Worksheet, Page 8.
 - Responsibility for Finances, Page 9. If the patient can not afford the Room & Board fee, please contact the Social Worker at Coming Home Hospice.
 - Written confirmation of a chest x-ray taken within 3 months of admission to CHH that shows no evidence of pulmonary tuberculosis. (A PPD may be acceptable for persons with intact immune systems.) If the person has pulmonary TB, written confirmation of at least 2 weeks of treatment and three consecutive negative AFB smears is required, Page 10.
 - Admission Agreement signed by the patient, a close family member or a Durable Power of Attorney, Pages 11-12.
 - Medical guidelines for determining prognosis in selected non-cancer diseases.

3. Mail or fax application to:

CHH Intake Coordinator
Coming Home Hospice
115 Diamond Street
San Francisco, CA 94114
FAX to (415) 861-576

COMING HOME HOSPICE

FINANCIAL INFORMATION/ASSESSMENT

Residence Charges:

Each hospice resident has a double fee structure.

- A. All residents will be charged a fee payable directly to Coming Home Hospice which includes rent, care, meals and certain support services. The resident or his/her designated responsible other is responsible to pay charges every month. Generally, third party payer sources (insurance) do not reimburse for the above charges.
- B. Medical services provided by the hospice team of Sutter Care at Home or other Hospice agency and costs for medications and equipment and other medical services will be charged to the resident's third party payer source. The resident is responsible for the portion of the bill that the third party payer source does not pay.

Coming Home Hospice: Room and Board charges are \$200 per day. If the resident is unable to pay \$200 per day, a daily rate must be negotiated with the Director at Coming Home Hospice before admission.

The Adjusted Net Income Worksheet - Determination of Fees

Instructions

Note the following information on the worksheet.

- Income sources, such as supplemental security income, social security, pensions, interest, and dividends.
- Assets: such as checking, savings, stocks and bonds, real estate holdings, life insurance, etc.
- Expenses that will be ongoing once the patient is living at Coming Home Hospice; this excludes housing, utilities, and food costs. Be sure to include ongoing medical expenses, insurance, medical share-of-cost, etc.

COMING HOME HOSPICE

ADJUSTED NET INCOME WORKSHEET

Applicant's Name: _____ Social Security Number: _____

To be used for determination of residence charges.

<u>MONTHLY INCOME SOURCE</u>	<u>AMOUNT</u>	<u>ASSETS ITEM</u>	<u>*MONTHLY EXPENSES AMOUNT</u>	<u>ITEM</u>	<u>AMOUNT</u>
SSI	_____	Savings	_____	Physicians	_____
SSA	_____	Checking	_____	Prescriptions	_____
State Disability Ins.	_____	Stocks/Bonds	_____	Medical Transp.	_____
Private Disability Ins.	_____	Real Estate**	_____	Health Insurance _____ (Include Medical Share of Cost)	
Retirement/Pension	_____	Dividends	_____	Life Insurance	_____
Rental Income	_____	Life Ins.	_____	Other _____ (Describe)	_____
Salary	_____	Other	_____		
Other	_____				
TOTAL	\$ _____	TOTAL	\$ _____	TOTAL	\$ _____

**Does not include family home. *Exclude housing, food, utilities, etc.

COMING HOME HOSPICE

REGISTRATION and RESPONSIBILITY FOR FINANCES FORM

Patient Name _____ MR# _____

The rate for room and board for my stay at Coming Home Hospice is \$ _____ per day, starting on _____. Please send all billing for payment of room and board charges for my stay at Coming Home Hospice to _____ who is my **(1) next of kin, (2) Durable Power of Attorney for Finance, (3) executor of my estate** (Circle all that are appropriate).

The following information is provided to assist the agency with the billing process:

PATIENT:

Name _____ Admit Date _____

Date of Birth _____ SSN _____

Street Address _____

City, State, Zip _____

Physician's Name _____

Diagnosis _____

RESPONSIBLE PARTY TO SEND BILL TO:

Guarantor Name _____ SSN _____

Street Address _____

City, State, Zip _____

Cell Phone _____ Home Phone _____

Patient Signature _____
(Date)

Guarantor Signature _____
(Date)

For billing questions, please call 415-861-1110, and ask for the CHH Intake Coordinator.

ADMISSIONS PLEASE NOTE: USE #30291 COMING HOME HOSPICE-COMMUNITY BENEFIT.

COMING HOME HOSPICE

DOCUMENTATION OF PULMONARY TUBERCULOSIS STATUS

Applicant's Name: _____ Social Security#: _____

People infected with HIV, and people living in group residential facilities are considered to be at high risk for pulmonary tuberculosis. In order to protect patients and staff, the following documentation is required:

Patient is HIV Negative

PPD Date: _____ Negative Positive
(Within 3 months)

If PPD positive,

CXR Date: _____ Negative Positive
(Within 3 months) (For Pulmonary TB) (For Pulmonary TB)

Patient is HIV Positive

CXR Date: _____ Negative Positive
(Within 3 months) (For Pulmonary TB) (For Pulmonary TB)

In either case, if patient has active pulmonary TB, patient must have received continuous treatment for at least 2 weeks and show 3 consecutive negative AFB smears prior to admission.

Date treatment started: _____

Date of negative AFB's: 1. _____ 2. _____ 3. _____

Attending Physician _____
Signature Physician CA License

Date _____ Physician (Please Print) _____

Street Address _____

City, State, Zip _____

Office Phone _____ Pager/Cell _____

Fax _____

COMING HOME HOSPICE

ADMISSION AGREEMENT

Applicant's Name: _____ Social Security#: _____

____ I, the above named individual, request admission to Coming Home Hospice checked below and I acknowledge, consent, and agree to the following:

Or

____ I, the DPOA and/or the member of the immediate family for the above named applicant, request his/her admission to Coming Home Hospice checked below and agree to the following:

(Please check each statement)

- 1. As the resident, I ask that my family/friends respect my choice for palliative care at Coming Home Hospice.
- 2. I understand that the care provided at Coming Home Hospice is palliative, not curative, in its goals and techniques; that the program emphasizes the alleviation of physical symptoms, including pain, and the identification and meeting of emotional and spiritual needs which I, the resident and my family/friends may experience related to my illness.
- 3. I understand that medical and professional nursing services are provided by Sutter VNA & Hospice, or other Hospice agency in consultation with my physician. These services include 24-hour home care aides, medical social workers, regular visits made by registered nurses and 24-hour on-call nurses and physician for emergencies. I understand that admission to Coming Home Hospice is dependent upon admission to certified hospice services.
- 4. I understand that if my need for medical or nursing care should at any time exceed those services able to be provided by CHH staff or through the certified hospice agency, or if my condition should stabilize to the point where hospice services are no longer appropriate, I will be discharged from Coming Home Hospice and transferred to home or another appropriate facility.
- 5. I understand that conditions for discharge from Coming Home Hospice could include: a) a psychiatric emergency, b) failure of progression of illness, and c) behavioral management issues.
- 6. I understand that should I need 24 hour one-to-one supervision, I will need to provide a sitter or have this service provided by a family member.
- 7. I give consent and approval for notation to be made both on the records of Coming Home Hospice and the certified hospice service regarding the care provided at Coming Home Hospice.
- 8. I give consent and approval for the release of information and appropriate medical records to or from any health care provider or organization involved with my care.
- 9. Prior to admission, I understand that I am required to be screened by my physician for pulmonary tuberculosis (TB). This is in compliance with recommendations of the San Francisco City & County Department of Public Health. I understand that if the screening shows that I have active TB, I must start on effective medical treatment prior to admission and continue that treatment during my stay.

Applicant's Name: _____ Social Security#: _____

- 10. I understand that I am requested, prior to admission to Coming Home Hospice, to have and submit a copy of a Durable Power of Attorney for Health Care and a Durable Power of Attorney for Finances.

- 11. Coming Home Hospice has a double-fee structure.
 - A. All residents will be charged a fee payable to Coming Home Hospice which includes rent, meals and certain support services. I understand that it is my responsibility, or that of my designated responsible other, to make payments every month, using my funds, and that failure to make such payments may result in discharge from Coming Home Hospice. Generally, third party payer sources do not reimburse for the above charges.

 - B. Medical services provided by the Sutter VNA and Hospice or other certified hospice service and costs for medications and equipment and other services will be charged to my third party payer sources or will be billed separately to me. I understand that I am responsible to pay for that portion of the bill that my third-party payer source does not pay.

- 12. I understand that Coming Home Hospice may include both private and semi-private rooms and that assignment will be based on need and availability. I agree to being assigned or transferred to other rooms as necessary. Fees are the same for private and semi-private rooms.

- 13. I understand that smoking is not permitted inside Coming Home Hospice. Outside areas are provided for this purpose.

- 14. I understand that I may drink alcohol in moderation as directed by my physician and that abuse of alcohol or disruptive behavior may result in discharge from Coming Home Hospice.

- 15. I understand that I am not permitted to keep or use weapons and/or illegal drugs of any kind at Coming Home Hospice.

- 16. I understand that visitors may be limited at any time at my request, and that visitors will be asked to leave at any time if they become disruptive and/or disturb other residents.

- 17. I understand that I may voice my concerns regarding the care provided at Coming Home Hospice in writing to the Manager of Coming Home Hospice and/or the Director of the hospice.

- 18. I understand that my home address will become the address of Coming Home Hospice. I hereby authorize services to be provided to me at CHH and accept full responsibility for payment of such services.

My signature acknowledges that I understand all of the above and that I have been given ample opportunity to ask questions concerning Coming Home Hospice, the care provided, related charges, and complaint procedures.

Applicant

DPOA/Immediate Family Member

Signature

Date

Signature

Date

Print Name

Print Name

Relationship

ADMISSION APPLICATION
Facility: COMING HOME HOSPICE

Reference Date: _____

Referred By: _____

Name	Agency/Facility	Title
Phone	Pager	Fax



Name _____ Social Security # _____ In need of Immediate Placement? Yes No

Street _____ Apt. # _____ City _____ State _____ Zip _____ Phone _____

Currently at: Home Hospital (Room# _____) Other _____

/ / / /

Facility/Hospital	Contact	Title	Phone	Pager
/	/	/	/	/

Home Care Agency	Contact	Title	Phone	Pager
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DEMOGRAPHICS:

Male Female

DOB _____ Age _____ Ethnicity _____ Religion _____ Primary Language(s) _____ Sexual Orientation _____



Medical Diagnoses and Dates: _____

Recent Surgeries and Dates: _____

Current Infusions: _____

Psychological History and Dates: _____

Substance Abuse History and Dates: _____

Relevant Personal History: _____

Relevant Personal History: _____

Relevant Personal History: _____



Symptoms: Difficulty Swallowing Difficulty Breathing Pain Nausea/Vomiting Diarrhea Rash/Itching

Treatment: Radiation Infusion Wound Care Oxygen Other _____

Mobility: Independent Assistance Wheelchair Bed Bound

Toileting: Independent Assistance Incontinent Bladder Incontinent Bowel Foley Catheter

Mental State: Clear/Oriented Short-term Memory Loss Confused Mild Dementia Severe Dementia

Smoker: Yes No

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Primary Physician Name	Office Phone	Pager	Fax
Street	City	State	Zip
Secondary Physician: (RN, PA, or NP)	Office Phone	Pager	Fax
Name	City	State	Zip
Psychiatrist/Therapist:	Office Phone	Pager	Fax
Name	City	State	Zip

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Medicare #: _____ MediCal #: _____

Private Insurance: _____

Company Name	Contact	Phone
Street	City	State Zip
Policy#	Group ID#	Individual ID#
Case Manager	Phone	Employer Phone
Responsible Party	Phone	

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Health Care (Attach Copy)

Name	Work Phone	Home Phone
Street	City	State Zip

Finances (Attach Copy)

Name	Work Phone	Home Phone
Street	City	State Zip

Executor (Attach Copy)

Name	Work Phone	Home Phone
Street	City	State Zip

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1. _____

Name	Relationship
Street	City State Zip Home Phone Work Phone

2. _____

Name	Relationship
Street	City State Zip Home Phone Work Phone

3. _____

Name	Relationship
Street	City State Zip Home Phone Work Phone

COMMENTS