Ball Memorial Hospice supports the concept of family/community oriented health care and is committed to the premise that all individuals and families have the right to self-determination and to achieve their maximum potential. As part of these goals, Ball Memorial Hospice recognizes that patients and their families have a number of rights. These rights include: participation in health care decisions and planning of future actions, obtaining high quality health care, care in the process of dying, assistance in achieving and maintaining comfort and human dignity and upon request, an itemized statement of services and supplies delivered to the patient, as submitted to the patient's payor.

In meeting a patient's health-related goals and ensuring his or her maximum comfort and dignity, Ball Memorial Hospice provides the following Core Services:

a) Physician services;
b) Nursing services;
c) Medical social services; and,
d) Counseling services

Other services provided by Ball Memorial Hospice are as follows:

a) Physical therapy;
b) Occupational therapy;
c) Speech-language therapy;
d) Home health aide;
e) Homemaker;
f) Volunteers;

As part of its mandate for patient care, Ball Memorial Hospice can also provide certain medical supplies to patients, based on physician's orders and the patient's plan of care. Listed below are those supplies that Ball Memorial Hospice is able to provide, when appropriate:

1) durable medical equipment
2) oxygen
3) mouthcare kits
4) wound care supplies
5) anchored catheters and maintenance supplies
Generally, these supplies are available to a patient either through pick-up or delivery to the home. How the supplies will be made available will depend on the type of supply and the need of the patient, and will be agreed to between the Ball Memorial Hospice and the patient before the provision of services and supplies begins.

All services and supplies shall be dispensed to the patient based solely on that individual's needs and pursuant to a physicians orders, and a patient has the right to refuse any component of the hospice’s services or supplies.

If a patient, his/her caregiver/legal representative disagrees with a service provided or action taken by Ball Memorial Hospice, or if an individual wishes to register a complaint regarding the quality or nature of the care and/or supplies received, a Complaint form can be obtained from Ball Memorial Hospice. This form should be completed and returned to the manager of Ball Memorial Hospice. A complaint may also be registered by calling the Hospice toll free number at 1-877-824-6918.

Once the manager receives the formal complaint, he/she will initiate an internal investigation into the matter and based upon that investigation will write a brief report of the allegations, whether those allegations were substantiated and what action, if any, the Hospice will take as a result.

If an individual disagrees with the findings or actions taken, he/she may appeal the issue to the Administrative Director of Cancer Services. The findings and actions will be reviewed and a written statement will be issued either confirming the initial findings or reversing the findings and ordering new actions to be taken. If the individual disagrees with the findings, he/she may appeal it in writing to the Cardinal Health System Corporate Compliance Committee.

Ball Memorial Hospice is part of a regulated community, overseen by the Indiana State Department of Health. Any questions or complaints that are not addressed to an individual's satisfaction by Ball Memorial Hospice may be addressed by calling the Indiana State Department of Health's toll-free number. 1-800-227-6334.
Declaration made this __________ day of __________________________ (month, year).

I ____________________________________________________________________________, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease, or illness; (2) my death will occur within a short time; and (3) the use of life prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialling or making your mark before signing this declaration):

____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

Signed: __________________________

City/County/State of Residence __________________________

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness __________________________________ Date ______________________

Witness __________________________________ Date ______________________
I understand that by signing this form I am electing to receive Hospice Care.

I understand that:

1. My illness is considered progressive and no longer curable by my attending physician, and he/she has recommended Hospice Care.

2. Home visits and care by the Hospice physician, professional nurses, and/or others as may be appropriate, will be provided as often as necessary to permit freedom from pain, discomfort, anxiety, and other disturbing symptoms of my illness. I understand Hospice Care is not intended to be curative but is palliative and intended to alleviate, to the extent possible, symptoms connected with my illness.

3. By signing this election form requesting Hospice Care, I am entitled to Hospice Care in sequence of election periods.

   These periods are as follows:
   
   - First Benefit Period ............... 90 days
   - Second Benefit Period ............. 90 days
   - Third Benefit Period ............... unlimited 60-day periods

   Care will be evaluated at the end of each period.

4. I understand that this election is continuous through the benefit periods and that I can choose to cancel this benefit in writing at any time. I understand that if I cancel/revoke my benefit, I will then forfeit any days remaining in the benefit period. For example, if I cancel my Hospice Medicare benefit after the first 10 days, I will give up the remaining 80 days in that benefit period.

5. By electing Hospice Care, I waive Hospice Care by any other Hospice than Ball Memorial Hospice and all other Medicare Services related to the treatment of my disease process by any other agency or institution.

6. Ball Memorial Hospice will attempt to assure the continuity of my care in the home, as an outpatient, and for inpatient Hospice Care.

7. Hospice inpatient care/respite care will be provided at Ball Memorial Hospital. Transfer to inpatient Hospice Care will be made only with the consent of the patient/caregiver, attending physician, and Hospice Medical Director.

8. All Hospice services will be provided only with the express authority of Ball Memorial Hospice.

9. I understand I have the right to and can continue seeing my attending physician, and I will continue whatever payment arrangement I currently have with my physician. I understand that I still have the right to treatment or therapy for any condition unrelated to my disease process.
10. Ball Memorial Hospice will, within the limits of its resources, provide emotional, social, and spiritual support to my caregivers and others closely involved in my life.

11. There will be a weekly conference regarding my care in terms of my physical, emotional, social, and spiritual needs.

12. I have been given the opportunity to ask questions about my care by Ball Memorial Hospice and all questions have been answered to my satisfaction.

13. I accept the conditions of Ball Memorial Hospice as described, with the understanding that I may withdraw my consent to continue Hospice Care at any time.

14. All treatment and therapy decisions will be made with the consent of the patient/caregiver, attending physician, Hospice Medical Director, and Interdisciplinary Team.

15. I understand that my medical record will remain confidential and that it will not be released unless my permission is given.

16. I understand the Hospice Services available to me through Ball Memorial Hospice include:
   A. Nursing Services including Home Health Aides.
   B. Physician Services - by attending physician and the Ball Memorial Hospice Medical Director as consultant as appropriate.
   C. Medical Social Services
   D. Counseling/Pastoral Services.
   E. Physical Therapy - Speech Therapy - Occupational Therapy.
   F. Volunteer Services
   G. Bereavement Services.

(Patient or Legal Representative)

(Ball Memorial Hospice Representative)

12-9-04  
(Date of Election)
**Goals for Care:**
- Effective and safe personal care
- Client clean, comfortable
- Other (specify)

**Directions to Home:**
Yorktown, turn (L) at Main & Gas Station 500
Come to (T) turn (R) on 400 S 3rd
Hour on the (T)

---

### CLIENT INFORMATION

<table>
<thead>
<tr>
<th>Lives Alone</th>
<th>Lives with</th>
<th>Urinary Catheter</th>
<th>Urinary Catheter</th>
<th>Urinary Catheter</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Walter &amp; Janet</td>
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<td>Colostomy</td>
<td>Urostomy</td>
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<tr>
<td></td>
<td></td>
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<td>Denture</td>
<td>Upper</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>Partial</td>
<td>Partial</td>
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</table>

**Diagnosis:**
Renal Disease

**Allergies:**
PCN

**Functional Limitations:**
- Amputee
- Prosthesis
- Incontinent Bowel / Bladder
- Paralysis
- Contracted
- Right
- Left
- Partial Weight Bearing
- Left
- Non Weight Bearing
- Hearing Deficit
- Hearing Aid
- Poor Endurance
- Dyspnea
- Ambulation Difficulties
- Speech / Communication Deficit
- Vision Deficit
- Legally Blind
- Glasses
- Contacts
- Other

**Activities Permitted:**
- Up as tolerated
- Bedrest with BRP's
- Independent in the home
- Crutches / Cane / Wheel Chair / Walker
- Transfers
- Hoyer Lift
- 2 People Transfer

**Mental Status:**
- Oriented
- Disoriented
- Forgetful
- Confused
- Agitated
- Depressed
- Lethargic
- Comatose
- DNR

**Symptoms for HHA's to watch for that may occur due to client's diagnosis (Report to Office):**

---

**Emergency Contact:**
- Walter or Janet Rubins
- Phone #: 759-9331

**Special Instructions:**

---

**Date Careplan Communicated to Aide:** 10/9/04

**Careplan left in the home:**
- Yes
- No

---

1st Call Home Health & Hospice
1-800-354-1247

HHA / PCA / HMA CAREPLAN Information page 1
MRH003 (06/03)
<table>
<thead>
<tr>
<th>BATH</th>
<th>HYGIENE / GROOMING</th>
<th>ACTIVITY</th>
<th>HOUSEKEEPING</th>
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<tbody>
<tr>
<td>10 Complete Bath or Shower</td>
<td>12 Shampoo/Hair Care</td>
<td>60 Assist with Mobility</td>
<td>80 Make/Change Bed</td>
</tr>
<tr>
<td>11 Partial Bath</td>
<td>13 Oral Care</td>
<td>61 Range of Motion/Exercise/Walk</td>
<td>81 Laundry</td>
</tr>
<tr>
<td></td>
<td>14 Perineal Care</td>
<td>62 Assist with Mobility Devices</td>
<td>82 Light Housekeeping</td>
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<tr>
<td></td>
<td>15 Shave/Groom/Deodorant</td>
<td>63 Apply Assist Ortho Devices</td>
<td>83 Shopping once a week or errands</td>
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<tr>
<td></td>
<td>16 Nail or Foot Care</td>
<td>64 Turning and Positioning</td>
<td>84 Transport</td>
</tr>
<tr>
<td></td>
<td>17 Skin Care</td>
<td>65 Transfer using Assist Devices</td>
<td>85 Diversional Activity or Companion</td>
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<td>66 Transfer Assist</td>
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<tr>
<td></td>
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</tr>
<tr>
<td>30 Remind to take meds</td>
<td>40 Prepare Meal or Snack</td>
<td>90 Called Office</td>
<td></td>
</tr>
<tr>
<td>31 T P R</td>
<td>41 Offer Fluids</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>42 Assist with Feeding or Fed</td>
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</table>

**ELIMINATION**

- 50 Assist with Elimination
- 51 Cath Care
- 53 Empty/Assist with Ostomy

**NUTRITION**

- 40 Prepare Meal or Snack
- 41 Offer Fluids
- 42 Assist with Feeding or Fed

**PAYOR SOURCE, FREQUENCY**

- Private Duty HHA
- Private Duty HMA
- Intermittent HHA
- Hospice HHA
- Contracted Hospice HHA

**CLIENT LABEL**

1st Call Home Health & Hospice
1-800-354-1247

HHA / PCA / HMA CAREPLAN page 2
MRH003B (06/03)
**Hereafter referred to as “the Company”**

<table>
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<tr>
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<td>W3590371</td>
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<td>ROBBINS, NORMA</td>
<td>TRUCK</td>
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<td></td>
<td></td>
<td>12/09/04</td>
<td>8400 WEST 400 SOUTH</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>YORKTOWN</td>
<td>IN 47396</td>
</tr>
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</table>

**INSURANCE**

Primary:
- **HIC#**
- **EFF. DATE**
- **PHYSICIAN**
- **Phone:** (765) 759-9331
- **Emergency**
- **Phone:** (111) 111-1111
- **LHR/DAY**
- **HT/WT.**

Secondary:
- **HIC#**
- **EFF. DATE**

**PURCHASE ORDER**

<table>
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<tr>
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<td>NEW SETUP APP</td>
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<tr>
<td>1 EA</td>
<td>M102100</td>
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**SET UP APP**

*----- DELIVERY -----*

*** 1 MONTH RENTAL OF ***

**APP PUMP AND PAD STANDARD**

**1 EA M013741 ALTERNATING PRESSURE PUMP & PAD**

**SERIAL#: H0103**

**MODEL#:**

**MANUF.**

*** SALE OF ***

**ALTERNATING PRESSURE PADS AIRFL**

**MODEL#: PAF-655**

**57.45**

**57.45**

**0.00**

---

**By signing this document you are acknowledging that you have read and agreed to the additional terms on the back of this document.**

**Beneficiary’s Name**

**Representative’s Name**

**Reason Beneficiary Cannot Sign**

**Representative’s Address**

**Beneficiary (or Parent/Guardian/Agent) Signature**

**Date**

**Relationship to Beneficiary (if applicable)**

**Technician Initials**

**I have not changed insurers nor joined a Medicare managed care program in the last 90 days.**

**Signature:**

---

**IMPORTANT: RETURN THIS PORTION WITH YOUR PAYMENT TO ENSURE PROPER CREDIT**

**BRANCH:** 0613

**WORK ORDER:** W3590371

**INVOICE REF:**

**PARTIAL PAYMENT WILL NOT BE ACCEPTED. PAYMENT IS EXPECTED IN FULL.**

**AMOUNT DUE:**

**PAYMENT DUE BY:** 12/09/04

**AMOUNT PAID:**

**CHECK □ VISA □ M/C □ DISCOVER □**

**CARD #:**

**EXPIRATION DATE:**

**SIGNATURE X**

---

**CUSTOMER**

**PLEASE REMIT PAYMENT TO:**

**APRIA HEALTHCARE INC**

**1703 SOLUTIONS CENTER**

**CHICAGO**

**IL 60677**

**(317) 865-4200**

**ACCOUNT:** AIU558

**CONTACT:** 12/09/04 13:37:32

---

**OPS 0017 (Rev. 02/03)**
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<td></td>
<td></td>
<td>MANUF: GAYMAR INDUSTRIES</td>
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**SUB-TOTAL:**
- submerged:
  - total: $57.45

**STATE TAX:**
- 3.45

**TOTAL:**
- 60.90

Thank you, Jim

---

**Beneficiary’s Name**

**Representative’s Name**

**Reason Beneficiary Cannot Sign**

**Beneficiary’s Address**

**Date**

**Relationship to Beneficiary**

**Technician Initials**

---

I have not changed insurers or joined a Medicare managed care program in the last 90 days.

Signature:

---

**CUSTOMER**

**PLEASE REMIT PAYMENT TO:**

ROBBINS, NORMA
8400 WEST 400 SOUTH
YORKTOWN IN 47396

APRIA HEALTHCARE INC
1703 SOLUTIONS CENTER
CHICAGO IL 60677
(317) 865-4200

ACCOUNT: AIUS58
CONTACT: AIUS58

12/09/04 13:37:32

**SIGNATURE:**

---

**CUSTOMER COPY**
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<td>Norma Robbins</td>
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<tr>
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**INSURANCE**

Primary:
- HIC#:
- Eff. Date:

Secondary:
- HIC#:
- Eff. Date:

**PURCHASE ORDER**

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**INVOICE**

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**ACCOUNT:**

**CONTACT:**

**PLEASE REMIT PAYMENT TO:**

**CUSTOMER COPY**