Interior Health

COMMUNITY HOSPICE BED (CHB) AGREEMENT

Palliative Care and End of Life Services

Name *(last)* _____

(first) _____

DOB *(dd / mm / yyyy)* _____

PHN _____ MRN _____

Account / Visit # _____

The purpose of this form is to provide information to you and substitute decision makers (SDM) about Community Hospice Bed (CHB) services, including the cost of care and agreement to pay the rate for the length of the stay.

Community Hospice Beds are adult, palliative beds intended for **short-stays** *(up to 3 months)*. They may be found in a free standing hospice or long-term care home. They are used for **palliative respite**, to **manage symptoms**, and to **support end of life care**.

Client / SDM Initial: _____

Criteria to be eligible for access to a CHB:

- Registered with Interior Health Palliative Care Services.
- Registered for BC Palliative Care Benefits which cover the cost of most palliative medications.
- Agree goals of care will aim for comfort, dignity and quality of life, and be planned in partnership with you, your family and the health care team.
- A Medical Orders for Scope of Treatment (MOST) form is completed with an M designation.

When a CHB is required:

- You or your SDM (if you are unable) must provide consent for the admission.
- A request for admission will be made on your behalf.
- You or your SDM will be notified when a bed is available.
- You or your SDM will plan for transfer to the available CHB by private vehicle, or non-emergency transfer services.
- While in a CHB your condition will be assessed regularly by your health care team.
- If your condition stabilizes and the CHB setting is no longer suitable, a discharge plan will be developed to meet your care needs which **may include** going home with community supports *or* permanent admission to a long-term care home if discharge home is not possible. These services will require a financial assessment.

Client / SDM Initial: _____

You and / or your SDM are agreeing to:

- Sign applicable payment forms upon admission to the CHB facility.
- Pay costs of medications not covered by the BC Palliative Benefits.
- Pay all transportation costs.
- Pay the provincial CHB rate $ _____ per day, not to exceed $ _____ per month while _____ is admitted.
  If this rate causes serious financial hardship (e.g. unable to afford this and maintain the family home), a Temporary Rate Reduction (TRR) can be requested through your care manager. TRR applications are based on financial assessment, and are effective the day all required documentation is provided to support your application.
  ☐ TRR initiated

Client / SDM Initial: _____

I (Individual / SDM) _____ agree to pay the CHB rate noted above for

(name of individual) _____

Signature _____ Date _____

Address of person responsible for payment of services (for billing purposes) (**cannot be address of CHB**):

_____

Clinician Name	Clinician Signature	Date (dd / mm / yyyy)

Clear Form Print Form

Permanent part of the health record