

BALL MEMORIAL HOSPICE

DISCLOSURE STATEMENT

Patient Name: Norma Robbins Date: 12-9-04

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.

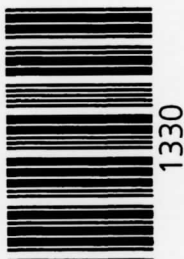
Signed: _____

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 _____



BALL MEMORIAL HOSPITAL, INC.
2401 University Avenue
Muncie, Indiana 47303-3499

LIVING WILL DECLARATION
(Indiana Code 16-36-4-10)

Case Management
SS-7
(05/04)

Patient Sticker

OR / PROCEDURE REPORTS	HISTORY & SCREEN	EDUC/DISCHARGE PLAN OF CARE	SOCIAL SERV DISCHARGE PLAN	MISCELLANEOUS NURSING	ADMISSION PAPERS	MISCELLANEOUS
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Ball Memorial Hospice
HOSPICE MEDICARE BENEFIT ELECTION CONSENT FORM

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.



BALL MEMORIAL HOSPITAL, INC.
2401 University Avenue
Muncie, Indiana 47303-3499

**HOSPICE MEDICARE BENEFIT
ELECTION CONSENT FORM**

Department of Hospice
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(02/00)

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.

X Walter C. Rophus
(Patient or Legal Representative)

Jennifer L. Jacobson
(Ball Memorial Hospice Representative)

12-9-04
(Date of Election)

BALL MEMORIAL HOSPITAL, INC.
2401 University Avenue
Muncie, Indiana 47303-3499

**HOSPICE MEDICARE BENEFIT
ELECTION CONSENT FORM**

Department of Hospice
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(4/97)

Norma Robbins 8400 W 400 S YORKTOWN IN 47396

<input type="checkbox"/> Intermittent HHA <input checked="" type="checkbox"/> Hospice HHA <i>3XWK Mon..</i> <input type="checkbox"/> Contracted Hospice HHA <i>WED, FRI</i>	<input type="checkbox"/> Private Duty HHA _____ <small>PAYOR SOURCE, FREQUENCY</small> <input type="checkbox"/> Private Duty HMA _____ <small>PAYOR SOURCE, FREQUENCY</small>
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Goals for Care:

<input type="checkbox"/> Effective and safe personal care	<input checked="" type="checkbox"/> Client clean, comfortable
<input type="checkbox"/> Other (specify) _____	

Directions to Home: *YORKTOWN turn (L) at Mon & Gas Station 550
Come to T turn (L) on 400 S 3rd
House on the (L)*

CLIENT INFORMATION

<input type="checkbox"/> Lives Alone <input checked="" type="checkbox"/> Lives with <i>Walter & Janet</i> <input type="checkbox"/> Urinary Catheter <input type="checkbox"/> Colostomy <input type="checkbox"/> Urostomy <input checked="" type="checkbox"/> Denture <input type="checkbox"/> Upper <input checked="" type="checkbox"/> Lower <input type="checkbox"/> Partial	<input type="checkbox"/> Diet (specify) _____ <input type="checkbox"/> Feeding tube <input type="checkbox"/> O ₂ _____ L / NC / Mask <input type="checkbox"/> IV / Location: _____ R / L <input type="checkbox"/> Seizure Precautions
Diagnosis: <i>Renal Disease</i>	Allergies: <i>PCN Sulfa Phenergan</i>

Functional Limitations: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Amputee <input type="checkbox"/> Incontinent Bowel / Bladder <input type="checkbox"/> Contracted <input type="checkbox"/> Partial Weight Bearing <input type="checkbox"/> Non Weight Bearing <input type="checkbox"/> Hearing Deficit <input checked="" type="checkbox"/> Poor Endurance <input type="checkbox"/> Ambulation Difficulties <input type="checkbox"/> Speech / Communication Deficit <input checked="" type="checkbox"/> Vision Deficit <input type="checkbox"/> Legally Blind <input checked="" type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Other _____ </div> <div style="width: 50%;"> <input type="checkbox"/> Prosthesis <input type="checkbox"/> Paralysis <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Dyspnea </div> </div>	Activities Permitted <input type="checkbox"/> Up as tolerated <input checked="" type="checkbox"/> Bedbound <input type="checkbox"/> Bed rest with BRP's <input type="checkbox"/> Independent in the home <input checked="" type="checkbox"/> Crutches / Cane / Wheel Chair / Walker <input type="checkbox"/> Transfers <input type="checkbox"/> Hoyer Lift <input type="checkbox"/> 2 People Transfer _____ Mental Status <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input checked="" type="checkbox"/> Oriented <input type="checkbox"/> Forgetful <input type="checkbox"/> Agitated <input checked="" type="checkbox"/> Lethargic </div> <div style="width: 50%;"> <input type="checkbox"/> Disoriented <input type="checkbox"/> Confused <input type="checkbox"/> Depressed <input type="checkbox"/> Comatose </div> </div> <input checked="" type="checkbox"/> DNR
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Symptoms for HHA's to watch for that may occur due to client's diagnosis (Report to Office)

Emergency Contact: <i>Walter or Janet Robbins</i>	Phone #: <i>759-9331</i>
Emergency Contact: _____	Phone #: _____
Emergency Contact: _____	Phone #: _____
Special Instructions:	Date Careplan Communicated to Aide: <i>12/9/04</i> Careplan left in the home <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

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

Norma Robbins 8400 W 4605 Yorktown IN 47396

<input type="checkbox"/> Intermittent HHA 759-9331 <input checked="" type="checkbox"/> Hospice HHA DOB 10/13/19 SS# 305141338 <input type="checkbox"/> Contracted Hospice HHA	<input type="checkbox"/> Private Duty HHA _____ PAYOR SOURCE, FREQUENCY <input type="checkbox"/> Private Duty HMA _____ PAYOR SOURCE, FREQUENCY
BATH <input checked="" type="checkbox"/> 10 Complete Bath or Shower SPECIAL INSTRUCTIONS: bed ✓ shower ✓ sponge ✓ <input checked="" type="checkbox"/> 11 Partial Bath <input checked="" type="checkbox"/> per client request	ACTIVITY <input checked="" type="checkbox"/> 60 Assist with Mobility <input checked="" type="checkbox"/> per client request <input type="checkbox"/> 61 Range of Motion/Exercise/Walk <input type="checkbox"/> per client request <input checked="" type="checkbox"/> 62 Assist with Mobility Devices <input checked="" type="checkbox"/> per client request <input type="checkbox"/> 63 Apply Assist Ortho Devices <input type="checkbox"/> per client request <input checked="" type="checkbox"/> 64 Turning and Positioning <input checked="" type="checkbox"/> per client request <input checked="" type="checkbox"/> 65 Transfer using Assist Devices <input checked="" type="checkbox"/> per client request <input checked="" type="checkbox"/> 66 Transfer Assist <input checked="" type="checkbox"/> per client request
HYGIENE / GROOMING <input checked="" type="checkbox"/> 12 Shampoo / Hair Care <input type="checkbox"/> per client request <input checked="" type="checkbox"/> 13 Oral Care <input type="checkbox"/> per client request <input checked="" type="checkbox"/> 14 Perineal Care <input type="checkbox"/> per client request <input checked="" type="checkbox"/> 15 Shave/Groom/Deodorant <input type="checkbox"/> per client request <input checked="" type="checkbox"/> 16 Nail or Foot Care <input type="checkbox"/> per client request <input checked="" type="checkbox"/> 17 Skin Care <input type="checkbox"/> per client request <input type="checkbox"/> 30 Remind to take meds <input type="checkbox"/> 31 T P R	HOUSEKEEPING <input checked="" type="checkbox"/> per client request <input checked="" type="checkbox"/> 80 Make / Change Bed <input type="checkbox"/> 81 Laundry <input type="checkbox"/> 82 Light Housekeeping <input type="checkbox"/> 83 Shopping once a week or errands <input type="checkbox"/> 84 Transport <input type="checkbox"/> 85 Diversional Activity or Companion 4pt IS NO CODE <input type="checkbox"/> 90 Called Office
NUTRITION <input type="checkbox"/> 40 Prepare Meal or Snack <input type="checkbox"/> per client request <input type="checkbox"/> 41 Offer Fluids <input type="checkbox"/> per client request <input type="checkbox"/> 42 Assist with Feeding or Fed <input type="checkbox"/> per client request	
ELIMINATION <input checked="" type="checkbox"/> 50 Assist with Elimination <input type="checkbox"/> 51 Cath Care <input type="checkbox"/> 53 Empty / Assist with Ostomy	

Client Signature: Walter E. Robbins

Date: 12-9-04

SIGNATURE	DATE	SIGNATURE	DATE	SIGNATURE	DATE
<u>R. VanDoosere</u>	<u>12/9/04</u>				

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

(Hereafter referred to as "the Company")

PAGE: 01

BRANCH	WORK ORDER	ROUTE #	DELIVER TO	AIU558 F	REFERRAL	REF. CODE
0613	W3590371		ROBBINS, NORMA		BALL MEMORIAL H	#DHX19
DELIV. DATE	TIME	DELIV. TYPE	8400 WEST 400 SOUTH		ORDERED BY	
12/09/04		TRUCK	YORKTOWN		JENNY	
INSURANCE			IN 47396		Phone: (765) 747-3111	
Primary: BALL HOSPITAL HOSPICE			Cross Streets:		PHYSICIAN	
HIC#	NA	Eff. Date	Phone: (765) 759-9331		ALLEN, STEVEN	
Secondary:			Emergency		Phone: (765) 289-1011	
HIC#		Eff. Date	NA		LTR / MIN.	HRS / DAY
PURCHASE ORDER			Phone: (111) 111-1111		HT.	WT.
					61	185

QTY.	U/M	STOCK NO.	DESCRIPTION	INVOICE	BILLED	CO-PAY
Primary Payor: BALL HOSPITAL HOSPICE						
Environment Suitable? Yes No I have been instructed on the proper care and use of the following equipment.						
SET UP APP						
----- DELIVERY -----						
1	EA	907	*** 1 MONTH RENTAL OF *** APP PUMP AND PAD STANDARD APP	57.45	57.45	.00
			NEW SETUP			
1	EA	M013741	ALTERNATING PRESSURE PUMP&PAD SERIAL#: A0103 MODEL#: _____ MANUF: _____			
1	EA	M102100	*** SALE OF *** ALTERNATING PRESSURE PAD AIRFL MODEL#: PAF-655	.00	.00	.00
Continues.....						

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

by _____
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 _____

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

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

BRANCH: 0613
WORK ORDER

INVOICE REF:

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

W3590371

* Refer To Last Page *

CUSTOMER

PLEASE REMIT PAYMENT TO:

ROBBINS, NORMA
8400 WEST 400 SOUTH

APRIA HEALTHCARE INC
1703 SOLUTIONS CENTER

YORKTOWN
IN 47396

CHICAGO
IL 60677
(317) 865-4200

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

AMOUNT PAID: \$

CHECK ☐ VISA ☐ M/C ☐ DISCOVER ☐

CARD #: _____
EXPIRATION DATE: ____/____/____

ACCOUNT: AIU558
CONTACT:

12/09/04 13:37:32

SIGNATURE: X

CUSTOMER COPY

OPS 0017 (Rev. 02/03)

QTY.	U/M	STOCK NO.	DESCRIPTION	INVOICE	BILLED	CO-PAY
			MANUF: GAYMAR INDUSTRIES			
			SUB-TOTAL		57.45	
			STATE TAX		3.45	
			TOTAL:		60.90	
			THANK YOU, JIM			
			170103			

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

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

PLEASE REMIT PAYMENT TO:

AMOUNT DUE: .00
PAYMENT DUE BY: 12/09/04

AMOUNT PAID: \$

CARD #: _____
EXPIRATION
DATE: / /

SIGNATURE: **X**

(Hereafter referred to as "the Company")

PAGE:

BRANCH	WORK ORDER	ROUTE #	DELIVER TO	REFERRAL	REF. CODE
	67594178		Norma Robbins 8400 W4005 YORKTOWN IN. 47396		
DELIV. DATE	TIME	DELIV. TYPE		ORDERED BY	
				Phone:	
INSURANCE				PHYSICIAN	
Primary:			Cross Streets:	Phone:	
HIC#	Eff. Date				
Secondary:			Phone: (765) - 759-4331		
HIC#	Eff. Date		Emergency	LTR / MIN.	HRS / DAY
PURCHASE ORDER			Phone:	HT.	WT.

QTY.	U/M	STOCK NO.	DESCRIPTION	INVOICE	BILLED	CO-PAY
1		M1832749	APP Pump SN# A0103 MD# APP-31 MF - GAYMIAP	P/U		
1		M101765	Bed SN# 89001ED52300 MD# 5890 MF - INV.	P/U		

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: WALTER ROBBINS by WALTER ROBBINS Representative's Name: WALTER ROBBINS Reason Beneficiary Cannot Sign: DECEASED
Representative's Address: 12-13-14 HUSBAND

Beneficiary (or Parent/Guardian/Agent) Signature: _____ Date: _____ Relationship to Beneficiary (if applicable): _____ Technician Initials: W/171

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

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

BRANCH:
WORK ORDER

INVOICE REF:

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

CUSTOMER

PLEASE REMIT PAYMENT TO:

AMOUNT DUE:
PAYMENT DUE BY:

AMOUNT PAID: \$

CHECK ☐ VISA ☐ M/C ☐ DISCOVER ☐

CARD #: _____
EXPIRATION DATE: ____/____/____

ACCOUNT:
CONTACT:

SIGNATURE: X

CUSTOMER COPY

OPS 0017 (Rev. 02/03)