**SAMPLE FORM**

When Hospital at Home patients are admitted to an acute inpatient stay under the CMS waiver, a consent form similar to that used for any inpatient admission would be used. What additional language might be appropriate for the Hospital at Home admission? Here is an example of the language used by one system. Any consents should be reviewed by the legal counsel and compliance teams at your institution.

 **Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOSPITAL AT HOME CONSENT FORM**

**HOSPITAL AT HOME PROGRAM:** I have consented to be a patient in the Hospital at Home program. I understand that this program is completely voluntary and that, instead of participating in the Hospital at Home program, I can be admitted to a (Name of Institution) acute care hospital. I also understand that if at anytime during the course of my treatment with the Hospital at Home program, I feel that I would rather be admitted to the hospital, I can call and discuss with my doctor my desire to terminate the Hospital at Home program and be admitted to an acute care hospital. I understand that my condition can possibly worsen, whether I am treated at the hospital or at home. I further understand and agree that, if at any time, I feel that I am having a medical or mental health emergency, that I should call 911 to obtain immediate emergency services.

**REVIEW OF HOSPITAL AT HOME INFORMATION:** I hereby acknowledge that I have been given a copy of the (Name of Institution) Hospital at Home Program description, that I have reviewed this, have been given the opportunity to ask questions, and that all of my questions have been answered to my satisfaction.

**SERVICE BY OTHER CONTRACTED PROVIDERS: Some providers, including, without limitation, radiologists, anesthesiologists, pathologists and other contracted providers provide services in our facilities and in our programs. They may not be employees or agents of (Name of Institution), or the (Name of Institution) Hospital at Home program. I understand and agree that some of these providers include (can insert a list of common contracted service providers) and that these entities and their doctors and employees are not employees or agents of (Name of Institution), or of the (Name of Institution) Hospital at Home program, and that any claims concerning services rendered by these providers cannot be pursued against (Name of Institution) or its programs, including the (Name of Institution) Hospital at Home program.**

**RELEASE FROM HOSPITAL AT HOME PROGRAM:** I understand that my Hospital at

Home physician may determine that my condition has improved so that care from Hospital at

Home is no longer needed. My care will be transitioned back to my Primary Care Physician. The

Hospital at Home physician will no longer visit my home. I should consult my Primary Care

Physician for ongoing care needs. If I believe I am having an emergency, I will call 911.