The Dorothy Ley Hospice

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Website: www.dlhospice.org

RESIDENTIAL PROGRAM SERVICE AGREEMENT

Name _____ **Date of Birth** _____/_____/_____

Numerical Day / Month / Year

I, or my, Substitute Decision Maker (SDM) request admission to The Dorothy Ley Hospice Residential Program for short-term (less than three months) hospice palliative care.

I understand that the services that are provided by the residential program will focus on addressing my end of life care needs and will support me in the last weeks of my life. I understand that the Hospice does not offer cardiopulmonary resuscitation as a treatment option but allows natural death to occur.

I understand that the focus of care in the residential program is quality of life through pain and symptom management and psychosocial/spiritual/practical support. My care may include services such as Integrative Wellness Care, Day Program, Spiritual and Bereavement Care.

I give The Dorothy Ley Hospice permission to collect and share all appropriate personal health information with the trans-disciplinary team in order to ensure safety and continuity of care.

I am aware that my care needs will be reviewed at regular intervals and documented in my care plan. If my condition improves or stabilizes to the point where the Dorothy Ley Hospice Residential Program is no longer the most appropriate place for my care delivery, a comprehensive review of my situation will take place by the trans-disciplinary team, myself and my family member(s)/SDM. The Dorothy Ley Hospice Residential Program will ensure that I am discharged to the most appropriate place where I will be cared for safely and comfortably.

I acknowledge that this agreement does not fall under the *Residential Tenancies Act* (Ontario) or the *Tenant Protection Act, 1997* (Ontario) but rather that my access to the residential program is based on my end of life care needs.

I understand that it is my responsibility to appoint Powers of Attorney to handle my medical and legal affairs, if I so choose. If I do not have a Power of Attorney for Personal Care (POAPC) my decision-maker, SDM, will be determined as per the *Health Care Consent Act 1996(Ontario).*

My Power of Attorney for Personal Care is _____

If no POAPC, my Substitute Decision Maker(s) is/are_____

_____

Relationship_____

Consent for Service

I, or my SDM, consent to receiving services from The Dorothy Ley Hospice Residential Program.

i. I understand that I may withdraw this consent at any time by verbal notification, which will result in discontinuation of hospice services and transition to an alternate place of care.

Release of Information

I understand that the Dorothy Ley Hospice collects personal health information necessary for purposes related to the services they provide, including:

- Determining my needs and coordinating the services that can be provided to me
- Reviewing my needs and services on an ongoing basis
- Directly or indirectly providing me with health and related social services
- Monitoring the quality of service I am receiving
- Planning and evaluation of the services they provide
- Purposes permitted or required by law

In order to provide me with these services, the Dorothy Ley Hospice will share my personal health information with:

- Authorized team members (including volunteers)
- Health care organizations, physicians and healthcare professionals involved in my care
- The following individuals identified by myself:

_____

_____

I understand that:

i. The Dorothy Ley Hospice staff and volunteers who will have access to my personal information have agreed in writing to protect the privacy of this information.
ii. The Dorothy Ley Hospice will use appropriate safeguards to store any confidential and sensitive information it collects.
iii. The Dorothy Ley Hospice will not use or share personal information collected by its staff and volunteers for any purposes other than those listed above without my prior consent.
iv. I may review any information I have given to The Dorothy Ley Hospice for the purposes identified above and may make any additions or revisions to this information by contacting my Care Team.

Consent for Volunteer Services

I have been made aware of the role of volunteers in the provision of hospice services and understand that they are part of my care team. I understand that volunteers are screened and trained to provide emotional, spiritual and physical assistance but cannot provide medical care and will not administer medication.

Fee for Services

The Dorothy Ley Hospice is a charitable, non-profit organization. Charitable No: BN 13019 3394 RR0001

The services of the residential program are provided **at no cost** to me thanks to the generosity of donors and community partners, and government funding.

I understand that if I wish to employ services over and above what the Dorothy Ley Hospice offers I will be responsible for their costs. I am responsible for any medication costs not covered by the Ontario Drug Benefit Plan.

Financial donations, in-memoriam donations and bequests are gratefully accepted. To discuss donation opportunities, please contact the Dorothy Ley Hospice office.

Waiver

I understand and accept the conditions noted above and I agree not to hold Dorothy Ley Hospice or any directors, officers, volunteers or employees legally responsible for any of the following:

- Personal injury, illness, incapacity or death that occurs, or
- Loss of property or damage (unless intentionally committed)

during the time that Hospice personnel are providing service on my behalf or on behalf of any member of my family.

I agree to release the Dorothy Ley Hospice along with its officers, directors, employees and volunteers of all actions, claims or demands of any nature or kind arising out of or in any way connected with the provision of service by the Dorothy Ley Hospice except if claims arise from intentional or deliberately harmful or criminal actions.

Signatures

I agree to all provisions of this agreement and understand their meaning. I have read and voluntarily agree to execute this Agreement.

_____	_____
Please Print : Name of Service Recipient/Substitute Decision Maker	Signature: Name of Service Recipient/Substitute Decision Maker
_____	_____**, 20**_____
Relationship to Individual Receiving Service	Date
_____	_____
Please Print: Hospice Staff	Signature: Hospice Staff
_____	_____**, 20**_____
Position/Title	Date