Dear Friend,

Thank you for your interest in the Zen Hospice Project Guest House. Our 6-bed facility is licensed as an RCFCI (Residential Care Facility for the Chronically Ill), providing care and support to individuals and their families facing terminal illness. We welcome residents who are in need of hospice and palliative care, as well as patients in need of short-term respite care.

Since 1987, the Guest House has provided a warm, intimate, home-like atmosphere. It is a unique environment dedicated to easing issues that arise during the profound human experience of confronting the closing days, weeks or months of life. Our exceptionally skilled nursing staff provide personalized medical care 24-hours a day, seven days a week. This care is enhanced by our highly-trained, committed volunteers, devoted to bearing witness and responding to the individual needs of each resident.

Residents pay privately for the care provided at the Guest House; most insurance does not reimburse for these costs. A two-week deposit is expected at the time of admission.

Before filling out an application, please take a few minutes to read the "Zen Hospice Project Guest House Admission Procedures." Feel free to call with any questions about our program. You can call our main number at 415-913-7682, Monday to Friday from 9:00am to 5pm and speak with a member of the Guest House staff. We look forward to speaking with you.

Thank you and blessings,

Hanne Jensen-Male, RN
Nurse Manager
Zen Hospice Project

ZEN HOSPICE PROJECT GUEST HOUSE ADMISSION INSTRUCTIONS

STEP 1

Before beginning the paperwork, please do the following:

- ☐ Review the General Criteria for Admission found in this packet (page 3).
- ☐ Call the Guest House intake staff at 415-913-7682 to check on availability of rooms.

STEP 2

If a referral is appropriate, print, complete, and submit the following three documents:

- ☐ Resident Information Form (pages 4-5 of this packet)
- ☐ Family Income Worksheet (page 6)
- ☐ Authorization to Exchange Confidential Information (page 7)

STEP 3

When we inform you that a bed is available, submit the additional documents listed below:

- ☐ Resident Agreement (pages 8-9)
- ☐ Documentation of TB Status (page 10)

With your prior authorization, we will also obtain the following required documents from your health care providers:

- ☐ History and physical and/or discharge summary and/or progress notes.
- ☐ Name of Bay Area physician and/or hospice agency
- ☐ Code Status/DNR/POLST
- ☐ Physician's order for hospice (if not already enrolled in hospice)

Mail or fax all documents to:
Zen Hospice Project Guest House
273 Page Street, San Francisco, CA 94102
Fax: 415-374-7458 Tel: 415-913-7682
We process intakes from 9am-5pm Monday to Friday, unless agreed otherwise.

BED AVAILABILITY AND WAITING LIST INFORMATION:

If a bed is unavailable, then wait-time for a bed varies. Potential residents will be placed on a waiting list and will be informed when a bed becomes available. Please feel free to call and check on the status of your referral at any time. The main number at the Guest House is 415-913-7682.

IMPORTANT NOTE:

Zen Hospice Project reserves the right not to accept any resident who does not meet the admission criteria. We also reserves the right to make exceptions on a case-by-case basis regarding residents that might fall within or outside the basic admissions parameters.

GENERAL CRITERIA FOR ADMISSION

Take a moment to read the general criteria below before filling out our application to avoid unnecessary paperwork. Only persons who are eligible for admission into a certified hospice program and who meet the following admission criteria will be considered.

1. **Terminal Illness**. The resident (18 years or above) must have a diagnosis of a terminal disease and a prognosis of six months or less. The resident and his/her physician must agree that the focus of care is comfort care only. The prognosis and focus on palliative care must be confirmed in writing by the primary physician.

2. **Intravenous Medications**. The person will not have requirements for continuous intravenous therapy.

3. **Continuous Care**. The person will not have requirements for continuous 24-hour one-to-one supervision. Should this be necessary, the patient will be financially responsible to hire a sitter. Family members may provide this care as well.

4. **Negative TB Status**. The person must be certified by an MD to be non-contagious with pulmonary TB within 3 months of admission.

5. **Decubitis**. No person may be admitted with a documented Stage III or greater decubitis ulcer.

6. **Financial Status**. The resident will be responsible for paying room and board on a bi-monthly basis. Every resident must complete the Family Income Worksheet and be screened prior to admission.

7. **Durable Power of Attorney for Health Care**. Prior to admission, identification of a Durable Power of Attorney for Health Care or another responsible party is required to make critical medical decisions after admission for the resident if he/she is no longer competent to make such decisions.

8. **Durable Power of Attorney For Finances**. Prior to admission, identification of a Durable Power of Attorney for Finances or another responsible party is required to make decisions and to handle pertinent financial matters after admission.

9. **Illegal Substances**. The person may not have or use illegal drugs while a resident at the Zen Hospice Project Guest House.

10. **Resident Agreement**. The person, a close family member, Durable Power of Attorney or the identified responsible person must sign the Resident Agreement.

11. **A Completed Application** must be submitted to the Guest House to establish status on the waiting list.

ZEN HOSPICE PROJECT GUEST HOUSE RESIDENT INFORMATION

REFERRAL INFORMATION

Referred by: Date:

Agency/hospital: Phone:

Address:

Phone: Fax: Email:

RESIDENT INFORMATION

Name: Date of birth: Ethnicity:

Hospice diagnosis: Secondary diagnoses:

Address:

City/State/Zip:

Primary phone #: Secondary phone #:

Currently at: ☐ Home ☐ Other Facility name:

Facility Contact Phone: Email:

☐ Address is same as referral address above.
☐ Other address:

Does applicant have a primary hospice/home care agency? ☐ Y ☐ N If yes, agency name:

Hospice/agency contact person:

Phone: Email:

PRIMARY CONTACTS

Durable Power of Attorney: ______________________ Relationship: ______________

Address: ______________________

City: ______________ St: ______________ Zip: ______________

Phone: ______________ Email: ______________

Secondary contact name: ______________________ Relationship: ______________

Address: ______________________

City: ______________ St: ______________ Zip: ______________

Phone: ______________ Email: ______________

PRIMARY PHYSICIAN:

Name: ______________ Phone: ______________ Email: ______________

OTHER PRIMARY MEDICAL PROVIDER

Name: ______________ Phone: ______________ Email: ______________

PLEASE CHECK ALL THAT APPLY

SYMPTOMS:
- ☐ Difficulty swallowing
- ☐ Difficulty breathing
- ☐ Nausea/vomiting
- ☐ Pain
- ☐ Rash/Itching
- ☐ Diarrhea
- ☐ Other: ________________

____

MOBILITY:
- ☐ Independent
- ☐ Assistance
- ☐ Wheelchair
- ☐ Bed bound
- ☐ Recent falls

ALLERGIES:
- ☐ ____________________

MENTAL:
- ☐ Clear/oriented
- ☐ Short-term memory loss
- ☐ Confused
- ☐ Depression
- ☐ Other psych history:

____

____

____

PAIN:
- ☐ Scale 1-10:____________
- ☐ Other concerns / issues:

____

____

SMOKER:
- ☐ Yes
- ☐ No

SPECIAL NEEDS:
- ☐ Hearing impaired
- ☐ Sight impaired
- ☐ Adaptive devices
- ☐ Other: ________________

____

DIETARY NEEDS:
- ☐ ____________________

____

____

ADDITIONAL NEEDS:
- ☐ Night supervision
- ☐ Wandering
- ☐ Insulin dependant
- ☐ Feeding tube
- ☐ Other: ______________

____

TREATMENT:
- ☐ Radiation
- ☐ Palliative chemo
- ☐ Wound care
- ☐ Oxygen
- ☐ Other: ______________

____

____

TOILETING:
- ☐ Independent
- ☐ Assistance
- ☐ Incontinent bladder
- ☐ Incontinent bowel
- ☐ Foley catheter
- ☐ Other: ______________

____

SPIRITUAL/CULTURAL INFORMATION:

PERSONAL HISTORY:

Please provide relevant personal history (friends/family involved, prior living situation, etc.):

FOR RESPITE REFERRALS ONLY:

Please let us know what your respite goals are for this applicant; when would you expect to return home?

FAMILY INCOME WORKSHEET

NOTE: Please complete the following information as fully and completely as possible. Offering an honest description of your finances is the best way to recognize the extraordinary care you will receive at the Guest House.

PERSON/PARTY RESPONSIBLE FOR PAYMENTS	
TYPE (Check one): ☐ Self ☐ Guarantor ☐ Money management agency ☐ Durable Power of Attorney ☐ Family member ☐ Other ___________________	RESPONSIBLE PARTY CONTACT DETAILS: _______________________ Name _______________________ Email address _______________________ Phone

SOURCES OF INCOME (Monthly)		
Monthly sources of income:	Resident:	Family:
SSDI: Social Security Disability Insurance	$	$
SSI: Supplemental Security Income	$	$
Social Security benefits	$	$
State Disability benefits	$	$
Private disability	$	$
Retirement/pension	$	$
VA benefit	$	$
Rental income	$	$
Spousal support	$	$
Other:	$	$
TOTAL:	$	$
ASSETS		
Monthly assets	Resident:	Family:
Savings (must attach current statement)	$	$
Checking (must attach current statement)	$	$
Stocks/bonds	$	$
Dividends	$	$
Life insurance	$	$
Real estate	$	$
Other:	$	$
TOTAL:	$	$

RECURRING EXPENSES (Monthly):	
Insurance premium	$
Medications	$
Physicians	$
TOTAL:	$

Zen Hospice Project is not responsible for costs that fall out of the basic range of services we provide to patients and their families.

I CERTIFY THAT THE INFORMATION ABOVE IS COMPLETE AND ACCURATE

X _____________ X ________________________________ X ____

Date Print Name Signature of applicant/Durable Power of Attorney/Guarantor

AUTHORIZATION TO OBTAIN FINANCIAL INFORMATION: (Optional) : I hereby authorize Zen Hospice Project to obtain financial information, if I utilize a money management agency or other, in order to determine my room and services fee.

X _____________ X ____

Date Signature of applicant/Durable Power of Attorney/Immediate Family

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

It is the policy of the Zen Hospice Project to hold all information about clients as confidential and to not release information without permission. In order to facilitate your application process we need permission to contact your healthcare providers and to get information about your physical and mental health.

I, ____ (name), hereby give my permission to obtain or disclose my private health information for the purpose of admission to the Guest House residence. This authorization is valid for the duration of the intake process.

While it is your right to limit or exclude information from disclosure, this authorization is for full disclosure of all records, including diagnosis, treatment, assessment, dates of hospitalizations, mental health/psychiatric conditions, HIV/AIDS testing results, drug and alcohol information, and sexually transmitted disease information.

You may revoke your consent at any time.

You have the right to a copy of this authorization.

Your confidential information is protected by the Federal Privacy Act and California Law.

X ____ X ______________

Signature of Client or Representative Date

RESIDENT AGREEMENT

Upon admission to Zen Hospice Project's Guest House I acknowledge, consent and agree to the following (please initial each statement):

____1. I understand that nursing and comprehensive care services are provided by Zen Hospice Project staff in conjunction with visiting hospice agency services.

____2. I understand that if my need for medical or nursing care should at any time exceed those services able to be provided by Zen Hospice Project staff, or if my condition should stabilize to the point where Zen Hospice Project Guest House services are no longer appropriate, I will be discharged from the Guest House and transferred to another appropriate facility or home.

____3. I understand that I am required to have TB test or a chest x-ray within three months prior to admission, for screening by my physician for pulmonary tuberculosis (TB). I understand that if the screening should show me to have active TB, I must start on effective medical treatment prior to admission and continue that treatment during my stay.

____4. I understand that smoking is not permitted indoors in the Guest House. Limited outside areas will be provided.

____5. I understand that I may drink alcohol in moderation as directed by my physician and that abuse of alcohol or disruptive behavior may result in discharge from the Guest House.

____6. I understand that I am not permitted to possess or use weapons, replica weapons, illegal drugs and/or paraphernalia of any kind at the Guest House. Illegal activity of any kind will result in discharge.

____7. Visiting hours are from 9 AM – 9 PM. I understand that visitors may be limited at any time at my request, and that visitors will be asked to leave if they become disruptive and/or disturb other residents. Arrangements can be made for overnight guests with approval of the Administrator and/or Facility Manager.

____8. I understand that I may voice my concerns regarding the care provided at the Guest House to the Administrator and/or the Nurse Manager at the Guest House.

____9. I understand that I will be presented with information from Guest House staff regarding basic services, optional services, rights, refund conditions and additional information pertaining to my stay at the facility.

___10. I understand that pets, with the exception of fish, cannot be kept at the Guest House. Arrangements can be made for limited pet visits.

___11. I understand that my room will be furnished and due to lack of storage space, I am allowed to bring only items that will safely fit in the room.

___12. I understand that the use of medical marijuana is permitted at the Guest House when recommended in writing by my primary-care physician and upon acceptance of the Guest House policies concerning medical marijuana including possession of a valid Department of Public Health cannabis ID. House smoking rules apply.

___13. I understand that the Zen Hospice Project Guest House is funded and staffed for residents who are seriously ill and normally homebound. If I am able to leave the building on my own, I must sign out with the nurse on duty and provide an approximate time of return.

___14. I understand that the Guest House includes both private and semi-private rooms and that assignment will be based on preference and availability. If I request a move from a semi-private room to a private room, I agree to pay the higher daily rate.

___15. I understand that all residents will be charged a daily fee payable to Zen Hospice Project, which includes rent, meals, and comprehensive support services. I understand that it is my responsibility, or that of my designated responsible other to pay the daily rate, and that failure to make such payments may result in discharge from Zen Hospice Project Guest House. Payments will be made on a bi-monthly basis. I will be given 30-days notice to any changes to the daily rates.

___16. I understand that all fees and costs associated with outside non-medical services and care during and after my residence at the Guest House will be my responsibility or the responsibility of my designated responsible other. Examples might include outside counseling/therapy or costs associated with funeral and/or mortuary arrangements.

___17. I understand that all staff, volunteers and residents are to be treated respectfully. This means no yelling, profanity, or derogatory remarks. Disruptive, threatening, or intimidating behavior can result in discharge from the Guest House.

___18. I understand that if I should need 24-hour one-to-one supervision, I will need to provide a sitter or have this service provided by a family member. Zen Hospice Project's license does require transfer to other facilities for residents who cannot be cared for safely under our level of staffing.

___19. I understand personal hygiene is an integral part to my health and overall well being, therefore I agree to shower or bathe at least once per week.

___20. I understand that the possessions I bring with me will be screened for infestation and may be quarantined until cleared.

___21. I understand that any personal possessions remaining after my discharge will be held for a maximum of 30 days after which they will be donated.

___22. I understand that I am requested, prior to admission to the Zen Hospice project Guest House, to have and to submit a copy of a Durable Power of Attorney for Health Care and a Durable Power of Attorney for Finances.

___23. I understand that Zen Hospice Project has a non-discrimination policy and that I will not be discriminated against based on the fact or perception of race, religion, color, creed, ancestry, age, height, weight, sex, sexual orientation, gender expression, disability, place of birth, creed, national origin, military obligations, marital status, domestic partner status, or AIDS/HIV.

___24. I give Zen Hospice Project permission to use my name in memorial services or other tributes to the residents of the Guest House.

I acknowledge that I have been given ample opportunity to ask any and all questions concerning the Guest House, the care provided, related fees and policies governing Zen Hospice Project, and operation of the Guest House.

PARTIES TO THIS AGREEMENT:

______________________________	____________________	__________
RESIDENT SIGNATURE or Durable Power of Attorney	PRINT NAME	DATE
______________________________	____________________	__________
GUEST HOUSE MANAGER SIGNATURE	PRINT NAME	DATE

DOCUMENTATION OF PULMONARY TUBERCULOSIS STATUS

To: Physician/health care provider Re: Zen Hospice Project Guest House Application

NAME OF CLIENT:

PPD (Mantoux) TB TEST

DATE: ____________

☐ Negative
☐ Positive

PULMONARY TB TEST

People infected with HIV, and people living in group residential facilities are considered to be at high risk for pulmonary tuberculosis.

In order to protect patients and staff, the following documentation is required:

CXR* DATE: _____________

☐ Negative (For Pulmonary TB)
☐ Positive (For Pulmonary TB)

* The CXR (Chest X-Ray) must be within three months of admission

IF PATIENT HAS ACTIVE PULMONARY TB

Patient must have received continuous treatment for at least 2 weeks and show 3 consecutive negative AFB smears prior to admission.

Date treatment started ______________________

Dates of negative AFB's 1. ________________ 2. ________________ 3. ___________________

X ____________________________________
Signature of Health Care Provider (MD, PA, NP)

X____________________________________
Print Name

X ____________________________________
Date

X____________________________________
License#

____
Phone

____
Email