☐ Initial Request ☐ Continuing Request

HOSPICE GENERAL INPATIENT INFORMATION SHEET

This document summarizes the reasons for the transfer of a Medi-Cal hospice patient to a general inpatient level of care. It must be submitted to the Medi-Cal Field Office along with the Treatment Authorization Request (TAR) when transferring a patient to a general inpatient level is proposed or for continuation of service.

Patient name	Medi-Cal number

Facility name and type

Date hospice elected	Primary diagnosis

Brief clinical summary to include specific symptoms or alterations in patient condition making general inpatient level of care medically necessary (both for initial authorization and symptomology for continuation of services reauthorization):

Goals to be achieved with general inpatient level of care (or update which demonstrates need for continuing days):

Expected length of stay at general inpatient level of care necessary to achieve above-stated goals:

Summary of professional interventions by appropriate disciplines needed to stabilize, alleviate, or reduce the progression of the general inpatient symptoms justifying general inpatient level of care:

Physician team member signature (or check if copy of inpatient order sheet is attached) ➤	Hospice name

Hospice contact person	Telephone number

Address	City	State	ZIP code

FAX number	Date

INSTRUCTIONS

- The **Hospice General Inpatient Information Sheet** (DHS 6194) has been designed for use by Hospice providers.
- Submit the DHS 6194 with the TAR (DHS 50-1) to document the medical necessity for the transfer of a Medi-Cal Hospice patient to a general inpatient level of care.
- Submit the DHS 6194 with the TAR (DHS 50-1) when a request is made to extend the length of stay at the general inpatient level of care.

Item	Description

1. **Initial Request:** Check this box if this is the initial general inpatient level of care TAR request for the Hospice patient.
2. **Continuing Request**: Check this box if the TAR requests additional days at the general inpatient level of care for a Hospice patient with a TAR approved for level of care.
3. **Patient Name:** Enter the Hospice patient's full name.
4. **Medi-Cal Number:** Enter the Hospice patient's 14-digit Medi-Cal identification number.
5. **Facility Name and Type:** Enter the name of the facility and its license type, e.g., Nursing Facility (NF) Level A, NF Level B, etc.
6. **Date Hospice Elected:** Please enter the date of Hospice Election. Please remember that a copy of the election sheet must be sent to the Department of Health Services, Medi-Cal Eligibility, 714 P Street, Room 1601, Sacramento, CA 95814, Attention: Hospice Clerk. The original Hospice Election must be kept on file at the Hospice for post-service audit purposes.
7. **Primary Diagnosis:** Enter the patient's diagnosis of the terminal condition which led to the election of the hospice benefits.
8. **Brief clinical summary to include specific symptoms or alterations in patient condition making general inpatient level of care medically necessary:** Enter descriptive documentation and secondary diagnoses that substantiate the medical necessity of the general inpatient level of care or continuing the length of stay at this level of care, including why other available hospice levels of care are insufficient to meet the patient's current medical needs.
9. **Goals to be achieved with general inpatient level of care (or update for continuing days):** Outline the specific clinical outcomes expected to be achieved by a period of general inpatient care. If continuing care request, update the goals stated in the initial request.
10. **Expected length of stay at general inpatient level of care necessary to achieve the above-stated new or continuing goals:** State the days anticipated to be necessary to stabilize the patient sufficiently in order to return him/her to a routine level of care and to justify the basis for the number of days requested.

    If this is a continuing care request, document why the initial expected length of stay was insufficient to stabilize the patient and meet the initially stated goals.

    Remember that transfers to the general inpatient level of care are anticipated to be **short-term** only.
11. **Summary of professional interventions by appropriate disciplines needed to stabilize, alleviate, or reduce the progression of the symptoms justifying general inpatient level of care**: Describe the specific interventions to be delivered in the inpatient setting that are medically necessary to stabilize the patient prior to returning him/her to a routine hospice level of care.
12. **Physician Team Member Signature/Copy of Inpatient Order Sheet**: The Hospice General Inpatient Information Sheet must be signed by the physician member of the Hospice Treatment Team or a copy of the inpatient admitting order sheet must be submitted.
13. **Hospice Name:** Enter the name of the Hospice providing the elected benefits to the patient.
14. **Hospice Contact Person**: Enter the name, telephone number, FAX number, and address of the Hospice staff person whom the Medi-Cal field office can contact should there be questions regarding the form or the TAR.
15. **Date:** Enter the date the form is signed.