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## **Hospice Care: General Inpatient Information Sheet**

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Page updated: August 2020

This section contains instructions for completing the *Hospice General Inpatient Information Sheet*, which is used to transfer a Medi-Cal hospice patient to a general inpatient level of care.

### **Hospice General Inpatient Information Sheet**

The *Hospice General Inpatient Information Sheet* (DHS 6194) must be submitted with fax TARs (form 50-2) or general TARs (form 50-1) for recipients who have elected to be transferred to general inpatient care. The following item numbers and descriptions correspond to the sample form. A blank form is at the end of this section.

State of California-Health and Human Services Agency
Department of Health Services

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Initial Request 1
 Continuing Request 2

### 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 services.

Patient Name: \_\_\_\_\_ 3      Medi-Cal #: \_\_\_\_\_ 4

Facility Name and Type: \_\_\_\_\_ 5

Date Hospice Elected: \_\_\_\_\_ 6      Primary Diagnosis: \_\_\_\_\_ 7

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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): \_\_\_\_\_ 8

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Goals to be achieved with general inpatient level of care (or update which demonstrates need for continuing days): \_\_\_\_\_ 9

\_\_\_\_\_

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\_\_\_\_\_

Expected length of stay at general inpatient level of care necessary to achieve above stated goals: \_\_\_\_\_ 10

\_\_\_\_\_

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: \_\_\_\_\_ 11

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Physician Team Member Signature (or check if copy of inpatient order sheet is attached) \_\_\_\_\_ 12      Hospice Name \_\_\_\_\_ 13

Hospice Contact Person \_\_\_\_\_ 14      Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

FAX Number \_\_\_\_\_ 15      Date \_\_\_\_\_ 16

**Figure 1:** Sample Hospice General Inpatient Information Sheet (DHS 6194)

## Explanation of Form Items

### «Explanation of Form Items Table»

Item	Description
1.	<b>Initial Request.</b> Enter an “X” in this box if this is the initial general inpatient level of care TAR for the hospice patient.
2.	<b>Continuing Request.</b> Enter an “X” in 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.	<b>Patient Name.</b> Enter the hospice patient’s full name.
4.	<b>Medi-Cal #.</b> Enter the hospice patient’s Medi-Cal identification number.
5.	<b>Facility Name and Type.</b> Enter the name of the facility and its license type (for example, Nursing Facility [NF] Level A, NF Level B).
6.	<p><b>Date Hospice Elected.</b> Enter the date of hospice election. Remember that a copy of the election sheet must be sent to:</p> <p style="padding-left: 40px;">Attn: Hospice Clerk, Department of Health Care Services, Medi-Cal Eligibility Division, MS 4607, 1501 Capitol Avenue, P.O. Box 997417-7417, Sacramento, CA 95899-7417.</p> <p>The original Hospice Election must be kept on file at the hospice for post-service audit purposes.</p>
7.	<b>Primary Diagnosis.</b> Enter the patient’s diagnosis of the terminal condition that led to the election of the hospice benefits.
8.	<b>Brief clinical summary to include specific symptoms or alterations in patient condition making general inpatient level of care medically necessary.</b> Enter the descriptive documentation and secondary diagnosis that substantiate the medical necessity of the general inpatient level of care or the continued 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.	<b>Goals to be achieved with general inpatient level of care (or update which demonstrates need for continuing days).</b> Outline the specific clinical outcomes expected to be achieved by a period of general inpatient care. If the request is for continuing care, update the goals stated in the initial request.

«Explanation of Form Items Table (continued)»

Item	Description
10.	<p><b>Expected length of stay at general inpatient level of care necessary to achieve the above stated goals.</b> State the days anticipated to be necessary to stabilize the patient sufficiently in order to return him or her to a routine level of care, and justify the basis for the number of days requested.</p> <p>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.</p> <p>Remember that transfers to the general inpatient level of care are anticipated to be short-term only.</p>
11.	<p><b>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.</b> Describe the specific interventions to be delivered in the inpatient setting that are medically necessary to stabilize the patient prior to returning him or her to a routine hospice level of care.</p>
12.	<p><b>Physician Team Member.</b> The <i>Hospice General Inpatient Information Sheet</i> must be signed by the physician member of the hospice treatment team, or a copy of the inpatient admitting order sheet must be submitted.</p>
13.	<p><b>Hospice Name.</b> Enter the name of the hospice providing the elected benefits to the patient.</p>
14.	<p><b>Hospice Contact Person.</b> Enter the name, telephone 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.</p>
15.	<p><b>Fax Number.</b> Enter the telephone number (including area code) of the fax machine to which the processed TAR should be sent if sent to the field office via facsimile.</p>
16.	<p><b>Date.</b> Enter the date the form is signed.</p>

**<<Legend>>**

<<Symbols used in the document above are explained in the following table.>>

<b>Symbol</b>	<b>Description</b>
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.