Fairfield County House
COMPASSIONATE END OF LIFE CARE

Admission Criteria

Admission for residency must be approved by either the Executive Director or the Nursing Supervisor of the Fairfield County House (FCH) based on an assessment including clinical and financial information.

Eligibility for admission shall be determined without regard to gender, race, religion, nationality, or sexual orientation. Prospective residents must be at least 18 years of age.

Under hospice care or palliative care: Applicants must be under the care of a participating, certified hospice agency with DNR-RN pronouncement orders and funeral arrangements secured from the hospice agency and provided to FCH.

Terminal Illness: Applicant must have a diagnosis of a terminal illness and a prognosis of six (6) months or less, in accordance with Medicare hospice eligibility criteria. Applicant (or in the case of incapacity, his or her authorized representative and primary physician) must confirm the prognosis and agree in writing to FCH that the focus of care is comfort and palliative only. Symptomatic, psychosocial and spiritual distress will be addressed as desired, but no resuscitative or life-prolonging measures will be taken. Treatment of acute changes may be undertaken for symptom management only and only under the direction of your hospice provider.

Intravenous Therapy: No resident shall require intravenous treatment therapy. Consideration may be made, on a case-by-case basis, regarding the use of intravenous analgesics or enteric therapy. The resident's therapy must be agreed to and overseen by his or her hospice agency.

Mechanical ventilation: No resident shall require mechanical ventilation.

Psychiatric/Behavioral: No resident shall have a condition with behavioral issues that impair the safety or comfort of self or others.

Free of communicable disease: All residents must provide written certification that they are free of communicable diseases.

Medications: Residents who have elected the hospice benefit will have medication delivered to FCH through the hospice provider's existing arrangements. Medications not provided by the hospice agency will be provided by Connecticut Pharmacy. The resident/POA will be billed directly for such medications by Connecticut Pharmacy.

Health Care Proxy: Prior to admission, each resident shall submit a Health Care Proxy designating and authorizing an individual to make critical medical decisions for the resident if he/she is no longer competent to make such decisions. This may be provided to the hospice agency who will share it with us.

Durable Power of Attorney for Finances: Prior to admission, each resident shall submit a Durable Power of Attorney designating and authorizing an individual to make financial decisions and to handle pertinent financial matters for the resident if he/she is no longer competent to make such decisions. This may be provided to the hospice agency who will provide it to us.

Illegal Substances: No resident may have or use illegal drugs while at FCH.

Financial Status: Each applicant, a close family member, the individual designated in the Durable Power of Attorney or other identified responsible person must sign the Resident Service Agreement. An individual responsible for payment of FCH charges must be identified and must fill out a financial worksheet prior to admission.

FCH asks for a deposit of $8,400.00 ($600.00 per day for two (2) weeks of care) in advance. Any days not used will be refunded to the resident or her/his estate. If this is not possible, we may make other arrangements, but the goal is for you to focus on time with the resident rather than finances.

In recognition of the time it takes to admit a resident to FCH, including but not limited to: completing admission paperwork, preparing the room, obtaining and reviewing medical records, coordinating admission with the hospice agency and or current place of residence, there will be $350 one time, non-refundable admission fee. FCH accepts checks, credit cards and ACH for payment.

Documentation is required to confirm sufficient funds to cover six (6) months of residency, unless otherwise agreed upon in writing by the Executive Director.

If you have days of care you have not used, remaining funds will be returned to the responsible party via check from FCH within 30 days of the last day of stay. The remaining funds can also be donated back to FCH and be taken as a tax deduction by the responsible party.

A Completed Application along with the documents outlined in this document must be submitted to the FCH to confirm your room unless otherwise confirmed with the Executive Director.

Termination of Care: A resident may leave or be removed by their legal representative from FCH at any time. All fees due the FCH for stay/services rendered will be collected at the time of departure.

I HAVE READ AND UNDERSTAND AND AGREE TO THE FOREGOING:

Name of applicant or applicant's legal representative: _____

Signature of applicant or applicant's legal representative: _____

Date: _____

Return To:
Julia Portale
Fairfield County House Executive Director
execdtr.fchh@gmail.com or
Fax 203-517-9968 or
One Den Road, Stamford CT 06902

Questions: Call our office 203-921-6405 or cell 203-273-4645

Application for Residency

Fairfield County House (FCH) serves people over 18 years old who are terminally ill without regard to gender, race, ethnicity, nationality, or sexual orientation. FCH serves those in need of home hospice care in the final stages of life. Licensed staff provide nursing and personal care to residents. Trained staff and volunteers provide spiritual and emotional support in collaboration with hospice care delivered by licensed hospice agencies.

Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

What is your primary diagnosis or condition: _____

Other information we should know about your health not on your medical record that would help us plan for your care: _____

Name of your hospice organization: _____
(if you do not have one yet please let us know)

Name of Power of Attorney: _____

Address of POA: _____

Phone number of POA: _____

Name of Healthcare Representative*: _____

Address of HCR: _____

Phone number of HCR: _____
*If POA and HCR are the same, just note "same as above" in HCR spaces.

Financial Resources (this information will be used only to determine financial eligibility)

Total monthly income: $_____

Source(s) of income: _____

_____

Total cash assets (checking, savings): $_____

Total investment amount: $_____
(401K, IRA, Pension, Stocks, Bonds)

__ Other family resources sufficient to cover costs of care

I understand and agree that my residency at Fairfield County House may be re-evaluated at any time for changes in diagnosis, prognosis, financial status, or behavior. The information I have provided here is true and accurate to the best of my knowledge.

_____ _____
Applicant signature Person signing for applicant

_____
Date

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Resident Service Agreement

I understand that the care provided at Fairfield County House (FCH) during my stay is palliative and comfort focused, not curative, in its goals and care; that the program emphasizes alleviation of physical symptoms including pain and the identification and meeting of emotional and spiritual needs which I, and my family and friends, may experience related to my illness.

I understand that if my need for medical or nursing care should, at any time, exceed the services that FCH staff and/or staff of the certified hospice agency are able to provide, or if my condition should stabilize to the point where hospice services are no longer appropriate as deemed by the certified hospice agency, I will be discharged from FCH and will make other arrangements for my care.

I understand that Fairfield County House reserves the right, in its sole discretion, to change a resident's room whenever such change is required in connection with resident's care or safety, by operational considerations, or for any other reason. Fairfield County House staff may require resident/family to retain a bedside sitter at their own expense if required for resident safety.

I give consent and approval for notation to be made in both the records of FCH and the certified hospice service about the care provided at FCH.

I give consent and approval for the release of information and appropriate medical records to or from any health care provider or organization involved with my care.

I understand that I may limit the number of visitors who can visit me and that my visitors will be asked to leave if they become disruptive and/or disturb other residents.

I understand that I may voice my concerns about the care provided at FCH verbally or in writing to the Supervisor of Assisted Living Services or the Executive Director of FCH.

I authorize services to be provided to me at FCH and accept full responsibility for payment of such services at a cost of $600.00 per day which includes 24-hour nursing and personal aide care, room and board, emotional and spiritual support, and coordination with my hospice agency for hospice provided services.

I understand that I will provide advance payment equivalent to two (2) weeks of care at FCH. Should two weeks of care not be needed, I understand that FCH will refund me the balance within 30 days of the last day of my care at FCH.

My signature, or that of my responsible party, acknowledges that I understand all of the above and that I have been given ample opportunity to ask any and all questions concerning FCH, the type of care being provided, my financial responsibility, and complaint procedures.

Resident or Health Care Representative

Name: _____

Signature: _____

Relationship: _____

Date: _____