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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-62232 (01/2024) | **STATE OF WISCONSIN**42 CFR 418.100(e)DHS 131.30(2) |
| **HOSPICE CONTRACTS AND AGREEMENTS REVIEW** |
| Hospice Agency Name      | License No.      | Surveyor Name/Surveyor No.      | Date – Review       |
| **CONTRACT SERVICES:**Does hospice retain professional management responsibility and ensure overall continuity of care? *(P4400, L655)*[ ]  Yes [ ]  NoAre contracts evaluated annually? *(P4410)*[ ]  Yes [ ]  No | **COMPONENTS OF WRITTEN CONTRACT AGREEMENT** |
| **L655****P4405** | **L655****P4405** | **L655****P4405** | **P4405** | **L655****P4405** | **P4405** |
| **Identification of services to be provided** | **Stipulation that hospice authorized provision of services and are delivered in accordance with hospice POC**  | **Manner of coordination and supervision by hospice** | **Delineation of the roles of****hospice and service provider in admission process; assessment, IDG meetings and ongoing provision of palliative and supportive care** | **Personnel Qualifications** | **Method of evaluation of effectiveness of contracted services through a QA program** |
| **CONTRACT TYPE** | **CONTRACT NAME** | **Date Last Reviewed** | **Y** | **N** | **Y** | **N** | **Y** | **N** | **Y** | **N** | **Y** | **N** | **Y** | **N** |
| **PT/OT or Speech** |       |       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Medical Supply/DME** |       |       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
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| **SNF/NF** |       |       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Pharmacy** |       |       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Medical Director\*** *(Must Identify Physician)* |       |       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Physician** |       |       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Inpatient Unit (IPU)** |       |       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |