<INSERT HOSPITAL LOGO>

Patient Choice Form

MRN: <Insert>
Date: <Insert>

Dear <Insert Patient Name>:

Follow up care has been recommended for you after you leave the hospital. You have the right to select any facility or agency to provide that care . If you have insurance, they may designate a selected network of providers for you depending on the care needed. Regardless, it is your choice to select the facility or agency you prefer.

Type of services identified by assessment/reassessment: <select one>.

___ Skilled Nursing Facility
___ Home Health Agency
___ Hospice Services
___Long Term Acute Care
___Inpatient Rehabilitation Facility

Our Case Management Department will provide you with the necessary information and a list of facilities and agencies to assist you in making your decision. Please provide (3) choices, if available. If you have insurance we will assist you by contacting them in order to obtain any necessary authorization for services. The list is provided to you in accordance with federal law and those facilities or agencies that are owned, operated or affiliated with **<Insert Hospital Name>** or its affiliates are <**Insert NONE or list applicable facility or agency names.**>.

Federal and/or State regulations require a disclosure that your referring Physician may have a financial relationship or compensation arrangement with the facility or agency providing care after you leave the hospital. If you would like additional information regarding the possible existence and nature of any such relationship or arrangement, please contact your referring Physician.

Please indicate the name of the facilities or agencies you have selected on this form. If you do not have a preference, please indicate whether or not you will allow placement with the first available provider. Once you make your selection, the Case Management Department representative will make the necessary arrangements for you.

I have been provided information by the hospital to make this decision. I have been included in planning for the care I will need after leaving the hospital and agree with the care that is being arranged.

I have selected the following facility(ies) or agency(ies):

____

____

____

I will allow placement with the first available provider ____ Yes ____ No

I would like this choice to by valid for one year from the date of signature below. ___Yes __No

Patient or Patient Representative: ___________________________ Date: __________

Hospital Representative: ___________________________________ Date: ___________