HOSPICE AIDE EXTENDED SERVICE CHECKLIST
Rev 04/19

For staff use only to determine eligibility for Hospice Aide hours > 10 hours/week —
NOT part of a patient’s clinical record.

Name ________________________________________________  Date ___________
Diagnosis _____________________________________________  Age ____________
__________________________________________________________________________
Lives alone  ☐Yes  ☐No
Insurance ________________________________________________
Location of patient at time of request _____________  PCP ______________________
Hours requested _____________________________  Agency ____________________

Patient-Related Criteria (check factors present)
☐ Unable to position self; requires frequent positioning/turning.
☐ Skin breakdown present, requiring care BID or more often.
☐ Incontinence, requiring frequent changing (q2-3 hrs or more often).
☐ Gross ascites/edema.
☐ Marked impairment of mental status: agitation, severe confusion, unresponsiveness.
☐ Multiple/frequent symptoms.
☐ Safety issues (specify): ________________________________

PCP-Related Criteria (disregard if no PCP)
☐ Unable to understand and/or learn necessary patient care activities.
☐ Physically ill, resulting in observed/documentated functional limitations (describe): _________

☐ Actively abusing drugs/alcohol.
☐ Physically or emotionally abusing patient.
☐ Evidence that PCP is unwilling/incapable of providing needed care (medication, meals,
bathing, turning, etc.) and a competent patient asserts the right/desire to remain in the home
despite these conditions.

Comments:

Date ___________  Case Manager Nurse __________________________________________

Policy: Hospice Aide Services CP229