RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

ADMINISTRATIVE POLICY AND PROCEDURE

Subject: REHABILITATION PROGRAM DISCLOSURE STATEMENT **Policy No.:** B821

Supersedes:	March 16, 2019	Review Date:	April 17, 2024
Origin Date:	March 1, 1995	Revision Date:	

PURPOSE:
To provide a disclosure statement to communicate the rehabilitation treatment program to the patient/support system.

The "Patient Program Information / Disclosure Statement" Form serves as the disclosure statement, for rehabilitation patients. This document provides general overview information about the nature of the rehabilitation program, including scope and intensity of services, estimated length of stay, and financial coverage. The form shall be discussed and given to the patient and/or support system, depending on the patient's ability to understand and participate.

DEFINITION:
Care Coordinator: The Clinical Social Worker serves as the care coordinator and rehabilitation team facilitator. The care coordinator shall ensure that the form is finalized, given to the patient and/or support system, and filed in the electronic medical record.

POLICY:
1. The form shall be completed and discussed with the patient (and/or support system). The discussion with shall take place as soon as is reasonably possible after the rehab team develops a preliminary plan of care – generally within the first 7-10 days of admission.

2. A new form is required for each patient admission. **Exception:** For intra facility discharges and admissions, the previous admission's form may be used.

GUIDELINES:

Form Completion

A. Responsibilities of the Provider/Physician or Designee:
   1. Completes the Patient Program Information Form (except section entitled "Financial Coverage")
   2. Meet with the patient and/or support system after the team develops a preliminary plan of care.
   3. Discuss key points on the form with the patient and/or representative
   4. Identify the date and person(s) involved in the discussion
   5. Medical Provider/Designee shall hand-off the Disclosure Statement to the assigned Clinical Social Worker to be finalized.

B. Responsibilities of the Care Coordinator / Rehab Program Facilitator (Social Worker or Designee)
   1. Finalize the form
   2. Identifies the name/contact info of the Clinical Social Worker/Care Coordinator.
   3. The issue date reflects the date the form was completed and finalized by the Care Coordinator.

Approved By: Aries Limbaga
Digitally signed by Aries Limbaga
Date: 2024.04.17 12:24:04 -07'00'

4. Meets with the patient (and/or support system) to discuss general overview of the program and the section of the form identified as Financial Coverage.
5. Reviews and gives document to the patient and/or support system
6. A copy of the form shall be filed in the medical record.

ATTACHMENT:
Patient Program Information Disclosure Statement Form

Rancho Los Amigos National Rehabilitation Center
Patient Program Information / Disclosure Statement
Información del Programa para el Paciente / Declaración de Divulgación

Rancho Los Amigos provides medical and rehabilitation services using a team of specialists who focus on helping each patient reach the highest level of independence possible. The specialists assigned to your team and the services you will receive are based on your individual needs. Your medical and rehabilitation needs will be evaluated by the team each week. The type and length of services that will be provided may change to meet your needs. Your expected discharge date may also change based on the weekly evaluation. You and your support system are an important part of the team and are encouraged to be actively involved in making decisions about your rehabilitation program.
Rancho Los Amigos brinda servicios médicos y de rehabilitación por medio de un equipo de especialistas que se enfocan en ayudar a cada paciente a alcanzar el más alto nivel de independencia posible. Los especialistas asignados a su equipo y los servicios que usted recibirá se basan en sus necesidades individuales. Dichas necesidades médicas y de rehabilitación serán evaluadas por su equipo cada semana. El tipo y duración de los servicios que se prestarán pueden cambiar para satisfacer sus necesidades. Su fecha de alta anticipada también puede cambiar según la evaluación semanal. Tanto usted como su sistema de apoyo son parte importante del equipo y se les motiva a que participen activamente en la toma de decisiones acerca de su programa de rehabilitación.

Date of Discussion: *Fecha de discusión*	**Discussion By Medical Provider/Doctor (Name):** *Realizado por proveedor de salud/Doctor (nombre)*	**Interpreter's Name *or* ID Number:** *Nombre del intérprete o N^{o} de identificación*

The Following Information was Discussed With: *La siguiente información se habló con*	**Discussion Did Not Occur Because:** *No se informó debido a*
□ **Patient** *Paciente* □ **Patient Representative** *Representante del paciente* **Name of Representative:** *Nombre del representante* _____	□ **Patient lacks capacity** *Paciente carece de capacidad* □ **No identified surrogate** *No se identificó un sustituto* □ **Other:** *Otro* _____
Diagnosis (Your injury or illness): *Diagnóstico (su lesión o enfermedad)*	**Prognosis (Expected recovery from your injury/illness):** *Pronóstico (recuperación esperada de su lesión/enfermedad)*

Major Goals You and Your Team Agreed to Work on:
Metas principales que usted y su equipo acordaron trabajar

PATIENT INFORMATION

MRUN

NAME

DOB/GENDER

The following information is based on what we have learned through our initial evaluation of your medical condition and ability to participate in a rehabilitation program. If you need additional services, the team will discuss plans and make arrangements with you.
La siguiente información se basa en lo que hemos aprendido a través de nuestra evaluación inicial acerca de su condición médica y su capacidad de participar en un programa de rehabilitación. Si necesita servicios adicionales, el equipo hablará de los planes y hará los arreglos con usted.

The length of time we expect you will be at Rancho to complete your program is:
El tiempo esperado que usted estará en Rancho para completar su programa es

□ **Approximately** *Aproximadamente* _____**weeks** *semanas*
□ **Difficult to determine at this time due to:** *Difícil de determinar en este momento debido a*

You will receive an average of 15 hours of therapy per week from the following therapies:
Usted recibirá un promedio de 15 horas a la semana de las siguientes terapias

□ **Physical Therapy** *Terapia física* □ **Occupational Therapy** *Terapia ocupacional* □ **Speech Therapy** *Terapia de habla*

Other services may include: *Otros servicios pueden incluir*

□ **Nursing Care** *Atención de enfermería*
□ **Social Work Services** *Servicios de trabajo social*
□ **Nutritional Services** *Servicios nutricionales*
□ **Psychological Services** *Servicios de psicología*
□ **Respiratory Therapy** *Terapia respiratoria*
□ **Recreation Therapy** *Terapia recreativa*

□ **Other:** *Otro* _____

Financial Coverage: *Cobertura financiera*

□ **Medi-Cal** □ **Medi-Cal Application Pending Approval** *Aprobación de solicitud pendiente*
□ **Medicare** □ **California Children Services** *Servicios para niños de California*

□ **Private Insurance (Specify Coverage):** *Seguro médico privado (especifique cobertura)* _____

□ **Other (Specify Coverage):** *Otro (especifique cobertura)* _____

A meeting may be scheduled at a later date with you and your support system to discuss your program and discharge plan in more detail. Contact the Social Worker if you would like more information or need help to understand your program or financial coverage.
Se puede programar una reunión con usted y su sistema de apoyo en una fecha posterior para hablar con más detalle sobre su programa y plan de alta. Comuníquese con el trabajador social si desea más información o si necesita ayuda para entender su programa o cobertura financiera.

Medical Provider Name: *Nombre del proveedor de salud*

_____

Social Worker Name: *Nombre del trabajador social*

_____ (562) 385-_____

Form Given To: *Formulario entregado a* _____

Issue Date: *Fecha de entrega* _____

PATIENT INFORMATION

MRUN

NAME

DOB/GENDER