University of California
San Francisco
advancing health worldwide

UCSF Health

From: UCSF Transfer Center
Phone: 415.353.9166
Fax: 415.353.9172 or 415.353.1996

A patient at your facility has been accepted for inpatient transfer to the UCSF Medical Center.

The following documents need to be completed and returned via fax:

- **Transfer Agreement (*must have both an administrator and a physician's signature*)**
- **Provider Information Form**
- **Terms and Conditions (*if patient able to sign*)**
- **Medicare MSP Questionnaire (*if applicable*)**
- **Discharge summary (*dated within 24 hours of bed release*)**

Once all documents are received, the patient is clinically stable, and a bed is identified, you will be notified by the UCSF Transfer Center to arrange transport.

UCSF Medical Center has two campuses in San Francisco:

- ***Parnassus Campus* – 505 Parnassus Avenue, San Francisco CA 94143**
- ***Mission Bay Campus* – 1975 4th Street, San Francisco CA 94158**

The campus location, unit name/room, and phone number for RN report will be provided upon bed release. Please do not arrange transport until a bed has been released.

Please prepare a CD of all imaging, as well a copy of all portions of the medical record (unless available via EPIC), to accompany patient upon transfer.

Contact the UCSF Transfer Center at 415.353.9166 for any questions or concerns.

UCSF Medical Center

TRANSFER CENTER
505 Parnassus Ave.
M-140A, Box 0208
Phone: (415) 353-9166
Fax: (415) 353-9172

TRANSFER AGREEMENT

Transferring Facility: _____ **Date of Transfer:** _____

Referring Physician: _____ **Phone:** _____

Contact Person: _____ **Phone:** _____ **Fax:** _____

Patient's Name: _____

1. **This is to confirm that UCSF has received a request to accept the above patient as a transfer from your facility for tertiary or quaternary clinical care which your facility is unable to provide to your patient.**
2. **The transferring facility will provide a transfer summary, a copy of the appropriate portions of the medical record, diagnostic test results and all requested/appropriate diagnostic films to accompany the patient.**
3. **The transferring facility will not transfer the patient until the receiving physician has consented to accept the patient and the transfer has been cleared by the UCSF Transfer Center.**
4. **The transferring facility will ensure that the patient is medically stable and suitable for all procedures and treatments at the time of transfer.**
5. **By signing below, it is confirmed and binding that the transferring facility and referring physician, or appropriate clinical leadership, agree to accept the patient in return transfer upon notice from UCSF.**
6. **Under no circumstances will UCSF assume financial responsibility for the cost of transferring or transporting any patient to or from UCSF.**
7. _____ **(Transferring Facility) agrees to be responsible for the transportation cost to UCSF Medical Center not covered by the patient's insurance.**

X _____ _____
Signature of Administrator Authorizing Acute Transfer back **Date/Time**

X _____ _____
Print Name and Title of Administrator Authorizing Acute Transfer back **Date/Time**

X _____ _____
Signature of Physician Accepting Acute Transfer back **Date/Time**

X _____ _____
Print Name of Physician Accepting Acute Transfer back **Date/Time**

THIS IS A BINDING AGREEMENT. BREACH OF THIS AGREEMENT MAY IMPACT FUTURE TRANSFERS.

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PROVIDER INFORMATION FORM

Please complete form and fax back to transfer center as part of your transfer request:

Referring MD Provider Information:

Referred by (Full name): _____ Sex:___

Cell Phone: _____ Office:_____ Fax: _____

Address: _____

City:_____State: _____ Zip:_____ Specialty:_____

***E-mail Address:** _____
[Requested for professional and provider use only for collaborative patient care]

Primary Care Provider Information:

Referred by (Full name): _____ Sex:___

Cell Phone: _____ Office:_____ Fax: _____

Address: _____

City:_____State: _____ Zip:_____ Specialty:_____

Patient Information: *(Please provide copy of patient demographics/face sheet):*

Last Name:_____First Name:_____

DOB: _____ Gender: ☐ Male ☐ Female

Referring Facility:_____

Form completed by: _____ **Phone:**_____

Date:_____

UCSF Medical Center

UCSF Benioff Children's Hospital

UNIT NUMBER

PT. NAME

BIRTHDATE:

DATE OF SERVICE:

TERMS AND CONDITIONS OF SERVICE: ADMISSION, MEDICAL SERVICES, AND FINANCIAL AGREEMENT (Page 1 of 3)

1. **UCSF MEDICAL CENTER:** is part of the University of California and is comprised of its hospital(s) (UCSF Medical Center, UCSF Medical Center at Mt. Zion, and UCSF Benioff Children's Hospital), its hospital-based clinics, its Primary Care Network clinics, and the UCSF School of Medicine.

2. **MEDICAL CONSENT:** I consent to medical treatments or procedures, X-ray examinations, drawing blood for tests, medications, injections, taking of treatment related photographs, videotaping, laboratory procedures, and hospital services rendered to me under the general and special instructions of the physicians or other health care professionals assisting in my care. To facilitate my care, I consent to evaluation and examination by a physician or other health team professionals who may be physically distant from me via telehealth technologies, including but not limited to two-way video, digital images, and other telehealth technologies as determined by my providers. I also consent to my admission to the UCSF Medical Center if this is necessary for my care.

   I understand that I may be receiving education and instructions about my medical condition. UCSF Medical Center uses a variety of methods and vendors for this education and instruction and I consent to receiving this instruction using those methods and vendors, including, but not limited to Oneview, EMMI, Healthwise and Healthnuts.

3. **TEACHING, RESEARCH AND HEALTHCARE INSTITUTION:** The University of California including UCSF Medical Center, is a teaching, research and healthcare institution. I understand that residents, interns, medical students, students of ancillary health care professions (e.g., nursing, x-ray, rehabilitation therapy), post-graduate fellows, and other trainees and visiting professors may observe, examine, treat, and participate at the request and under the supervision of the attending physician in my care as part of the University's medical education programs.

   I also understand that a University institutional review board approves projects conducted by the University researchers in accordance with state and federal law. As a result, I understand that I may be contacted and asked to participate in research studies but I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.

4. **USE OF MEDICAL INFORMATION AND SPECIMENS:** I understand that my medical information, photographs, and/or video in any form may be used for other UCSF Medical Center purposes, such as quality improvement, patient safety and education. I also understand that my medical information and tissue, fluids, cells and other specimens (collectively, "Specimens") that UCSF Medical Center may collect during the course of my treatment and care may be used and shared with researchers and any such use will be in accordance with state and federal law, including all laws and regulations governing patient confidentiality, in the manner outlined in the UCSF Medical Center Notice of Privacy Practice. I understand that under California law, I do not have any rights to any commercially useful products that may be developed from such research.

5. **PERSONAL VALUABLES:** UCSF Medical Center asks patients and families not to bring valuable items into its facilities. UCSF Medical Center shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, cell phones, electronic devices or other articles of unusual value and shall not be liable for loss or damage to any personal property, unless deposited in the fireproof safe maintained by UCSF. The liability for loss of any personal property deposited with UCSF Medical Center shall be no more than $500.

UCSF Medical Center

UCSF Benioff Children's Hospital

UNIT NUMBER

PT. NAME

BIRTHDATE:

DATE OF SERVICE:

TERMS AND CONDITIONS OF SERVICE: ADMISSION, MEDICAL SERVICES, AND FINANCIAL AGREEMENT (Page 2 of 3)

6. **RELEASE OF MEDICAL INFORMATION:** The State of California Information Practices Act requires UCSF Medical Center to provide the following information to individuals who supply information about themselves. As a patient of UCSF Medical Center, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under federal and state laws and regulations, UCSF Medical Center is authorized to maintain this information. As required by UCSF Medical Center, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage.

   UCSF Medical Center will obtain my written authorization to release information about my medical treatment, except in those circumstances when UCSF Medical Center is permitted or required by law to release information (see UCSF Medical Center's Notice of Privacy Practices for a description of the specific circumstances under which UCSF Medical Center may release this information). For example, UCSF Medical Center may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with cancer, a reportable disease in California, UCSF Medical Center is required by law to report my diagnosis to the State Department of Health Services.

7. **SMOKING:** Smoking is NOT allowed on the campuses of UCSF Benioff Children's Hospital, UCSF Medical Center and UCSF Medical Center at Mount Zion (herein referred to as the Medical Center). Smoking has been determined to be hazardous to your health. If you are a smoker, we advise you to stop smoking. If you have a recent history of smoking in the last year, we advise you to continue to stop smoking. Alternatives to help curb your cravings for nicotine are available. Patients are not allowed to leave the hospital to smoke. Please speak with your clinical team to learn more about these alternatives or if you have any questions concerning smoking cessation. This policy applies to patients and visitors of the Medical Center.

8. **BEHAVIOR:** UCSF has a zero tolerance for violence in our facilities. As such, UCSF is committed to maintaining a safe workplace that is free from threats and acts of intimidation and violence. For the safety and security of our patients, visitors and staff, weapons, knives, alcohol, illegal drugs and other dangerous materials are not allowed in our facilities. It is the expectation of the Medical Center that you conduct yourself in a respectful, non-violent and non-abusive manner and that you do not leave the hospital at any time during your stay. It is against hospital policy for you to leave your assigned unit with property belonging to the hospital (example: gowns, IV machines, oxygen tanks, etc.). You may be discharged if you leave the hospital without informing your clinical team or if you repeatedly violate the hospital's smoking policy.

   I also understand that under California law I may not film or record any images or sounds of our/my conversation with a UCSF employee or physician without the consent of all parties to the conversation and that violation of this law may result in criminal or civil liability. Please refer to your patient handbook for more information concerning your stay here at UCSF's hospitals and facilities.

9. **FINANCIAL AGREEMENT:** I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay The

UCSF Medical Center

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TERMS AND CONDITIONS OF SERVICE: ADMISSION, MEDICAL SERVICES, AND FINANCIAL AGREEMENT (Page 3 of 3)

Regents of the University of California for professional, hospital and clinic services, including UCSF Medical Center physician services, in accordance with the regular rates and terms of UCSF Medical Center. I also agree to pay for other professional services provided at UCSF Medical Center by other health care providers. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.

10. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):** I authorize and direct payment to UCSF Medical Center of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UCSF Medical Center services, including emergency services, at a rate not to exceed UCSF Medical Center actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to UCSF Medical Center by me.

I have read, agreed to and received a copy of this Terms and Conditions of Service.

_____

Signature of Patient or Signature of Patient Representative

_____

Signature of Witness (required if patient unable to sign) Relationship of Representative to Patient

_____

Signature of Interpreter Language Used

Date of Signing _____

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 9) and Assignment of Benefits (including Medicare Benefits) (Paragraph 10) set forth above.

_____ _____ _____

Date Financially Responsible Party Witness

Elective Section:

PATIENT RIGHTS NOTICE: (This question only applies to inpatient admissions only)
Would you like your agent under a durable power of attorney for health care or your next of kin to receive a copy of the Patient Rights and Responsibilities Notice? If so, please ask your admitting representative or contact the Patient Relations Department at (415) 353-1936.

500-0512C (Rev. 03/16) MEDICAL RECORD COPY GENERAL WITH FINANCIAL AGREEMENT

UCSF Medical Center
UCSF Benioff Children's Hospitals

Medicare Secondary Payer Questionnaire

The following questionnaire is an abbreviated MSPQ to be completed in Transfer Center Patient Screening and during rare instances of APEX "Downtime".

Beneficiary Information

Medicare Beneficiary: _____ Patient MRN #_____
Person Interviewed: _____ Date of Service: _____
Relationship to Patient: _____ Staff: _____

PART I

1. Are you receiving Black Lung (BL) Benefits?

☐ Yes Answer following Questions:
Date Benefits began:_____
Are these services related to Black Lung?
☐ Yes BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL
☐ No Go to #2

☐ No Go to #2

2. Are the services to be paid by a government research program?

☐ Yes GOVERNMENT RESEARCH PROGRAM IS PRIMARY FOR THESE SERVICES
☐ No Go to #3

3. Are you entitled to benefits through the Department of Veterans Affairs (DVA) and have they authorized and agreed to pay for care at this facility?

☐ Yes DVA IS PRIMARY FOR THESE SERVICES
☐ No Go to #4

4. Is the illness/injury due to a work-related accident/condition?

☐ Yes WC IS PRIMARY PAYER ONLY FOR CLAIMS FOR WORK-RELATED INSURIES OR ILLNESS
Answer following Questions:

Plan name _____	Employer Name _____
Adjuster Name _____	Claim # _____
Adjuster Phone _____	Auth #_____
Claims address _____	Policy owner address _____
City _____	City_____
State_____ Zip_____	State_____ Zip_____

☐ No Go to #5

5. Is the illness/injury due to a non-work-related accident? (If work-related, go to #4)

☐ Yes **NOTE: UCSF does not accept third party liability, other than Workers' Compensation**
FOR UCSF ED Patients – Register with Medicare and set BI (Billing Indicator) to 216 Suspected TPL (FC will F/U)
If TPL, FC will remove Medicare, remove BI, and change to Self-Pay
If billable to Medicare, FC will remove BI and note account with findings
FOR ALL OTHER account types – Register as Self Pay
NOTE: UCSF does not accept third party liability <u>without an exception approval from Admitting Manager.</u> Upon exception approval, Admitting Manager will provide instruction on account documentation.

☐ No Go to #6

Medicare Secondary Payer Questionnaire

6. Is the patient entitled to Medicare based on End Stage Renal Disease (ESRD)

☐ Yes

Is patient within the 30-month coordination period?

☐ Yes GHP and/or COBRA primary

☐ No Medicare is primary

The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis). If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.

☐ No Go to #7

PART II

7. Is the patient entitled to Medicare based on Age or Disability?

☐ Yes ☐ Age or ☐ Disability

☐ No

8. Is the patient currently employed?

☐ Yes _____ Approximate number of employees

☐ No If applicable, date of retirement _____

☐ No, Never Employed

9. Does the patient have a spouse who is currently employed?

☐ Yes _____ Approximate number of employees

☐ No

10. Is patient covered under a Group Health Plan through their own or spouse's employer?

☐ Yes Patient or Spouse _____

Employer name _____

Employer address _____

Employer sponsoring the plan employs (choose one):

☐ < 20 employees ☐ ≥ 20 employees ☐ ≥ 100 employees

If patient has Medicare based on age, and GHP of patient and/or spouse employs 20 or more employees, obtain information and bill insurance as primary.

If patient has Medicare based on disability, and GHP of patient and/or spouse employs 100 or more employees, obtain information and bill insurance as primary.

☐ No MEDICARE IS PRIMARY UNLESS PATIENT ANSWERED YES TO QUESTIONS IN PART I