PATIENT ELECTION FOR MEDICAID HOSPICE SERVICES BY HOSPICE AND ASSIGNMENT BENEFITS

The undersigned patient hereby elects to receive Medicaid hospice care in lieu of other Medicaid benefits (except attending physician, Medicaid Services not covered by Medicare and room and board in a nursing facility) related to treatment of the condition certified by the attending physician of the undersigned.

I have read and understand the description of service to be provided by _____ Hospice.

I understand that Hospice cannot provide 24-hour care in my home to take the place of family members or friends. Should it become necessary for me to have a "live-in" helper, I will need to use my own resources to pay that person or consider nursing home care.

I further understand that in making this election, I waive all other rights to Medicaid benefits as to the certified condition, except for the services of my attending physician, Medicaid Services not covered by Medicare and room and board in a nursing facility.

I further understand that I am entitled to four election periods of hospice care consisting of two ninety-day periods, and unlimited sixty-day periods.

I understand that I may revoke this election of hospice care at anytime by filing a revocation statement with _____ Hospice. If I revoke the benefit, I also revoke the remaining days of that benefit period.

In consideration of the foregoing, I agree to accept the services of and hereby assign my Medicaid hospice benefits to _____ Hospice.

Dated at_____ this __ day of _____, 20 _____.

_____ Patient Signature

_____ Witness Signature

_____ Patient Birthdate

_____ Patient Name (type or print)

_____ Age

_____ Address

_____ Medicaid ID#

_____ City State Zip