

**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