



# Election of Hospice Services

I, \_\_\_\_\_, the patient, am requesting that my attending physician, \_\_\_\_\_, will continue to be involved with my care. I understand that if it is necessary that I be admitted to the Hospital, I will continue to receive my in-hospital care at \_\_\_\_\_.

**I understand that:**

I want only comfort care: reducing symptoms, relieving suffering, while maximizing comfort, dignity, and control.

There are a number of Hospice services that may be ordered by my attending physician and the Hospice as outlined on the Disclosure Statement.

I will have my expenses related to the care of my terminal illness financially covered by the Hospice program.

I will need to go to a medical facility contracted with Hospice, if necessary for inpatient care, for Hospice to be financially responsible for treatments/services related to my terminal illness.

I will be certified/re-certified by the Hospice Medical Director at specific certification periods as eligible for the hospice benefit.

I will be discharged from Hospice services if I am determined to no longer be terminal.

I may revoke this Election of Hospice services at any time for any reason. Revocation must be made by me or my representative **prior** to seeking any treatments not authorized by hospice.

I may transfer to another Medicare Certified Hospice program one time in each election period.

I may re-elect Hospice services at anytime, if I still meet hospice eligibility requirements.

I will discuss with Hospice any medical appointments, treatments, and other medical care that is related to my terminal illness **prior** to receiving such care.

The Medicare Hospice Benefit takes the place of my Medicare Part A benefits related to my terminal illness. My Medicare Part A benefits are still in effect for all healthcare services unrelated to my terminal illness.

Hospice is **NOT** responsible for medical expenses that are not **prior** approved by Hospice and in the Hospice Plan of Care.

Hospice does **NOT** pay for Nursing Facility room and board.

I or my representative may contact Hospice to ask questions regarding what expenses are and are not covered under the Hospice benefit.

I hereby elect **Family Hospice of Northeast Indiana** to provide my care pursuant to the Medicare Hospice Services Benefit, authorize, and assign my hospice insurance benefits to be paid to **Family Hospice of Northeast Indiana**.

My Hospice Services Benefit is effective \_\_\_\_\_ at \_\_\_\_\_ a.m. / p.m.

The representative understands the effective date and time will be entered when the patient is eligible for admission due to \_\_\_\_\_.

I authorize the disclosure of all or any part of my clinical record or any other necessary information to any person or company that is or may be liable for all or part of the Hospice charges; to include but not limited to Medicare, Medicaid, commercial insurance, and Veteran’s Administration. This consent to the release of information from my clinical record may be revoked at any time by me upon written notice to Hospice.

Patient/Representative \_\_\_\_\_ Date \_\_\_\_\_

Hospice Representative \_\_\_\_\_ Date \_\_\_\_\_