Sample Hospice Election Form

INFORMED CONSENT AND MEDICARE BENEFIT ELECTION FORM

I, (Beneficiary's Name) have been informed that (Hospice Agency) offers hospice care under a Medicare hospice benefit program to those who have a terminal illness.

I understand the following explanation of the Medicare hospice benefit:

1. (Hospice Agency) will receive payment for my care, relating to my terminal illness.
   a. I understand the purpose of hospice care and that the treatment is primarily palliative rather than curative.
   b. Medicare will continue to make payment to my independent attending physician for services if my physician is not a hospice employee nor receiving payment from (Hospice Agency)
   c. I waive my rights to Medicare benefits related to my terminal illness while enrolled in the Medicare hospice program.
   d. I may be responsible for five percent of the reasonable cost up to a maximum of $5.00 for each outpatient individual prescription for my terminal illness and can be charged up to five percent of individual respite care.
   e. I am responsible for the cost of care for my terminal illness if I seek care beyond what is considered medically necessary by the hospice interdisciplinary team and documented on my plan of care.
2. I can change from one hospice to another, if I wish to do so. To change programs, I will confirm that I may be admitted to another hospice, and then I will inform (Hospice Agency) of my wishes so arrangements for transfer can be made. I will specify a date to discontinue care from (Hospice Agency), the name of the hospice from which I wish to receive care, and the date care will start. In changing to another hospice program, I will not lose any benefit days. I may change hospices only once during each benefit period.
3. The Medicare hospice program consists of two 90-day periods, and unlimited 60-day periods if no revocations or discharges occur. I will use the benefit periods in the above order.
4. I may discontinue hospice care at any time by completing a revocation statement. If I revoke during a benefit period, I lose the remaining days in that benefit period. (Example: If I revoke hospice care on the tenth day of the first 90-day benefit period, I give up the remaining 80 days of coverage.) I may, however, re-elect at any time when I am eligible.
5. Hospice care may involve skilled nursing care, volunteer companions and caregivers, emotional and spiritual care, physical or other therapies, social workers, and inpatient care.
6. All care is physician directed through my independent attending physician and the Medical Director for (Hospice Agency).

Acknowledging and understanding the above, I authorize Hospice Medicare services from (Hospice Agency).

Effective date for hospice care to begin: (date)

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Signature of beneficiary or legal representative

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