

**HOSPICE & PALLIATIVE CARE OF GREATER WAYNE COUNTY  
MEDICARE AND/OR MEDICAID BENEFIT ELECTION FORM**

I, \_\_\_\_\_, choose to receive hospice care from Hospice & Palliative Care of Greater Wayne County. I acknowledge the following:

1. Hospice care is not curative. Supportive, palliative care is provided by the hospice. The program's goal is not to cure my terminal illness, but to reduce symptoms such as pain or nausea and to provide emotional and spiritual support.
2. I choose hospice care and elect the Medicare and/or Medicaid Hospice benefit as the payment source for all services and treatment related to my terminal diagnosis of:

\_\_\_\_\_.

I understand that I must have prior approval from hospice before ordering or receiving treatment, supplies, equipment, or any other services related to the diagnosis listed above.

I understand that if I fail to get preauthorization from hospice for any services, equipment, supplies, etc. related to this diagnosis I may be financially responsible for any charges incurred.

Medicare and/or Medicaid will pay my doctor directly, unless my physician is a hospice medical director or contracted physician.

3. Medicare and Medicaid will continue to pay for care not related to the diagnosis listed above.
4. I can choose not to continue hospice care and may revoke my election in writing at any time.
5. If I revoke my hospice Medicare and/or Medicaid benefit in the middle of a benefit period, I give up the remaining days in the benefit period.
6. I can choose to receive hospice care from another hospice program at any time during the benefit periods. No benefit days will be lost by transferring to another hospice program.

ACKNOWLEDGING THE ABOVE, I AUTHORIZE HOSPICE MEDICARE and/or MEDICAID COVERAGE FROM HOSPICE & PALLIATIVE CARE OF GREATER WAYNE COUNTY TO BEGIN ON \_\_\_\_\_.  
Month/Day/Year

(I UNDERSTAND THAT ELECTION BEGINS AS OF THIS DATE AND CANNOT PRECEDE THE DATE OF MY SIGNATURE BELOW).

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Witness Signature

<b>For Office Use Only:</b> Medicare # _____ Medicaid # _____
Attending Physician _____