

I, \_\_\_\_\_ (Patient Name) choose to elect the Medicare hospice benefit and receive Hospice services from Hospice & HomeCare of Reno County to begin on \_\_\_\_\_ (Start of Care Date).

**(Note: The start of care date, also known as the effective date of the election, may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.)**

## Right to choose an attending physician

- I understand that I have a right to choose my attending physician to oversee my care.
- My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

I do not wish to choose an attending physician

I acknowledge that my choice for an attending physician is:

**(Please provide any information that will uniquely identify your attending physician choice.)**

**Physician Full name:** \_\_\_\_\_

## Hospice Philosophy and Coverage of Hospice Care

By electing hospice care under the Medicare hospice benefit, I acknowledge that:

- I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.
- Hospice services may include but not limited to: skilled nursing, medical social work, spiritual and bereavement counseling, home health aides and homemakers, volunteers, physical, occupational, and speech therapy, dietary counseling, physician services, medical supplies, durable medical equipment and OTC/prescription medications.
- Level of care is determined on the patient's medical necessity, hospice provides Routine Care, Respite Care, Inpatient Care, and Continuous Care.
- I was provided information on which items, services, and drugs the hospice will cover and furnish upon my election to receive hospice care.
- I was provided with information about potential cost-sharing for certain hospice services, if applicable.
- I understand that by electing hospice care under the Medicare hospice benefit, I waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.
- I understand that items, services, and drugs unrelated to my terminal illness and related conditions are exceptional and unusual and, in general, the hospice will be providing virtually all of my care while I am under a hospice election. The items, services, and drugs determined to be unrelated to my terminal illness and related conditions continue to be eligible for coverage by Medicare under separate benefits.
- Some items services or drugs may no longer be medically appropriate for you. Hospice will alert you to these items. If they occur, and will discontinue them from the hospice plan of care. If you choose to continue with these items, you will be financially responsible for them.

Patient Name: \_\_\_\_\_



- 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 benefits in the above order.
- 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. I may, however, re-elect at any time when I am eligible.
- I can change from one hospice to another, if I wish to do so. I will specify a date to discontinue care from Hospice & Homecare of Reno County, 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.

**Right to Request “Patient Notification of Hospice Non-Covered Items, Services, and Drugs**

- As a Medicare beneficiary who elects to receive hospice care, you have the right to request at any time, in writing, the **“Patient Notification of Hospice Non-Covered Items, Services, and Drugs”** addendum that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice.
  - The hospice must furnish this notification within 5 days, if you request this form on the start of care date, and within 72 hours (or 3 days) if you request this form during the course of hospice care.
- I request** to have a copy of the Patient Notification of Hospice Non-Covered Items, Services, and Drugs  
 Person requesting (please print): \_\_\_\_\_
- I decline** to have a copy of the Patient Notification of Hospice Non-Covered Items, Services, and Drugs

**Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)**

As a Medicare hospice beneficiary, you have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice’s determinations. The BFCC-QIO that services your area is:

**BFCC-QIO Name:** Livanta

**BFCC-QIO Phone Number:** (888)-755-5580; TTY: (888)-985-9295; Fax: (855)-694-2929

**Signatures**

\_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**Signature of Patient/Beneficiary**

Beneficiary is unable to sign

\_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**Signature of Legal Representative/Surrogate Decision Maker**

\_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**Signature of Agency Staff**