MinnesotaHospice
THE GOLD STANDARD of Care

Election of Hospice Benefit

I, _____, elect the Medicare/Medicaid Hospice benefit to be provided by Minnesota Hospice and understand the program is palliative (comfort-oriented), not curative, in its goals. I acknowledge, consent and agree to the following:

- The approximate cost and methods of payment through my payer have been explained to me.
- I understand that I am waiving my traditional Medicare benefit as related to my terminal hospice diagnosis.
- I am responsible for the cost of care for services or medications if I choose to seek medical care beyond what Minnesota Hospice has deemed medically necessary and is not part of my hospice plan of care.
- I authorize payment of benefits from any third-party vendor to be made directly to Minnesota Hospice for the services rendered.
- I authorize the release of medical records/information to and from other healthcare providers as required for continuity of care and payment as permitted by law.
- I understand that a Do Not Resuscitate (DNR) order is not required for admission to hospice.
- I understand that I may revoke this Hospice election in writing and withdraw from the Hospice program at any time and have traditional Medicare or Medicaid benefits fully restored immediately. I may choose to elect Hospice services again at any time. Care for all illnesses other than the primary diagnosis for which Hospice is treating me can be billed to Medicare or Medicaid in the traditional manner.

1. **INPATIENT:** Minnesota Hospice may authorize inpatient care related to the hospice diagnosis. In the event I require inpatient care, I am likely to use _____ Hospice/Facility.

☐ This facility has a contract with Minnesota Hospice to provide inpatient hospice care. Services will be paid through the hospice benefit if the admission has been authorized by Minnesota Hospice, is related to the hospice diagnosis and the plan of care is to manage symptoms which cannot be managed in the home setting.

☐ This facility does not have a contract with Minnesota Hospice. I understand that an admission to a non-contracted facility will be considered a decision to revoke my hospice benefit. I may choose to receive inpatient care at a Minnesota Hospice contracted facility to assure my hospice benefit overage is not interrupted.

2. **CUSTODIAL, SUPPORTIVE OR RESPITE:** Medicare Hospice Benefit provides skilled nursing services and Home Health Aides, for personal care, according to the needs specified in my hospice plan of care. The Medicare benefit also provides coverage for respite care at a Minnesota Hospice contracted facility for caregiver relief. I understand respite care is limited to five consecutive days.

3. **ATTENDING PHYSICIAN:** I have selected _____ as my attending physician.
Attending physician NPI Number: _____

I have read or have had read to me, this election form and the outline of services provided by Minnesota Hospice. I understand the services and fully understand the care provided under the Medicare Hospice Benefit. I elect to receive this benefit and sign this form of my own free will.

Acknowledging and understanding the above, I authorize Medicare hospice coverage to begin on ___/___/___

_____ _____
Signature of Patient Date

I attest I am the patient's legal Authorized Representative: ___ POA ___ DPOA ___ Guardian

Authorized Representative (Print name) _____ Relationship_____
Signature of Authorized Representative _____ Date: _____

Reason patient is unable to sign election of benefit: _____

_____ _____
Minnesota Hospice Representative Signature Date