angels grace
HOSPICE

CONSENT FOR ELECTION OF MEDICARE HOSPICE BENEFIT

PATIENT NAME: _____ **PATIENT ID:** _____

INFORMED CONSENT

I acknowledge/understand the following:

I understand the nature of the hospice care available through the Medicare Hospice Benefit and am aware that all treatment will focus on comfort (palliative) rather than cure (curative) or life prolonging. Treatment will be for management of symptoms and to provide comfort for my terminal illness. The focus of my care will be to maintain me in my home rather than in a hospital.

I understand that I or my representative have the right to choose my attending physician. My attending physician is _____.

I understand that I and/or my caregiver will participate in developing the plan of care along with the hospice team composed of a physician, nurse, medical social worker, spiritual counselor, volunteer and other disciplines that may be necessary.

I waive the right to all other benefits under the Medicare Program while I am receiving hospice benefits. Only Angels Grace Hospice will be able to receive Medicare payment for care or services provided to me for my terminal illness or any other condition related to my terminal illness.

Medicare will make payment for unlimited hospice days; however, the days are broken into three benefit periods to be used in this order. These periods are as follows:

First Benefit Period	-	90 days
Second Benefit Period	-	90 days
Subsequent 60 day Period	-	Unlimited as long as beneficiary meets requirement for benefit.

Prior to the beginning of each benefit period my medical condition will be evaluated for continued hospice appropriateness by my physician and the hospice interdisciplinary group.

I understand that I may be responsible for five (5) 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 (5) percent of individual respite care.

I understand that I can use standard Medicare in the usual manner to pay the bill for:

1. My doctor, if not an employee of this hospice.
2. Treatment of a condition unrelated to my terminal illness. (See above)

I understand that I can revoke this benefit at any time and resume regular Medicare coverage. I know I will lose any hospice days remaining in the benefit period in which I revoke.

I understand that I may transfer my hospice care to another Hospice Program once during each election period.

Acknowledging/understanding the above, I authorize Medicare Hospice Benefit coverage to begin on: _____.
Month/Day/Year

_____ _____
Beneficiary or Representative Signature Date

_____
Relationship of Legal Representative to Beneficiary

_____ _____
Hospice Representative Signature Date

FOR OFFICE USE ONLY - Terminal/Principal Diagnosis: _____ **ICD Code:** _____