

## CONSENT FOR ELECTION OF MEDICARE HOSPICE BENEFIT

I understand the nature of the hospice care available through the Medicare Hospice Benefit and am aware that all treatment will for on comfort (palliative) rather than cure (curative) or life prolonging. Treatment will be for management of symptoms and to procomfort 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 I understand that I and/or my caregiver will participate in developing the plan of care along with the hospice team composed of 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 Hospill be able to receive Medicare payment for care or services provided to me for my terminal illness or any other condition related to terminal illness.  Medicare will make payment for unlimited hospice days; however, the days are broken into three benefit periods to be used in this on These periods are as follows:  First Benefit Period 90 days Second 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 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 outpatindividual prescription for my terminal illness and can be charged up to five (5) percent of individual respite care.  I understand that I may be responsible for five (5) percent of the reasonable cost up to a maximum of \$5.00 for each outpatindividual prescription for my terminal illness and can be charged up to five (5) percent of individual respite care.  I understand that I can re	PATIENT NAME:	PATIENT ID:
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