Iowa Department of Human Services

ELECTION OF MEDICAID HOSPICE BENEFIT

I understand that my disease is incurable. I consent to the management of the symptoms of my disease by the hospice. I understand the care services provided by the hospice are nursing care, physician services, medical social services and counseling. If needed I may also receive short-term inpatient care, medical appliances and supplies, home health service and physical therapy, occupational therapy and speech or language pathology service. I have been given a full understanding of hospice services.

I understand I waive my right to regular Medicaid benefits, except for payment to my regular physician and treatment for medical conditions unrelated to my terminal illness.

I understand the election of hospice care continues as long as I remain in hospice and do not revoke the election. If I revoke my choice of hospice benefits, I can resume regular Medicaid benefits if I am still eligible.

I understand Medicaid recipients are not responsible for co-pay or other deductibles.

I understand that if I reside in a nursing home and receive hospice, I must pay the amount of client participation determined by the Department of Human Services.

I understand that the hospice benefit is a home care program. If my family and I choose care not available from the hospice agency, I understand that the hospice and the Medicaid program are not financially responsible.

I understand that I may change hospice providers once during my certification by completing a new form.

Section 1. Medicaid Information

Recipient Name	Medicaid No.	Begin Date of Care
Hospice Name		Medicaid Provider No.
Attending Physician Name		Phone No.

Section 2. Medicare Information

Medicare Patient Name	Medicare Claim No.	Begin Date	End Date

Section 3. Nursing Facility Information

Facility Name	Medicaid Provider No.
Facility Address	

Section 4. Hospice Change

Present Hospice	Medicaid Provider No.	Effective Date of Change
New Hospice	Medicaid Provider No.	Effective Date of Change

Section 5. Signatures

Recipient's Signature or Mark	Date Signed	Witness' Signature	Date Signed

470-2618 (1/90)