MIDDLESEX
HOSPICE AND PALLIATIVE CARE

ELECTION OF HOSPICE MEDICARE BENEFIT

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

I am requesting admission to the Middlesex Hospice and Palliative Care Program. I have been advised by my physician of my diagnosis, prognosis and terminal illness.

I understand that the Hospice Program is not curative, but is palliative in its care and services. I understand that the focus of the care provided by the Hospice Program is to alleviate my pain and other symptoms, and that no extreme medical or surgical measures or artificial life support systems will be used.

I understand that my Hospice care will be coordinated and managed by the Middlesex Hospice and Palliative Care Interdisciplinary Group. Hospice services provided to me will be in accordance with my plan of care, which I have reviewed. Hospice services provided to me in my home include:

1. Nursing, counseling, social, pastoral, personal and homemaker care on an intermittent basis in my home.
2. Physical therapy, occupational therapy, speech therapy and diet counseling on an intermittent basis in my home.
3. Nursing and/or hospice aide/homemaker service on a continuous basis (from 8 to 24 hours/day) in my home during a crisis.
4. Counseling and emotional support for me and my caregivers.
5. Instruction in the management of my care for me and my caregivers.
6. Volunteers who have been trained in Hospice to supplement the professional care.
7. Durable medical equipment and supplies, which have been approved for my care, and are related to my illness.
8. Management of my related physical symptoms.
9. Prescriptions and biological as needed for pain and symptom control.

Inpatient Care for Control of My Symptoms: In addition to the home care services listed above, I understand that the Hospice Program may provide brief inpatient care to me in a Hospice-participating hospital or nursing home. The decisions concerning my admissions to an inpatient facility will be made by my physician, in collaboration with the Hospice Medical Director and the Interdisciplinary Group, and based on their agreement that my symptom control needs are too extensive to be met in my home.

Inpatient Care for Short-Term Respite Care: That the Hospice Program may provide me with inpatient short-term respite care for relief for my care givers, for a maximum of five (5) days at a time including day of admission - not day of discharge.

Limitation of Hospice Inpatient Care: I understand that the Hospice Program is not able to provide long-term hospitalization, custodial or nursing home care, but that inpatient care is meant to be brief, with the goal of helping me and my family become emotionally and physically stable, so that if at all possible, I may return home.

As a medicare beneficiary, I elect to receive the above care under the Medicare Hospice benefit. I understand that this Medicare benefit consists of two 90-day periods, and indefinite 60-day periods. Each benefit period must be approved by the Middlesex Hospice and Palliative Care Medical Director.

I understand that during the time period that I am receiving Hospice care, I agree to waive my rights for those services offered under the traditional Medicare Home Health benefit, which specifically related to my life-limiting illness. In the event that I have problems unrelated to my Hospice diagnosis, I may choose to receive medical care under my traditional Medicare benefit or other reimbursement arrangement.

I understand that I may revoke my election of Hospice Care any time during a benefit period, and therefore resume the Medicare coverage and benefits I had waived. I understand that in order to revoke this election, I need to sign a revocation statement with the Middlesex Hospice and Palliative Care Program. I understand that if my physician in collaboration with the Hospice Medical Director and Interdisciplinary Group deem that my prognosis no longer meets Hospice Criteria, I will be discharged from the Hospice Program with appropriate notification. If at any time, my status changes, and my prognosis meets Hospice eligibility requirements, I understand that I can elect the Hospice Benefit again in the next benefit period.

_____	_____	_____
Patient's Signature	Date	Responsible person or Legal Guardian Signature
_____	_____	_____
Witness Signature/Agency Representative	Date	Printed Name & Relationship of Person above

☐ *Patient unable to sign due to:*_____