HOSPICE MEDICAID BENEFIT ELECTION STATEMENT

CONSENT TO TREATMENT: The undersigned grants authority to employees, volunteers, and/or consultants of Prairie Haven Hospice to provide this patient and family with medical care, nursing care, psychosocial care, spiritual care and other professional and volunteer services which it deems necessary to promote the best interests and well being of this patient and family.

ACKNOWLEDGMENT OF THE NATURE OF HOSPICE CARE: The undersigned acknowledges that this patient and/or family understands that the goal of treatment in hospice care is not cure, but rather palliative care that promotes comfort and management of symptoms that are associated with this patient's terminal prognosis.

FOR MEDICAID ELIGIBLE PATIENTS: In electing hospice coverage under Medicaid you are entitled to the following:

A. Services of an interdisciplinary team, including physician, nursing, medical, social work and counseling services, including pastoral and dietary counseling.

B. Home Health Aide/Homemaker services.

C. Physical Therapy, Occupational Therapy, and Speech Therapy services.

D. Short term inpatient care.

E. Continuous home care during periods of crisis.

F. Medical equipment and supplies.

***Initials:*_____**

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Scottsbluff NE 69361

G. Coverage of palliative drugs and biologicals related to terminal illness.

H. Bereavement support.

By electing hospice care, you waive the right to Medicaid payments for the following:

A. Hospice care provided by a hospice, other than Prairie Haven Hospice (Patients may choose a different hospice provider once per each benefit period [defined below].)

B. Curative services related to the treatment for which hospice care was elected. Treatment of a condition that is directly or indirectly related to the physical condition for which hospice care was elected, may be covered under the Hospice Benefit.

ELECTION STATEMENT: Medicaid will make payment for hospice days in benefit periods as indicated below:

First Benefit Period - 90 days

Second Benefit Period - 90 days

Third Benefit Period - 60 days

Fourth Benefit Period - 60 days

Fifth Benefit Period - 60 days

REVOCATION OF HOSPICE CARE: The undersigned acknowledges that this patient may, at any time, revoke this hospice election and by doing so, understands that time remaining in the election period is forfeited.

***Initials:*_____**

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IN-PATIENT CARE: The undersigned acknowledges that if this patient's condition should become such that in-patient care is necessary, (either for the management of acute symptoms or for respite purposes) such care may be obtained only at Regional West Medical Center (Scottsbluff), Morrill County Community Hospital (Bridgeport), Box Butte General Hospital (Alliance), Kimball Health Services (Kimball) or Community Hospital (Torrington, WY.)

If the patient desires to seek in-patient care at a facility other than these facilities, the patient may do so only by revoking his/her Hospice Medicaid Benefit election.

_____	_____
Effective Date	Signature of Patient/Date
	___Patient lacks cognitive ability to sign.
	___Patient is physically unable to sign due to advanced disease/illness process.
_____	_____
Signature of Witness/Date	Signature of person identified by the patient as being family member or legal representative who is responsible for the care of this patient.
	_____
Patient's Physician	Relationship to Patient
_____	
_____	_____
Physician's Address	Physician's Telephone Number

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Original to Medical Record
Copy to Patient

HOSPICE MEDICAID BENEFIT ELECTION STATEMENT

Revocation Dates (If Applicable):_____

_____

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