



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 MO HEALTHNET DIVISION
HOSPICE ELECTION STATEMENT

1. PATIENT NAME (LAST, FIRST, MI)		2. DATE OF BIRTH		3. PARTICIPANT MO HEALTHNET NO. (DCN)	
4. NAME OF HOSPICE		5A. HOSPICE PROVIDER IDENTIFIER		5B. PROVIDER TAXONOMY CODE	
				6. HOSPICE TELEPHONE NO. ()	
7. ATTENDING PHYSICIAN NAME		8. EMPLOYED BY HOSPICE? (PLEASE CIRCLE ONE) YES NO		9. A.P. PROVIDER IDENTIFIER	
				10. TELEPHONE NO. ()	
11. NURSING HOME NAME		PROVIDER TAXONOMY CODE		12. MO HEALTHNET PROVIDER IDENTIFIER (NUR. HOME)	
				13. TELEPHONE NO. ()	
14. PRIMARY DIAGNOSIS (ICD-9 CODE)				15. SECONDARY DIAGNOSIS (ICD-9 CODE)	

HOSPICE PROGRAM – REQUEST FOR SERVICE

I hereby request services from _____ and authorize release of all medical records and/or information to or from Hospice as required to act on this request.
 (NAME OF HOSPICE)

I understand that the hospice named above provides physical, emotional and spiritual care to me and my family. This is my consent for the following services should they be needed in my care:

- | | | |
|--------------------------|-------------------------------------|--|
| Appropriate Nursing Care | Respite Care | Inpatient Services |
| Dietary Counseling | Trained Non-Medical Volunteers | Medications for Pain and Symptom Control |
| Medical Social Services | Home Health Aide/Homemaker Services | Equipment and Supplies |
| Counseling Services | Ancillary Therapy Services | Bereavement Services |

The above named services will be made available as need is determined and directed by the Hospice Interdisciplinary Team consisting of the Medical Director, Patient Care Coordinator, Medical Social Worker, and Counselor working cooperatively with my attending physician.

In accordance with Medicaid law, the following services are not covered by the hospice program:

- Home private duty nursing in absence of a physical crisis of the patient.
- Ongoing hospitalization when care needed no longer requires inpatient setting.

I understand that the hospice named above will provide its services to all persons without regard to race, creed, national origin, age, sex, handicap/disability or religious beliefs. I acknowledge I have received a copy of the hospice's service policy.

I understand that the goal for the hospice care given will be the relief of pain and symptom management and that no extraordinary life sustaining measures will be initiated.

I understand that as long as I remain eligible for MO HealthNet and choose to receive hospice care, I will be eligible for MO HealthNet benefits related to my terminal condition as they are arranged by the above named hospice.

I will also be eligible for regular MO HealthNet benefits for treatment or conditions not related to my terminal illness. I understand that I have the right to change my mind at any time and to discontinue Hospice MO HealthNet benefits by indicating my wishes in writing, at which time I will be eligible for return to regular MO HealthNet benefits for treatment of my terminal illness.

Date Hospice Election to Begin _____

UNTIL YOU RECEIVE YOUR OFFICIAL NOTIFICATION OF HOSPICE ELECTION, YOU SHOULD PRESENT A COPY OF THIS HOSPICE ELECTION, WITH YOUR CURRENT MO HEALTHNET CARD OR NEW APPROVAL LETTER, TO ANY PROVIDER FROM WHOM SERVICES ARE BEING REQUESTED. The provider should call the hospice provider shown above to determine how the services should be billed. You may be responsible for any active (curative) treatment services not approved by the hospice provider.

SIGNATURE OF PATIENT/PATIENT REPRESENTATIVE ▶	DATE SIGNED
SIGNATURE OF WITNESS ▶	DATE SIGNED