



HOSPICE ELECTION STATEMENT

MO HealthNet Participant: Until you receive your official notification of hospice election, you should present a copy of this hospice election, with your current MO HealthNet Identification Card or new approval letter, to any provider from whom services are being requested.

Provider: The provider should call the hospice provider shown below to determine how the services should be billed. You may be responsible for any active (curative) treatment services not approved by the hospice provider. After completion, this form should be faxed to (573) 526-2041 or mailed to MO HealthNet Division, Program Operation's Hospice Unit, PO Box 6500, Jefferson City MO 65102.

Participant Information

1. Participant Name	2. Date of Birth	3. MO HealthNet ID Number
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Hospice Information

4. Name of Hospice	5a. NPI
5b. Taxonomy Code	6. Hospice Telephone Number

Attending Physician / Nursing Home / Diagnosis Information

7. Attending Physician Name	8. Employed by Hospice <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. NPI	10. Telephone Number	
11. Nursing Home Name	12. NPI	13. Telephone Number
14. Primary Diagnosis (ICD Code)	15. Secondary Diagnosis (ICD Code)	Date Hospice Election to Begin

Hospice Program Request for Service

I hereby request services from the Hospice listed above (Field 4) and authorize release of all medical records and/or information to or from Hospice as required to act on this request.

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

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 required 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.

Signature of Participant/Participant Representative	Date
Signature of Witness	Date