

DEPARTMENT OF PUBLIC WELFARE
ELECTION OF HOSPICE CARE

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1 RECIPIENT NUMBER

2 RECIPIENT NAME ("PATIENT")	3 EFFECTIVE DATE OF CARE
4 NAME OF HOSPICE ("HOSPICE")	

I, Patient, hereby elect to receive hospice care on the effective date noted above. I elect to receive hospice care from the above named Hospice. The nature of my illness and of hospice care, the services provided by Hospice, and the coverage provided through the Pennsylvania Medical Assistance Hospice Care benefit ("Benefit") have been fully explained to me by Hospice. I have been given the opportunity to discuss the services, requirements and limitations of this Benefit and the hospice care provided by Hospice, and the terms of this Election of Hospice Care statement. All my questions have been answered to my satisfaction. I have also signed the separate Hospice statement of informed consent, which has been explained to me by Hospice.

I understand that before hospice services will start, the Hospice will develop a plan of care for me, and the services I receive will be consistent with this plan of care.

I understand that by signing this Election of Hospice Care statement, I voluntarily give up all rights to Medical Assistance benefits for services for the duration of the election of hospice care for the following:

- I. hospice care provided by a hospice other than the hospice designated by me (unless provided under arrangements made by the Hospice).
- II. any Medical Assistance services that are related to the treatment of the terminal condition for which hospice care was elected, or a related condition, or that are equivalent to hospice care except for:
 - A. services provided (either directly or under arrangement) by the Hospice;
 - B. services provided by another hospice under arrangements made by the Hospice;
 - C. services provided by my attending physician if that physician is not an employee of the Hospice or receiving compensation from the Hospice for those services.

I understand that my Medical Assistance benefits will continue to pay for the services that are not related to my terminal illness or a related condition or services that are not equivalent to hospice care.

I understand that I can revoke my election of hospice care at any time by signing the Revocation of Hospice Care form (MA 375) prior to the date I want to stop receiving hospice benefits. My other Medical Assistance benefits will resume when hospice benefits stop, if I am still eligible for Medical Assistance.

I understand that I can choose to receive hospice care from a different hospice provider by signing a Change of Hospice Provider form (MA 374), without a reduction of my Medical Assistance Hospice Care benefit.

5 DATE	6 SIGNATURE OF PATIENT	7 NAME OF PATIENT (PRINT)
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The Patient is unable to execute this Election of Hospice Care form for the following reason: 8

I hereby certify that I am authorized under the laws of the Commonwealth of Pennsylvania to execute this form on behalf of the Patient, as the Patient's legal representative. I understand and acknowledge all of the representations set forth in this Election of Hospice Care statement.

9 SIGNATURE OF LEGAL REPRESENTATIVE	10 DATE
11 NAME OF LEGAL REPRESENTATIVE (PRINT)	12 RELATIONSHIP TO PATIENT

THE PATIENT WILL RECEIVE CARE AT THE FOLLOWING LOCATION:

13 ADDRESS	CITY	STATE	ZIP CODE
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I hereby certify that I have personally explained the information set forth above in this Election of Hospice Care form, as well as the separate, executed informed consent form, to the above named Patient, or Patient's legal representative, if applicable, and have answered questions regarding hospice care, services provided by Hospice and the Medical Assistance hospice benefit, and have witnessed the execution of this Election of Hospice Care by Patient or patient's legal representative, if applicable.

14 PROVIDER MAID NO.	15 SIGNATURE OF HOSPICE REPRESENTATIVE	16 NAME OF HOSPICE REPRESENTATIVE (PRINT)
	17 DATE	18 TITLE OF HOSPICE REPRESENTATIVE

RECIPIENT COPY