FLORIDA MEDICAID HOSPICE SERVICES
Election Statement

- The Florida Medicaid Hospice Care Services program has been explained to me. I have been given the opportunity to discuss the benefits, requirements and limitations of this program and the terms of the election statement. I understand that I will be entitled to elect Medicaid hospice care coverage as long as I am Medicaid eligible and I am certified by the hospice physician as being terminally ill.

- I understand that by signing the election statement, I am waiving all rights to Medicaid services for the duration of the election of hospice care for the following services:

  1. Hospice care provided by a hospice other than the hospice designated by me (unless provided under arrangements made by the designated hospice); and

  2. Any Medicaid services that are related to the treatment of the condition, or a related condition for which hospice care was elected or that are equivalent to hospice care with the following exception: services provided by my attending physician (if that physician is not employed by the designated hospice or receiving compensation from hospice for those services).

- I understand that I may revoke the hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is to be effective and submitting the statement to the hospice prior to that date. At that time, I understand my rights to other Medicaid services will resume, provided I continue to be Medicaid eligible.

- By signing this statement, I am electing the following hospice to provide me with the services of the Medicaid hospice care program:

_____

NAME OF HOSPICE

_____ _____

Signature of Participant or Representative **Election Date**

_____ _____

Signature of Hospice Representative **Date**

Distribution of Copies:
White – Coordinator
Yellow – Physician
Pink – Hospice

AHCA 5000-21, July 1999

Patient Name: _____
ID #: _____
Team: _____

10.05