pennsylvania
DEPARTMENT OF HUMAN SERVICES

ELECTION OF HOSPICE CARE

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 the benefits that are applicable to adults 21 years of age and older, 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.
- 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 hospice care may be provided by a hospice other than my designated hospice under arrangements made by the designated hospice.
- 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.
- 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.

Patients 21 years of age and older:

I understand that by signing this Election of Hospice Care form, 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. 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.

Patients under the age of 21:

I understand that by signing this Election of Hospice Care form, I may continue to receive any Medical Assistance covered service related to my terminal illness at the same time I receive hospice care. Upon turning twenty-one (21) years of age, I will no longer be eligible to receive Medical Assistance services related to the terminal illness at the same time I receive hospice services with exceptions as described above in I.A-C under the "Patients 21 years of age and older" heading.

5 DATE _____ 6 SIGNATURE OF PATIENT _____ 7 NAME OF PATIENT (PRINT) _____

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

14 PROVIDER MAID NO.

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.

15 SIGNATURE OF HOSPICE REPRESENTATIVE _____ 16 NAME OF HOSPICE REPRESENTATIVE (PRINT) _____

17 DATE _____ 18 TITLE OF HOSPICE REPRESENTATIVE _____

HOSPICE

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5 DATE

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9 SIGNATURE OF LEGAL REPRESENTATIVE

10 DATE

11 NAME OF LEGAL REPRESENTATIVE (PRINT)

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15 SIGNATURE OF HOSPICE REPRESENTATIVE

16 NAME OF HOSPICE REPRESENTATIVE (PRINT)

17 DATE

18 TITLE OF HOSPICE REPRESENTATIVE

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9 SIGNATURE OF LEGAL REPRESENTATIVE

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14 PROVIDER MAID NO.

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15 SIGNATURE OF HOSPICE REPRESENTATIVE

16 NAME OF HOSPICE REPRESENTATIVE (PRINT)

17 DATE

18 TITLE OF HOSPICE REPRESENTATIVE

RECIPIENT COPY