Hospice of the Comforter
FLORIDA HOSPITAL CONNECTED CARE

Hospice Benefit Election

I have been informed that Hospice of the Comforter participates in the Hospice Benefit Programs of Medicare, Medicaid and some other insurance carriers. I have been given an opportunity to discuss the benefits, requirements and limitations of the Hospice Benefit Program and the terms of this election agreement. Hospice of the Comforter adheres to Medicare regulations and guidelines for all patients, regardless of payer.

I understand that I am eligible for the hospice benefit because of a life-limiting illness or condition with a prognosis of six months or less as certified by my physician and a hospice physician.

I understand the following explanation of the Medicare Hospice Benefit:

1. Hospice of the Comforter will receive payment for my care relating to my terminal illness
    a. Medicare will continue to make payment to my independent attending physician (if any) for services if my physician is not a hospice employee or receiving payment from Hospice of the Comforter.
    b. I waive my rights to curative treatment or other standard Medicare benefits related to my terminal illness, with the exception of services provided by my attending physician, while enrolled in the Medicare hospice program.
    c. I may be responsible for five percent of the reasonable cost up to a maximum of $5 for each outpatient individual prescription for my terminal illness and can be charged up to five percent of individual respite care.
    d. I am responsible for the cost of care for my terminal illness if I seek care beyond what is considered medically necessary by the hospice interdisciplinary team and documented in my plan of care.
    e. I may be financially liable for bills incurred for treatments/services related to my terminal illness obtained from a physician/facility not contracted with Hospice of the Comforter.
2. I can change from one hospice to another, if I wish to do so. To change programs, I will confirm that I may be admitted to another hospice, and then I will inform Hospice of the Comforter of my wishes so arrangements for transfer can be made. I will specify a date to discontinue care from Hospice of the Comforter, the name of the hospice from which I wish to receive care, and the date the care will start. In changing to another hospice program, I will not lose any benefit days. I may change hospices only once during each benefit period.
3. The Medicare hospice program consists of two 90-day periods and unlimited 60-day periods if no discharges or revocations occur. I understand that prior to each 60-day benefit period, a physician or nurse practitioner must make a face-to-face visit to confirm my continued eligibility for the Medicare hospice benefit. I agree to cooperate with scheduling the required visits.
4. I may discontinue hospice care at any time by completing a written revocation statement. If I revoke during a benefit period, I lose the remaining days in that benefit period. I may re-elect hospice care at any time when/if I am eligible.
5. Hospice care may involve physician services, skilled nursing care, social workers, aides, physical or other therapies, volunteer services, counseling, emotional and spiritual care and inpatient care if necessary.
6. All care is directed through my independent attending physician (if any) and the Medical Director or designee from Hospice of the Comforter. My choice of attending physician is:

    Printed name of attending physician _____ _____ _____
    First Name | Middle Initial | Last Name

    Attending physician phone number _____

My current payer for hospice services is ☐ Medicare Part A
☐ Other insurance (specify) _____
☐ Medicaid ☐ Medicaid pending ☐ No current third party payer source

Medicare Part D Card seen ☐ Yes ☐ No Medicare Part D effective date _____

Acknowledging and understanding the above, I authorize hospice services from Hospice of the Comforter.

Date of election of hospice benefit _____

_____ / / _____
Signature of patient | Date

_____
(If patient cannot sign, explain reason)

_____ / / _____
Signature of legal representative | Date

_____
Printed name of legal representative

_____ / / _____
Signature of Hospice of the Comforter representative | Date

_____
Printed name/title of Hospice of the Comforter representative

Authority of legal representative
☐ HCS ☐ DPOA ☐ Legal Proxy
☐ Court Appointed Guardian
☐ _____
Address of legal representative
_____
_____
_____

Patient Name _____

Patient # _____