

GILCHRIST HOSPICE CARE MEDICARE HOSPICE BENEFIT ELECTION FORM

I, _____ CHOOSE TO RECEIVE HOSPICE CARE FROM GILCHRIST HOSPICE CARE,
FOR MY LIFE LIMITING ILLNESS OF _____.

I UNDERSTAND THE FOLLOWING:

1. The goal of Hospice is to reduce physical symptoms such as pain or nausea and to provide medical, emotional and spiritual support. Hospice does not participate in efforts to cure my illness.
2. Only GILCHRIST HOSPICE CARE will be able to receive Medicare payment for care or services provided to me for my life limiting illness or related conditions, exceptions to this are:
 - a. Medicare may make payments to my attending physician if my attending physician is not receiving any payments from the hospice.
 - b. Medicare may make payment to other providers for services provided to me, which are unrelated to my life limiting- illness.
3. Medicare will make payment for specified periods of hospice care. The periods are broken into two 90-day periods followed by an unlimited number of 60-day periods.
 - a. I can change from one hospice to another, if I wish to do so. To change programs, I must confirm that I may be admitted to another hospice, and then I must inform GILCHRIST HOSPICE CARE of my wishes so arrangements for transfer can be made. I must specify a date to discontinue care from GILCHRIST HOSPICE CARE, the name of the hospice from which I wish to receive care, and the date 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.
 - b. I waive my rights to Medicare benefits related to my terminal illness while enrolled in the Medicare hospice program.
4. GILCHRIST HOSPICE CARE will evaluate on an ongoing basis my appropriateness for hospice care. I understand that should my condition no longer render me appropriate to receive hospice care, Gilchrist Hospice Care will assist my family and myself to coordinate services to meet my needs and I will be discharged from the hospice program.
5. I can choose not to continue hospice care at any time. To discontinue care, I must sign a statement, which can be obtained from any GILCHRIST HOSPICE CARE employee.
6. If I discontinue my Hospice Medicare Benefit in the middle of a benefit period, I give up the remaining days in the benefit period. For example, if I discontinue my Medicare Hospice Benefit after the first 10 days, I give up the remaining 80 days in the first benefit period.
7. The following services are available through the hospice as appropriate: nursing services, medical social services, physician services, spiritual care services, counseling, professionally trained volunteers, physical therapy, occupational therapy, speech and language therapy, home health aide, homemaker services, respite, short term inpatient care and bereavement services. Medications, medical supplies and durable medical equipment are also available through the hospice. MEDICARE HOSPICE COVERAGE WILL BEGIN ON: _____ (MONTH/DAY/YEAR).
8. Short-term inpatient care may be provided at a participating facility when procedures necessary for pain control or acute or chronic symptom management are required. I will notify my physician and hospice when a need arises.
9. Short-term inpatient respite care may be provided at a participating facility to relieve the stress of family and other persons providing patient care in the home.
10. I acknowledge that I have been given a full understanding of hospice care, including an understanding of the palliative rather than curative nature of hospice care as it relates to my terminal illness. I am aware that Gilchrist Hospice Care must participate in all decisions related to the management of my life limiting- illness. Failure to include the Hospice team in care decisions may result in the cost of care not being covered by the Medicare Hospice Benefit.

Date	Signature of Patient or Representative	Date	Signature of Family Member/Primary Care Giver
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Date	Signature of Hospice Representative
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WHITE - Medical Records YELLOW - Accounting PINK - Pt/Family

3/04/03

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