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ELECTION OF HOSPICE BENEFIT

HOSPICE ELECTION : As a Medicare Part A, Medi-Cal or Commercial SKIRBALL HOSPICE as my sole provider of hospice care effective (d	••
(Note: The start of care date, also known as the effective date of t care or a later date, but may be no earlier than the date of the ele designate an effective date that is retroactive.)	• • •
RIGHT TO CHOOSE AN ATTENDING PHYSICIAN: I understand that physician to oversee my care. My attending physician will work in related to my terminal illness and related conditions. I do not wish to choose an attending physician (a hospice production). I acknowledge that my choice for an attending is:	collaboration with the hospice to provide care
Physician Name	NPI (if known)
Office Address	Phone Number

HOSPICE PHILOSOPHY AND COVERAGE OF HOSPICE CARE

By electing hospice care under the hospice benefit, I acknowledge that:

- I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.
- I was provided information on which items, services, and drugs the hospice will cover and furnish upon my election to receive hospice care.
- I was provided with information about potential cost-sharing for certain hospice services, if applicable.
- I understand that by electing hospice care under the Medicare/Medi-Cal hospice benefit, I waive (give up) the right to Medicare/Medi-Cal payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.
- I understand that items, services, and drugs unrelated to my terminal diagnosis and related conditions are exceptional and unusual and, in general, the hospice will be providing virtually all of my care while I am under a hospice election. However, all decisions of coverage or non-coverage are made by the hospice physician and IDT assessment of medical necessities. The items, services, and drugs determined to be unrelated to my terminal illness and related conditions continue to be eligible for coverage by Medicare under separate benefits.

• I understand that there may be some items, services & drugs which are no longer medically appropriate for my care and the Hospice will review the discontinuation of these items with me.

RIGHT TO REQUEST MEDICARE PATIENT NOTIFICATION OF HOSPICE NON-COVERED ITEMS, SERVICES, AND DRUGS (ONLY FOR MEDICARE BENEFICIARIES): I understand as a Medicare beneficiary who elects hospice care, I have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Item, Services and Drugs" addendum that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions, and that will not be covered by the hospice. The hospice will furnish this notification within 5 days, if requested on the start of care date, and within 3 days if requested during the course of Hospice care.

BENEFICIARY AND FAMILY-CENTERED CARE QUALITY ORGANIZATION (BFCC-QIO)

I understand as a Medicare hospice beneficiary, I have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice's determinations. The BFCC-QIO that services your area is: Livanta (877) 588 – 1123, (885) 887-6668 TTY.

CKNOWLEDGEMENT		
cknowledge and agree to the terms and conditions describe	d herein:	
Patient or Representative Signature	Relationship to Patient	Date
If patient unable to sign, state reason:		
Name of Legal Representative (if applicable):		**************************************
Address of Legal Representative (if applicable):		
Hospice Representative Name/ Credential	Signature	Date
Patient Name (Last First)	NAT	0#