



**FLORIDA MEDICAID HOSPICE CARE 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:
- Hospice care provided by a hospice other than the hospice designated by me (unless provided under arrangements made by the designated hospice); and
- 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 the 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:

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NAME OF HOSPICE

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Signature of Participant or Representative

Election Date

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Signature of Hospice Representative

Date

	Distribution of Copies: 1. Coordinator (DCF) 2. Physician 3. Hospice 4. Area Medicaid Office 5. HMO (if applicable)
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