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:

NAME OF HOSPICE

Signature of Participant or Representative	**Election Date**
Signature of Hospice Representative	**Date**

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

AHCA 5000-21, July 1999 (59G-4.140, F.A.C.)

SERVICIOS DE HOSPICE DEL PROGRAMA – DE MEDICAID EN LA FLORIDA DECLARACION DE ELECCION

- He entendido las explicaciones que me han sido dadas acerca del programa de servicios hospice, subsidiado por Medicaid en el estado de La Florida.
- Se me ha brindado la oportunidad de discutir en que consisten los beneficios, requisitos, y limitaciones de dicho programa, asi como los terminos de esta declaracion de eleccion.
- Entiendo que tendre derecho a elegir servicios de hospice cubiertos por Medicaid, mientras permanezca siendo elegible para recibir Medicaid, y mientras el medico de hospice certifique que sufro una enfermedad terminal.
- Entiendo que al firmar esta declaracion de eleccion, voluntariamente renuncio, por el tiempo que sea efectiva, al derecho a recibir los seguientes servicios de Medicaid:
  1. Cuidados provistos pr otro hospice que no sea el que designo coneste documento (excepto si tal acuerdo fuera arreglado a traves del hospice que yo eligiera).
  2. Atencion relacionada al tratamiento de la enfermedad, o condiciones asociadas a esta enfermedad por la(s) cual(es) elegilos cuidados de hospice, o atencion que resulte equivalente a los servicios que hospice me dispensa, (con excepcion de los servicios provistos por mi medico personal, en caso de que no este empleado por el hospice que yo designara, ni recibiendo del mismo por servicios que a mi rinda).
- Entiendo que puedo revocar mi eleccion a recibir servicios de hospice en cualquier momento, firmando una declaracion a ese efecto, indicando la fecha en que la revocacion tomara validez, y remitiendo dicha declaracion a hospice antes de la fech de revocacion. A partir de ese momento, mi dercho a recibir los otros beneficios de Medicaid sera restablecido, siempre que yo continue siendo elegible para recibir Medicaid.

Al firmar esta Declaracion, yo elijo a ______________________________
Nombre del Hospice
para que me provea servicios de cuidados de Hospice de Medicaid.

______________________________ ______________________________
Firma del Participante o Representante **Fecha de Eleccion**

______________________________ ______________________________
Firma del Representante de Hospice **Fecha**

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