SUNCOAST HOSPICE | empath health
LICENSED TO SERVE SINCE 1981

Election of Hospice Benefit

☐ New Admission
☐ Change in Payment Source

Name ____ MR# ____________________

I choose to receive care from Suncoast Hospice and understand the program is palliative (comfort-oriented), not curative, in its goals. I acknowledge, consent and agree to the following:

- The approximate cost and methods of payment through my payer have been explained to me.
- The patient, family, attending physician and Suncoast Hospice interdisciplinary team together tailor an individual plan of care for the patient/family and determine the appropriate levels of care. I will work with Suncoast Hospice and my attending physician who together will make all necessary arrangements for care connected to the condition for which Suncoast Hospice is treating me. Suncoast Hospice will provide or arrange for care related to my diagnosis within the plan of care, as deemed reasonable and necessary.
- I am responsible for the cost of care for services if I choose to seek medical care beyond what Suncoast Hospice has deemed medically necessary and is not part of my hospice plan of care.
- I authorize payment of benefits from any third party vendor to be made directly to Suncoast Hospice for the services rendered.
- I authorize the release of medical records/information to and from other healthcare providers as required for continuity of care and payment as permitted by law.

☐ ELECTION OF HOSPICE MEDICARE or HOSPICE MEDICAID:

I elect the Medicare/Medicaid Hospice benefit to be provided by Suncoast Hospice, and I acknowledge, consent and agree to the following:

- For the duration of my election to receive Hospice care, I waive all rights to Medicare or Medicaid payments: (i) for Hospice care provided by a Hospice other than Suncoast Hospice unless such care is provided under an arrangement made by Suncoast Hospice; and (ii) any Medicare or Medicaid services that are related to the treatment of my terminal condition for which Hospice was elected or a related condition except for services provided by Suncoast Hospice or my attending physician if my attending physician is not an employee of Suncoast Hospice or does not receive compensation from Suncoast Hospice for such services.
- I understand that I may revoke this Hospice election in writing and withdraw from the Hospice program at any time and have traditional Medicare or Medicaid benefits fully restored immediately. I may choose to elect Hospice services again at any time. Care for all illnesses other than the primary diagnosis for which Hospice is treating me can be billed to Medicare or Medicaid in the traditional manner.

☐ INSURANCE COVERAGE:

I elect insurance coverage for hospice care to be provided by Suncoast Hospice, and I acknowledge, consent and agree that I understand that I am responsible for all deductibles, co-pays and any cost of services not covered by my insurance carrier.

☐ SELF PAY: ☐ SELF PAY SUNCOAST SUPPORTIVE CARE:

I understand that any fee for services will be based on the patient's ability to pay. If the patient's financial circumstances change or if any bill becomes a hardship to the patient, I agree to notify the team Social Worker or other hospice team member.

The undersigned certifies that the foregoing statements have been reviewed and understood. The undersigned understands the patient has the right to choose their attending physician and has made the choice of:

Name of attending physician (print name)____

Patient Signature ____ Date of Election:________________

Patient unable to sign election of benefits because: (Print)____

I attest I am the legal Patient's Authorized Representative: HCS ❑ HC Proxy ❑ POA ❑ DPOA ❑ Guardian ❑

Patient's Authorized Representative (Print name) ____________________________________ Relationship____________

Signature of Patient's Authorized Representative ____

Name of Suncoast Hospice Representative (Print name)____

Signature of Suncoast Hospice Representative____Date_______________