empath
SUNCOAST HOSPICE
of Hillsborough

Election Statement

I _____choose to receive care from Suncoast Hospice of Hillsborough. I acknowledge that I have been given a full explanation and understand the purpose of hospice care. Hospice care is to relieve pain and symptoms related to my terminal illness and related conditions. Hospice care is palliative (comfort-oriented), not curative, in its goals. The focus of hospice care is to provide comfort and support to both me and my family. I acknowledge, consent and agree to the following:

- The patient, family, attending physician and Suncoast Hospice of Hillsborough interdisciplinary team will together tailor an individual plan of care for the patient/family and determine the appropriate levels of care. Suncoast Hospice of Hillsborough and my attending physician will make all necessary arrangements for care connected to my terminal illness and related conditions, as identified within the plan of care and deemed reasonable and necessary.
- The approximate cost and methods of payment through my payer have been explained to me.
- I authorize payment of benefits from any third party vendor to be made directly to Suncoast Hospice of Hillsborough for the services rendered.
- **I have been provided with information about potential cost sharing for certain hospice services if applicable. I am responsible for the cost of any care or services I choose to seek beyond what Suncoast Hospice of Hillsborough has deemed medically necessary and is not part of my hospice plan of care. This includes any care or services (such as treatments, medications and ambulance transportation) received without prior approval from Suncoast Hospice of Hillsborough.**

☐ ELECTION OF HOSPICE MEDICARE or HOSPICE MEDICAID:

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

- I understand that by electing hospice care under the Hospice Medicare Benefit, I am waiving all rights to Medicare payments for services related to my terminal illness and related conditions and I understand 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 services not related to my terminal illness and related conditions may be eligible for coverage by Medicare and/or other third party payor.
- 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.
- I understand that services unrelated to my terminal illness and related conditions are exceptional and unusual and in general the hospice will be providing all of my care while under hospice election.
- As a Medicare beneficiary who elects to receive hospice care, I have the right to request at any time in writing, the **"Patient Notification of Hospice Non-Covered Items, 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 will not be covered by the hospice.
- The hospice must furnish this notification within 5 days, if I request this form on the start of care date.
- If I request this form during the course of hospice care, the hospice must furnish within 72 hours (or 3 days).
- In the event it is determined that there are non-covered items, services and drugs at the time of this election I request a copy of the **"Patient Notification of Hospice Non-Covered Items, Services and Drugs."**

☐ **No** ☐ **Yes** (By checking yes, I agree to sign and return within the required timeframe)

☐ **INSURANCE COVERAGE or** ☐ **VETERANS ADMINISTRATION (VA):**
I elect insurance or VA coverage for hospice care to be provided by Suncoast Hospice of Hillsborough, 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 or** ☐ **SELF PAY SUNCOAST SUPPORTIVE CARE:**
I agree to pay for hospice care provided by Suncoast Hospice of Hillsborough and I understand that any fee for services will be based on the patient's ability to pay.

I understand I have the right to choose my attending physician to oversee my care. My attending physician will work with Suncoast Hospice of Hillsborough to provide care related to my terminal illness.

☐ **I do not wish to choose an attending physician**. Suncoast Hospice of Hillsborough physicians will follow for hospice medical management.

☐ **My choice of attending physician is:** Name of attending physician
(print name) _____
Office address: _____

Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) Medicare Beneficiaries Only:

You 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:

Kepro
1-888-317-0751

The undersigned certifies that the foregoing statements have been reviewed and understood and agrees to accept financial responsibility for services beyond what Suncoast Hospice has approved or deemed medically necessary.

Patient Signature: _____
Date of Election: _____
Patient unable to sign election of benefits because:
(Print)_____
I attest I am the documented and legal Patient's Authorized Representative for healthcare decision making:
☐ Health Care Surrogate ☐ Healthcare Proxy ☐ Durable Power of Attorney For Healthcare
☐ Court Appointed Guardian
Patient's Authorized Representative (Print name): _____
Relationship: _____

Signature of Patient's Authorized Representative: _____

Name of Suncoast Hospice of Hillsborough Representative: _____
Date: _____