# Medi-Cal Hospice Program Election Notice

**Email to: MCHospiceClerk@DHCS.CA.GOV** **Questions, call: (916) 552-9200**

| **Section 1** | | | | | |
|---|---|---|---|---|---|
| Recipient Name: | | | | | |
| Email: | Phone Number: | Medi-Cal ID: | Date of Birth: | | |
| Address: | City: | State: | Zip Code: | | |

| **Section 2** | |
|---|---|
| **I and/or the Legal Representative/Agent of the Medi-Cal recipient identified above understand the following:** | |
| I have a terminal illness with a life expectancy of six months or less if the illness were to run its normal course. | Initials: |
| Hospice care services alleviate pain and suffering and are intended to treat symptoms rather than to cure illness. Recipients younger than 21 years of age may concurrently receive both hospice care and curative treatments of the hospice-related diagnosis. The Medi-Cal Hospice Services and benefits have been explained to me and/or my legal representative. I understand that only recipients younger than 21 years of age may receive both hospice services and curative treatment concurrently. | Initials: |
| By choosing hospice, I waive my right to payment for all Medi-Cal services, except for:<br>1) services provided by my elected hospice,<br>2) services provided by another hospice through an arrangement made by my elected hospice provider,<br>3) services provided by my attending physician if that physician is not employed by my elected hospice, or receiving any compensation from the hospice for those services.<br>4) services that are unrelated to my terminal diagnosis. | Initials: |
| I understand that for recipients ages 21 and over:<br>1) All my care will be provided by my elected hospice provider for my terminal diagnosis and related conditions.<br>2) I am not eligible to receive services for my terminal diagnosis and related conditions from providers other than my elected hospice provider or attending physician.<br>3) I am still eligible for services needed for conditions not related to my terminal diagnosis, and related conditions, such as provider examinations, drugs, or other medical care. | Initials: |
| I and/or the Legal Representative/Agent of the Medi-Cal recipient identified above, understand that I may revoke my hospice election at any time by signing a statement to that effect, and that both I and/or the Legal Representative/Agent and the hospice provider must inform DHCS by submitting the hospice revocation form signed by me. I understand my rights to other Medi-Cal services will resume on that date if I continue to be Medi-Cal eligible. (This revocation is not to be pre-dated or post-dated). | Initials: |
| I understand that if I reach a point of stability and can no longer be certified as terminally ill, I will return to the traditional Medi-Cal benefits as long as I am eligible for Medi-Cal. | Initials: |

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|---|---|
| I understand that the elected Hospice provider is responsible for any Home Health, Private Duty Nursing, or Personal Care Services, if related to my terminal diagnosis, and related conditions. Medi-Cal benefits will cover care for treatments not related to the terminal diagnosis and related conditions. | Initials: |

**Section 3**

| | | |
|---|---|---|
| Admitting Terminal Diagnosis and related conditions ICD-10 Code(s): | | |
| Recipient is currently being admitted from a medical facility. | ☐ Yes ☐ No | |
| Facility Name: | | NPI Number: |
| Recipient is currently being admitted from home. | ☐ Yes ☐ No | |
| Home Address: | | NPI Number: |
| Recipient is transferring from another Home Hospice Agency. | ☐ Yes ☐ No | |
| Agency Name: | | NPI Number: |
| Recipient and/or the Legal Representative/Agent choice of attending physician. | | |
| Attending Physician: | | NPI Number: |
| **I and/or the Legal Representative/Agent of the recipient identified above, certify that the recipient DOES NOT have an attending physician separate from the hospice physician. Therefore, the hospice physician is my choice as an attending physician.** | | Initials: |

**Section 4**

**Services currently being provided to recipient by other Agencies:**

| | | |
|---|---|---|
| Home Health Services | ☐ Yes ☐ No | Agency Name & NPI: |
| Private Duty Nursing Services | ☐ Yes ☐ No | Agency Name & NPI: |
| Personal Care Services | ☐ Yes ☐ No | Agency Name & NPI: |
| Elected Hospice Provider Name: | | NPI Number: |

| **Recipient and/or Legal Representative/Agent Statement** |
|---|
| I, (Recipient's Name) _____, have read and understand the statements in this document.<br><br>Recipient Signature: _____ Date: _____ |
| I, (Legal Representative/Agent Name) _____, as the Legal Representative/Agent for (Recipient's Name) _____, have read and understand the statements in this document.<br>Relationship to Recipient: _____<br><br>Legal Representative/Agent Signature: _____ Date: _____ |
| **Hospice Provider Statement** |
| I, (Hospice Representative Name) _____, Hospice Representative for (Hospice Provider's Name) _____, understand that the The hospice provider is responsible for the coordination of services to ensure that there are no duplication of services.<br>Hospice Representative Title: _____<br><br>Signature: _____ Date: _____ |