MAP-374
(Rev. 5/19)

Election of Medicaid Hospice Benefits

I _____ / _____ , elect to receive the Medicaid Hospice
(Patient Name) (Member ID)
benefits from _____ / _____
(Facility Name) (Provider #)
this _____ day of _____ , 20 _____ . I am aware that my disease is incurable.

I consent to the management of the symptoms of my disease by _____ .
My family and I will help develop a plan of care based on our needs. My care will be supervised by
my attending physician _____ , and the Hospice Director.
My prescription medications related to the terminal illness will be provided by the elected Hospice Provider.

I may receive benefits which include home nursing visits, counseling, medical social work services, medical supplies and equipment. If needed, I may also receive home health aides/homemakers, physical therapy, occupational therapy, speech/language pathology, in-patient care for acute symptoms, medical procedures ordered by my physician and hospice, and continuous nursing care in the home in acute medical crisis.

I may request volunteer services, when available.

I realize that my family and I have the opportunity for limited respite or relief care in a nursing facility.

In accepting these services, which are more comprehensive than regular Medicaid benefits, I waive my right to regular benefits except for payment to my attending physician, treatment for medical conditions unrelated to my terminal illness, medical transportation, nurse anesthetist, or dental.

Recipients under the age of twenty-one (21) eligible for Hospice benefits will be eligible to receive curative treatment in relation to their terminal illness concurrently with Hospice services.

I understand that I can revoke this benefit at any time and return to regular Medicaid benefits. I understand, if I terminate the Medicaid Hospice Benefit, I can resume regular Medicaid if I am still eligible.

I understand that the Hospice benefit is a home care program. If my family and I choose care not available from the Hospice Agency I understand that the Hospice and the Medicaid Program are not financially responsible.

I understand that the Hospice Benefit consists of two 90-day periods, and an unlimited number of 60-day periods.

I understand that at the end of any benefit period, because of an improvement in my condition, I may choose to save the remainder of the benefit period(s). I may revoke the Hospice Benefit at this time.

I also understand that should I choose to do so, I am still eligible to receive the remaining benefit period(s); I am aware, however, that if I choose to revoke Hospice Benefits during a benefit period, I am not entitled to coverage for the remaining days of that benefit period.

I understand that if I choose to do so, once during each election period I may change the designation of the particular hospice from which hospice care will be received by filing a statement with the hospice from which care has been received and with the newly designated hospice. I understand that a change of hospice providers is not a revocation of the remainder of that election period.

I understand that, unless I revoke the Hospice Benefit, hospice coverage will continue indefinitely.

I understand that I may be responsible for Hospice charges if I become ineligible for Medicaid services.

Check all that apply:

- ☐ I am a Medicaid recipient and have elected to use the Medicaid Hospice Benefit. My Medicaid eligibility for Hospice benefits begins
- ☐ I am a Medicare recipient with Medicaid eligibility and elect to use both my Medicare and Medicaid Hospice benefit.
- ☐ My Medicare Hospice Benefits have been exhausted as of _____
- ☐ I am not a Medicare recipient.
- ☐ I am currently a Nursing Facility resident, residing at:

_____ _____
(Facility/Address) (Provider #)

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Hospice Benefit Election

Patient's Signature or Mark

Patient's Name (Print or Type)

Witness' Signature

Relationship to Patient

Date Signed

Effective Date of Election

Second Benefit Period: (To be signed only if benefits previously revoked or temporarily terminated.)

Patient's Signature or Mark

Patient's Name (Print or Type)

Witness' Signature

Relationship to Patient

Date Signed

Effective Date of Second Period

Additional Benefit Period: (To be signed only if benefits previously evoked or temporarily terminated.)

Patient's Signature or Mark

Patient's Name (Print or Type)

Witness' Signature

Relationship to Patient

Date Signed

Effective Date of _____ Period

Additional Benefit Period: (To be signed only if benefits previously evoked or temporarily terminated.)

Patient's Signature or Mark

Patient's Name (Print or Type)

Witness' Signature

Relationship to Patient

Date Signed

Effective Date of _____ Period

Submit form by faxing to DMS at 502-564-0039 or email to DMS inbox at dms.eligibility@ky.gov.

Clear Form