



STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

FLORIDA MEDICAID HOSPICE CARE SERVICES
 Election Statement

o 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.

o 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:

1. Hospice care provided by a hospice other than the hospice designated by me (unless provided under arrangements made by the designated hospice); and
2. 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).

o 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.

o 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