Jefferson Healthcare Hospice
Election of Hospice Benefit (EOB)

Patient Name (First, Last)_____ Date_____

I, _____, choose to elect the Medicare hospice benefit and receive hospice services from Hospice of Jefferson County.

I acknowledge that I have been informed that Hospice of Jefferson County offers hospice care under the Medicare and Medicaid hospice benefit programs and some third-party insurance carriers to those who have been certified by a physician to have a terminal illness. I have been given a full explanation that the services are palliative rather than curative in nature as they relate to the terminal illness.

Acknowledging and understanding the above, I choose and consent to have Hospice of Jefferson County provide for my care under the:

- ☐ Medicare Hospice Benefit
- ☐ Medicaid Hospice Benefit
- ☐ Third Party Insurance
- ☐ I am electing to pay for Hospice service privately.

I understand that I have a right to choose my attending physician to oversee my care. My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions. I understand that if I do not have a primary care physician, the Hospice Medical Director may be designated.

My designated physician is_____

I acknowledge and understand the above, and authorize Medicare hospice coverage to be provided by Hospice of Jefferson County to begin on **(Effective Date of Election **)** _____

**** (Note: The effective date of the election, which may be the first day of hospice care or a later date but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive)**

Patient Signature: _____ Date/Time: _____

If patient is unable to sign:

Legal Decision Maker Signature: _____ Date/Time: _____

Print Name: _____ Relationship: _____

Reason patient is unable to sign: _____

I have explained the hospice program and answered all related questions asked by the patient or the legal decision maker on behalf of the patient.

Hospice of Jefferson County
Representative Signature: _____ Date/Time: _____