MEADOWLARK HOSPICE
709 Liberty, Clay Center KS 67432
Phone: (785) 632-2225 Fax: (785) 632-3557

Assignment of Benefits

Patient	ID #	Primary Physician

I have read the Informed Consent form and understand that the Hospice program is palliative (comfort oriented), not curative in its goals. I agree to and seek Hospice care and hereby elect to receive the benefit(s) listed below for which I am eligible and assign these benefits to Meadowlark Hospice who will provide my care.

_____ Medicare Hospice Benefit _____ Medicaid Hospice Benefit

_____ Insurance (Specify) _____

_____No Insurance – Financial Assessment being completed

I understand that the decision to accept me into the Hospice program of care will not be based solely upon my ability or inability to pay and that Hospice service will neither be withheld nor curtailed based solely upon any change in my ability to pay.

I understand that if eligible, and I select the Hospice Medicare Benefit, treatment for the terminal illness and related conditions for which hospice was elected will be covered by the hospice benefit and waived under the regular Medicare payment coverage. Treatments for conditions not related to the terminal illness and related conditions remain covered under the regular Medicare coverage. The Medicare Hospice Benefit is broken up into periods of ninety (90), ninety (90), and consecutive sixty (60) days. I may choose to revoke the Hospice benefit at any time and be eligible for all regular Medicare benefits. After revocation, I can re-elect Hospice care, beginning with the next benefit period.

I understand that I may change Hospice at any time during the illness without loss of Hospice Medicare Benefit days, although I may change Hospice only once during each benefit period.

I understand that I have the right to choose my attending physician and that my attending physician may only be changed with written consent from me or my representative.

I acknowledge that I have been given ample opportunity to ask any and all questions I have concerning the Hospice program.

I elect Meadowlark Hospice to begin my care on: _____ Time:_____

It is my choice to have_____serve as my attending physician.
Physician NPI:_____
Physician address:_____

_____ _____
Patient's signature **Date**

_____ _____
Caregiver / Responsible party signature Date
(Person identified by patient as being family/significant other or legally responsible)

_____
Reason person is unable to sign

I have explained the purpose of the Hospice program of care and the nature of the involvement requested of the participants. I have answered all questions about the program asked by the patient or others on behalf of the patient.

_____ _____
Meadowlark Hospice Date