



ELECTION OF HOSPICE BENEFIT/CONSENT FORM — PAGE 1 OF 2

Patient Name: _____ MR # _____

I give my consent and elect to receive hospice care and services from Northern Illinois Hospice. I acknowledge and understand the following explanation of hospice benefits under the hospice Medicare/Medicaid/private insurance and private pay benefit.

Hospice Philosophy I have been given a full understanding of the palliative rather than curative nature of hospice care as it relates to my terminal illness, and of hospice care as an alternative to traditional covered Medicare/Medicaid/private insurance services. I understand the goal of hospice care is not to cure my terminal illness but to maintain my quality of life through palliative care and management of symptoms. Northern Illinois Hospice will manage my care under the direction of my attending physician and the hospice interdisciplinary team. Northern Illinois Hospice will work with me and my attending physician, if any, to develop and implement an individualized plan of care to meet my goals of care.

Hospice Services I understand that by choosing the Medicare/Medicaid/private insurance/private pay hospice benefit, I will receive the hospice services set forth in my plan of care, which may include the following care and services that are related to and are medically necessary for the palliation and management of my terminal illness and authorized by Northern Illinois Hospice. I understand hospice services are intended to supplement, not replace, care given to me by my family members, friends, hired caregivers, or my attending physician.

Nursing services provided by RNs	Complementary therapies as needed
Physician consultation	Respite care in a contracted facility (limited to five consecutive days)
Medical Social Work services	Short term care for crisis management
24 hour on-call service	Short term inpatient care in SwedishAmerican Hospital, SwedishAmerican Medical Center/ Belvidere or River Bluff Nursing Home when appropriate for pain control or acute or chronic symptom management
Home health aide/homemaker services	Curative treatment for patients up to age 20 on Medicaid
Volunteer visitors	
Counseling (spiritual, dietary, grief, and loss)	
Bereavement service	
Medical supplies and equipment	
Medications related to my terminal illness	
Physical, occupational, speech therapy when appropriate	

I understand hospice care does not include the following services. If I choose to receive these services, I may be responsible for their cost:

- Treatment or interventions that Northern Illinois Hospice determines are not related to my terminal illness or related conditions including, but not limited to, medication, equipment and supplies, laboratory and diagnostic tests, x-rays, transportation, and inpatient or outpatient services;
- Treatment or interventions that Northern Illinois Hospice determines are not medically necessary for the palliation and management of my terminal illness or related conditions, including, but not limited to, medication, equipment and supplies, laboratory and diagnostic tests, x-rays, transportation, and inpatient or outpatient services;
- Medications, equipment, and supplies related to my terminal illness that are not pre-approved by Northern Illinois Hospice;
- Room and board (Room and board may be covered by Medicaid depending upon eligibility);
- Restrictions on certain Medicaid services and items for adult patients age 21 and over, even if unrelated to the terminal illness.



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- Treatments/services that are not pre-approved or arranged for in the plan of care by the hospice team such as care in an emergency room, outpatient or inpatient care, 911 services, or ambulance transportation;
- Custodial care provided by live-in housekeepers or privately hired caregivers.

Medicare/Medicaid/Private Insurance Coverage I acknowledge that while this election is in effect, only Northern Illinois Hospice will be able to receive Medicare/Medicaid/private insurance payment for care or services provided to me for my terminal illness and related conditions. I understand that for the duration of my election of Medicare/Medicaid/private insurance hospice care, I am waiving my right to all other Medicare/Medicaid/private insurance payments for the following services:

- Hospice care provided by any hospice other than Northern Illinois Hospice (unless provided under arrangements made by Northern Illinois Hospice)
- Any Medicare/Medicaid/private insurance services that are related to the treatment of my terminal illness or a related condition or that are equivalent to hospice care, except for:
 - o Services provided or authorized by Northern Illinois Hospice
 - o Services provided by another hospice under arrangements with Northern Illinois Hospice
 - o Services provided by my attending physician if he or she is not employed by or receiving compensation from Northern Illinois Hospice for those services
 - o Medicaid room and board provided by a nursing facility, if I am an eligible nursing facility resident

I understand this waiver does not affect Medicare/Medicaid/private insurance payments for services I may receive that are unrelated to my terminal illness.

Revocation and Transfer I understand that I may revoke this election at any time by providing written notice to Northern Illinois Hospice on the Northern Illinois Hospice Statement of Revocation of Hospice Benefit Form and resume my Medicare/Medicaid/private insurance coverage of the benefits waived above. I may elect to again receive hospice coverage at any time. I also understand that I may transfer to another Medicare-certified hospice program at any time without reducing the benefits to which I am entitled. No benefit period days will be lost by transferring to another qualifying hospice program once during a given benefit period if arrangements are made through Northern Illinois Hospice.

Attending Physician An attending physician is a physician or nurse practitioner who will have the most significant role in the determination and delivery of my medical care. I designate as my attending physician.

(Print Full Name of Attending Physician)

(Phone Number of Attending Physician)

Effective Date Acknowledging and understanding the above, I authorize and elect to receive hospice services from Northern Illinois Hospice beginning on _____ at _____ AM/PM.
(Date) (Time)

I have been given the opportunity to discuss the information in this document and all other admission information with an Northern Illinois Hospice employee and had my questions answered to my satisfaction.

Signature of Patient/Legal Representative, if applicable

Date

Print Name of Patient/Legal Representative, if applicable

Print Authority of Legal Representative
(e.g., power of attorney for health care, legal guardian)