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819 South 13th Street, Mount Vernon, WA 98274

Compassion and Dignity Every Moment of Life

STATEMENT OF CONSENT AND ELECTION

Patient Name: _____ Patient ID Number: _____

I designate: _____ as my Primary Caregiver; _____ as my Attending Physician.

Informed Consent: I acknowledge that hospice services are limited to palliative care and I am not being offered a "cure" for my illness. I understand that should I choose to pursue curative treatment for my illness, I may be eligible to receive care from another provider of services. The Hospice of the Northwest (HNW) team will work with me and my Attending Physician to design and implement a palliative plan of care. I understand HNW is financially responsible only for those services included in the plan of care. If I do not agree with the recommended plan of care, I may choose to revoke the Hospice Benefit. I, or my legally authorized representative, shall have access to my medical records during and after the time I am receiving Hospice services to the extent allowed by law. I consent to receive care and visits from HNW (and hospice accrediting or regulatory surveyors authorized to observe my care or interview me). My signature on this form certifies I have been provided with a thorough explanation of the services provided by HNW and that I have received, reviewed, had a detailed explanation given, and had an opportunity to ask questions about:

- Pg 1 Eligibility for Hospice Care Pg 23 Patient Rights & Responsibilities Pg 38-43 Nutrition, Pain & Medications Guidelines
Pg 3, 5-9 Services & Care Levels Pg 25 Notice of Privacy Practices
Pg 12, 13, 23 Advance Directives Pg 31 Home, Fire & Equipment Safety Pg 53 Caregiver Information
Pg 21 Medicare Hospice Benefit Pg 33 Emergency Planning Guidelines
Pg 21 Room & Board

Payment Authorization: I hereby authorize any insurer or other organization from which I am entitled to receive payment for hospice services to make payment for such services directly to HNW.

Payment Source: _____ IID numbers: _____ [] Verified

MEDICARE HOSPICE BENEFIT ELECTION: I elect to receive the Medicare Hospice Benefit from HNW. Hospice is responsible to provide the services described above and certain prescriptions and durable medical equipment related to my hospice illness. I understand by electing to receive hospice benefits I am waiving Medicare coverage for:

- Any Medicare services related to the treatment of the condition for which I have elected hospice care, or a related condition, or that are the equivalent of hospice care; and
Hospice care provided by another hospice (unless care is authorized by HNW);

Medicare will pay for hospice services by HNW, my Attending Physician (if that physician is not an employee of, nor receiving compensation for those services from HNW), and services unrelated to the illness for which I am receiving hospice benefits. I understand by electing the Medicare Hospice Benefit, I am entitled to hospice care for two (2) election periods of ninety (90) days each, and unlimited sixty (60) day periods thereafter, based on Medicare criteria for eligibility.

Discharge and Right to Appeal: You will be notified in advance if HNW determines Medicare will no longer pay for your hospice services. You may have to pay for any hospice services provided after you are discharged. You have the right to appeal this determination.

REVOCAION: I understand I may revoke this Consent/Election and withdraw from HNW at any time by signing a Revocation Statement. If I do so, I will forfeit remaining days in the election period but will be eligible for Medicare benefits previously waived by electing the Hospice Benefit. I may re-elect my Hospice Benefit at a later date, if eligible.

ELECTION OF BENEFIT: I certify I have read and understand this Statement of Consent and Election in its entirety.

Start of Care date: I authorize HNW to provide services beginning: _____, _____, 20_____.

Consent:

Signature of Patient or Authorized Representative Date Time

Witness Date Time

If patient not signing, state reason: _____

Relationship to patient: _____ DPOA [] Yes [] No