Nevada Medicaid and Check Up

Nevada Medicaid Hospice Program Election Notice - Pediatric

Upload this form through the Provider Web Portal. **For questions regarding this form, call:** (800) 525-2395

SECTION I	
Recipient Name:	
Recipient Medicaid ID:	Date of Birth:
Address:	City/State/Zip:
Email:	Phone #:

SECTION II	
I/We as the Parents/Legal Guardians/Agents of the Medicaid recipient identified above understand the following:	
He/she has a terminal illness with a life expectancy of six months or less, if the illness were to run its normal course.	Initials
The Affordable Care Act will entitle him/her to concurrent care while an eligible recipient of the Medicaid Hospice Program, that is curative care and palliative care at the same time. Upon turning 21 years of age, he/she will no longer have concurrent care benefits and will be subject to the rules governing adults who have elected Medicaid hospice care.	Initials
The goal for the hospice care provided will be the relief of pain and symptom management. Pediatric hospice care is both a philosophy and an organized method for delivering competent, compassionate and consistent care to children with terminal illnesses and their families. This care focuses on enhancing quality of life, minimizing suffering, optimizing function and providing opportunities for personal and spiritual growth; planned and delivered through the collaborative efforts of an interdisciplinary team with the child, family and caregivers as its center.	Initials
If he/she reaches a point of stability and is no longer considered terminally ill, the physician will be unable to recertify him/her for hospice care and he/she will return to traditional Medicaid benefits.	Initials
We, as the Parents/Legal Guardians/Agents, may revoke his/her 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 provider prior to that date.	Initials
The Hospice provider is responsible for any Home Health, Private Duty Nursing or Personal Care Services if related to the recipient's terminal diagnosis and these services will not be covered by the traditional Medicaid benefit. The traditional Medicaid benefit will cover these services needed for conditions not related to the terminal diagnosis.	Initials

SECTION III			
Admitting Terminal Illness ICD-10 Code(s):			
Recipient is currently admitted in a Nursing Facility.	☐ Yes ☐ No	Facility:	NPI #:
Recipient is transferring from another Hospice Agency.	☐ Yes ☐ No	Agency:	NPI #:
Certification Period:	☐ 1st 90 days ☐ 2nd 90 days ☐ 60 days	Start date of current Certification Period:	

Recipient has an attending physician separate from the hospice physician.	☐ Yes ☐ No	Physician:	NPI #:
Disclaimer: I and/or the Legal Representative/Agent of the recipient identified above, certify that the recipient DOES NOT have an attending physician separate from the hospice physician.			Initials

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Recipient Name:		Recipient Medicaid ID:
SECTION IV		
Services currently being provided to recipient by other Agencies:		
Home Health Services	☐ Yes ☐ No	Name of Agency:
Private Duty Nursing Services	☐ Yes ☐ No	Name of Agency:
Personal Care Services	☐ Yes ☐ No	Name of Agency:

Elected Hospice Provider:	NPI #:
Date Hospice Election to Begin:	

Recipient and/or Legal Representative/Agent Statement

I, *(Recipient's Name)*_____, have read and understand the statements in this document.

Recipient Signature:_____ Date:_____

I, *(Legal Representative/Agent Name)*_____, as the Legal Representative/Agent for (Recipient's name)_____, have read and understand the statements in this document.

Relationship to Recipient:_____

Legal Representative/Agent Signature:_____ Date:_____

Hospice Provider Statement

I, *(Hospice Representative Name)*_____, Hospice Representative for *(Hospice Provider's Name)*_____, understand that the Hospice provider is responsible for the coordination of services to ensure there is no duplication of services.

Hospice Representative Title:_____

Signature:_____ Date:_____