Nevada Medicaid Hospice Program Election Notice - Adults

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 and/or the Legal Representative/Agent of the Medicaid recipient identified above understand the following:	
I have a terminal illness with a life expectancy of six months or less, if the illness were to run it's normal course.	Initials
The goal for the hospice care given will be the relief of pain and symptom management and that no extraordinary life sustaining measures will be initiated. The Nevada Medicaid Hospice Benefit and Services have been explained to me and/or my legal representative.	Initials
Any service(s) received related to the care of the terminal illness for which hospice was elected for will not be covered by the traditional Medicaid benefit.	Initials
I may revoke the 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 prior to that date. I understand my rights to other Medicaid services will resume at that time, if I continue to be Medicaid eligible.	Initials
If I reach a point of stability and can no longer be certified as terminally ill, I will return to the traditional Medicaid benefit.	Initials
The Hospice provider is responsible for any Home Health, Private Duty Nursing or Personal Care Services if related to my 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:_____