TRI CITY HOSPICE INC.
13096 Borden Ave Sylmar, CA 91342
Phone: (818) 433-4524 * Fax: (818) 452-5011
E-mail: tricityhospiceinc@gmail.com

ELECTION OF MEDICARE HOSPICE BENEFIT

I understand that:

1. By signing this election form requesting hospice care under the Medicare Hospice Benefit, I am entitled to unlimited days of hospice care in the sequence periods consisting of a) 90-day period, 1.1) 90day period, c) 60-day period, and d) unlimited days period. as long as certification of my terminal illness is confirmed and documented at the beginning of each election period.

   By electing hospice care under the Medicare Hospice Benefit, I waive all other Medicare Part A services, except, a) my right to treatment or therapy for any condition other than my terminal illness under Medicare Part A and b) I do not waive the right to continue seeing my attending physician and I will be responsible for any bills from my attending physician under Medicare part B, when appropriate.

3. By electing hospice care under the Medicare Hospice Benefit. I can choose to receive hospice care from another hospice program at any time during the benefit periods. To change programs, I must first confirm that the hospice I wish to be admitted to can admit me and on what date. I must inform TRI CITY HOSPICE INC. of my wishes so arrangements for transfer can be made. I must document the date I wish to discontinue care from TRI CITY HOSPICE INC.. the name of the hospice from which I wish to receive care, and the date of care will start. No benefit will be lost by properly converting to another hospice program.

4. By electing hospice care under the Medicare Hospice Benefit, I can choose not to continue hospice care from another hospice program at any time. To discontinue care, I must complete a revocation statement. I can obtain this statement from the visiting personnel from TRI CITY HOSPICE INC. If I revoke my Medicare Hospice Benefit in the middle of a benefit period. I give up the remaining days in the benefit period.
   For example, if I revoke my Medicare Hospice Benefit after the first 10-days, I give up the remaining 80-days in the first benefit period. I would then have the second 90-days period, the third 60-days period, and the fourth unlimited period left for future use.

I understand that hospice care provides:

1. Medical care from my primary physician, nursing care and all other services from TRI CITY HOSPICE INC. nurses and staff.

2. Care by the hospice physician, professional nurses and others as is appropriate will be provided as often as necessary to permit control of pain, discomfort. anxiety, and other disturbing symptoms of illness. I understand hospice care is not intended to be curative, rather it is to provide comfort and intended to alleviate, to the extent possible, symptoms connected with my illness.

3. Coverage for nursing care, medical social services, physician services, counseling services, medical appliances and supplies (including drugs and biologicals for palliation and the management of terminal disease symptoms), and physical, occupational and speech therapies as needed.

4. The hospice will, within the limits of its resources, provide emotional, social and spiritual support to me, my family and others closely involved in my life.

5. All hospice services will be provided only with the express authority of the patient/family by TRI CITY HOSPICE INC. and the attending physician, and the Interdisciplinary Team.
6. All treatment and therapy decisions will be made with the consent of the patient/family, attending physician TRI CITY HOSPICE INC., Medical Director, and the Interdisciplinary Team.
7. There will be ongoing conferences regarding my plan of care in terms of my physical, social and spiritual needs, and I may attend if I so choose.

1 understand that Inpatient Hospice Care:

1. Will be provided by TRI CITY HOSPICE INC. for pain control, symptom management and management of psychosocial problems related to my terminal illness. 1 understand that this care will be provided at a facility contracted with TRI CITY HOSPICE INC.

I understand that some hospice services may require procedures performed in a hospital outpatient setting, and that TRI CITY HOSPICE INC. will arrange for these services as needed. I understand that Respite Care:

1. Will be arranged by TRI CITY HOSPICE INC. under the Skilled Nursing Facility certification, for up to five (5) days at a time, occurring once over 60-days.

I have been given the opportunity to ask questions about my care by the hospice and all questions have been answered to my satisfaction. I accept the conditions of the hospice as described, with understanding that I may revoke my election for hospice care at any time. I understand that if, after admission to TRI CITY HOSPICE INC., my physician(s) and I no longer consider hospice services appropriate or sufficient, or if I wish to pursue life-prolonging therapies, I must revoke my election of hospice care without further penalty to any party. I understand that such action on my part will be regarded by **TRI CITY HOSPICE INC.** as a constructive revocation of the Medicare Hospice Benefit in the absence of any signed statement by me. I understand that the hospice will not be financially or medically responsible for any therapies or cost incurred as a result of my life-prolonging actions. As the patient, Primary Care Giver and/or Legal Responsible Party, we have researched other health care alternatives and have deemed that they are not an option for the patient as this time, As a result, I choose to elect the Medicare Hospice Benefit through the services of **TRI CITY HOSPICE INC.**

SIGNATURE: _____ DATE: _____

HOSPICE REPRESENTATIVE: _____