## FLORIDA MEDICAID HOSPICE CARE SERVICES
### Referral for Medicaid Eligibility

| | Date |
|---|---|
| TO: Department of Children and Families<br>Hospice Coordinator | FROM: |
| | Name of Hospice |
| Address | Address |
| | |
| | Medicaid Provider # |

The individual listed below has elected hospice care benefits to be provided by

(Name of Hospice)

This individual meets the hospice eligibility criteria as evidenced by the attached documentation.

| | |
|---|---|
| Name | Social Security Number |
| Address | Medicaid ID #: (if applicable) |
| Telephone Number | Date of Birth |
| Attending Physician | Hospice Election Date |

The above named individual has elected to receive Medicaid hospice care services. Please determine eligibility for Medicaid.

Signature – Hospice Provider

Attachments:
1. Election Statement, AHCA 5000-21
2. Physician Prognosis Certification

Distribution of Copies:
1. Coordinator
2. Physician
3. Hospice

AHCA 5000-20, July 1999 (59G-4.140, F.A.C.)