NOTICE OF HOSPICE ELECTION
NURSING FACILITY

TO: **Nursing Home Administrator** **FROM:** ____________________

____________________ ____________________

____________________ **PIN #:** ____________________

Phone: ____________________ **Phone:** ____________________

This is to advise that the recipient identified below has elected to receive hospice care benefits under:

☐ Medicare ☐ Medicaid

Name: ____________________ Election Date: ____________________

Medicaid ID#: ____________________ DOB: ____________________

Guardian: ____________________

Address: ____________________

Phone No.: ____________________

In order for institutionalized Medicaid-eligible recipients who elect hospice services to obtain such services, institutional payments must be terminated before the first day of hospice coverage.

Hospice services shall start on ____________________ (Date) . If you are not in accord with the hospice service start date, contact ____________________ (Name) at ____________________ (Phone Number) immediately.

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

AHCA 5000-24, July 1999 (59G-4.140, F.A.C.)