

NEVADA MEDICAID HOSPICE PROGRAM ELECTION NOTICE- Adults

Recipient Name: _____ **Medicaid ID#:** _____

Date of Birth: _____ **Email:** _____

Address: _____ **Phone #:** _____

City/State/Zip: _____

I and/or the legal representative 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 its 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
T = _____ if related to my terminal diagnosis and will not be covered by the traditional Medicaid benefit.	_____
	Initials

Services the recipient is currently receiving:

<i>Home Health Services</i>	Yes	No	Name of Agency: _____
<i>Private Duty Nursing Services</i>	Yes	No	Name of Agency: _____
<i>Personal Care Services</i>	Yes	No	Name of Agency: _____

Admitting Terminal Illness ICD Code(s):
