

Medicaid Hospice Election and Physician's Certification

I, _____ Patient's Name & Phone Number _____ Medicaid Number _____ elect to receive the Medicaid Hospice Benefit from _____ Hospice Name _____ Provider No. _____ Provider Phone No. _____ to be effective _____ Date.

Admitting Diagnosis Code(s) _____

PATIENT ACKNOWLEDGEMENT

I understand and acknowledge:

- that the Medicaid Hospice Benefit consists of the following certification periods, and that each period must be approved by my attending physician and Hospice Medical Director at the beginning of the benefit period.

1st Planning Period - 9th March

Therapeutic Period - 90 Days

Subsequent Benefit Periods - all Dates each

- that if I reach a point of stability, and am no longer considered terminally ill, that the Hospice will be unable to recertify me, and I will return to the traditional Medicaid benefit.
- that by electing the Medicaid Hospice Benefit, I waive all rights to Medicaid covered services that are also covered under the Medicare Program related to the treatment of the terminal illness or related condition for which Hospice Care is elected.
- that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefit simultaneously with the Medicaid Benefit.

Check applicable statement and provide requested information as indicated:

- ☐ I am a Medicare recipient and have elected the Medicare Hospice Benefit.
My Medicare number is _____
- ☐ I am not a Medicare recipient. (If I become eligible for Medicare I must notify hospice)
- ☐ I am currently a long term care facility resident residing at _____

Nursing Facility Name and Address	
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By this election I acknowledge that I have been fully informed and understand the services and limitations of hospice care available from the above named hospice under the Medicaid Hospice Benefit.

England's Silverware for Sale

Editor: *Shirleywood C. Jones*, *University of Houston*

Patient Representation's Significance

Date Signed of Election Date:

Relevance to Patient

^aVA, Veterans Affairs; CAGE, cut-point score of 3; BDI, Beck Depression Inventory.

PHYSICIAN CERTIFICATION

I certify that the above named patient is terminally ill based upon clinical judgement regarding the normal course of the individual's illness. I understand that intentional certification of patients as terminally ill for chronic debilitating diagnoses with documentation that fails to support the terminal illness will result in referral to Medicaid's Provider SUR Unit and further actions as determined by review.

III-ecarte-actif

IV-egre-actif

Author and Disclosures

Physician's Signature/Status
(Attending, Hospice Medical Director,
Hospice Team Physician, etc.)

Date: _____
Physician: _____

11

2000

Verbal Order Documentation (Initial Certification Only)

1111

Scholarship Title

Pharmacokinetic and Pharmacodynamic Parameters

Alabama Medicaid Hospice Manual

Alabama Medicaid Agency



Alabama Medicaid Hospice Manual:

Alabama Administrative Monthly ,1992 Monthly Catalog of United States Government Publications United States. Superintendent of Documents,1991 February issue includes Appendix entitled Directory of United States Government periodicals and subscription publications September issue includes List of depository libraries June and December issues include semiannual index *Monthly Catalogue, United States Public Documents* ,1991 **Alabama Medicaid Regulation Manual** Alabama Medicaid Agency,1981 *Hospice Programs and Public Policy* Paul Roger Torrens,1985
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Table of Contents Alabama Medicaid Hospice Manual

1. Understanding the eBook Alabama Medicaid Hospice Manual
 - The Rise of Digital Reading Alabama Medicaid Hospice Manual
 - Advantages of eBooks Over Traditional Books
2. Identifying Alabama Medicaid Hospice Manual
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Alabama Medicaid Hospice Manual
 - User-Friendly Interface
4. Exploring eBook Recommendations from Alabama Medicaid Hospice Manual
 - Personalized Recommendations
 - Alabama Medicaid Hospice Manual User Reviews and Ratings

- Alabama Medicaid Hospice Manual and Bestseller Lists
- 5. Accessing Alabama Medicaid Hospice Manual Free and Paid eBooks
 - Alabama Medicaid Hospice Manual Public Domain eBooks
 - Alabama Medicaid Hospice Manual eBook Subscription Services
 - Alabama Medicaid Hospice Manual Budget-Friendly Options
- 6. Navigating Alabama Medicaid Hospice Manual eBook Formats
 - ePub, PDF, MOBI, and More
 - Alabama Medicaid Hospice Manual Compatibility with Devices
 - Alabama Medicaid Hospice Manual Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Alabama Medicaid Hospice Manual
 - Highlighting and Note-Taking Alabama Medicaid Hospice Manual
 - Interactive Elements Alabama Medicaid Hospice Manual
- 8. Staying Engaged with Alabama Medicaid Hospice Manual
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Alabama Medicaid Hospice Manual
- 9. Balancing eBooks and Physical Books Alabama Medicaid Hospice Manual
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Alabama Medicaid Hospice Manual
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Alabama Medicaid Hospice Manual
 - Setting Reading Goals Alabama Medicaid Hospice Manual
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Alabama Medicaid Hospice Manual
 - Fact-Checking eBook Content of Alabama Medicaid Hospice Manual
 - Distinguishing Credible Sources

13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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