SNF FINANCIAL RESPONSIBILITY/SNF HOSPICE ELECTION

Hospice of Marion County, Inc.

Post Office Box 4860 • Ocala, Fl. • 34478-4860 • (352) 873-7400

Patient Hospice #:_____ DOB:_____/_____/_____

(Name):_____is a Hospice patient and will be monitored regularly by our team at (Facility)_____ . We are available by phone Monday-Friday from 8:00 a.m.to 5:00 p.m., at (352) 873-7400. For evenings and weekends, a Hospice nurse is **ON CALL** and can be reached by dialing the above number.

Hospice service will start on _____/_____/_____. If you are not in accord with the hospice service date, contact the Medicaid Verification Specialist at (352) 873-7400 immediately.

This patient is using the: ☐ Medicare ☐ Medicaid Medicaid #:_____ benefit for Hospice care. Hospice is responsible for DME, supplies, lab tests and medications as stated in this facility's current contract. Hospice is responsible for, as in the facilities contract related to the terminal diagnosis, **approving** and paying for the following checked items related to the **Terminal diagnosis**.

_____1. Room and Board_____Payee

_____ 2. Physician Consults: As related to terminal diagnosis only

_____ 3. Physical Therapy **Per Hospice Pre Approval for placement on Hospice of Marion County Plan of Care**

_____ 4. Occupational Therapy **Per Hospice Pre Approval for placement on Hospice of Marion County Plan of Care**

_____ 5. Speech/Language Therapy **Per Hospice Pre Approval for placement on Hospice of Marion County Plan of Care**

_____ 6. Hospitalization: Hospice of Marion County, Inc.'s contracted facilities,

MRMC/ORMC/WEST MARION COMMUNITY HOSPITAL

_____7. Transportation **Per Hospice Approval on a case by case basis**

Hospice of Marion County, Inc., is never responsible for laundry services, cable television, telephones, beauticians, sitters, or personal care items.

Patient is: ☐Skilled ☐ Not Skilled upon HMC admission.

HMC Diagnosis:_____ SNF Diagnosis:_____

Please call Hospice if you have any questions or concerns regarding billing or patient charges as they relate to this patient. We appreciate your efforts in working with us to provide Hospice care to patients in your facilities.

_____ ____/____/____ _____ _____/____/____

Print Name Patient/Patient Representative Date Patient/Patient Representative Signature Date

_____ ____/____/____ _____ ____/____/____

Print Name Hospice Representative Date Hospice of Marion Representative Signature Date

_____ ____/____/____ _____ ____/____/____

Print Name SNF Representative Date SNF Representative Signature Date

Return form to HIM upon completion

Form # H-00089	Revision Date: 11/13

WHITE-Chart YELLOW-Facility PINK-Patient/Family