

Michigan Department of Community Health
HOSPICE MEMBERSHIP NOTICE

Fax to: (517) 373-1437

<input type="checkbox"/> ENROLLMENT APPLICATION →	1. Effective Date
<input type="checkbox"/> ENROLLMENT UPDATE →	2. Effective Date
<input type="checkbox"/> DISENROLLMENT NOTICE →	3. Effective Date 4. Reason Code

SECTION I- PROVIDER INFORMATION:

5. Provider Name			6. a National Provider ID	6. b Provider I.D.	7. Control Number
8. Attending Physician Name			10. Hospice Phone Number () -		11. Hospice Fax Number () -
9. Physician Address (Number & Street, Suite Number)			12. Physician Provider ID Number		13. Provider Type
City	State	ZIP Code	14. Is this Beneficiary a Waiver Participant? <input type="checkbox"/> YES <input type="checkbox"/> NO		

SECTION II- FACILITY INFORMATION:

Is beneficiary currently in Nursing Facility, Hospice Owned Nursing Facility, Ventilator Dependent Care Unit or Hospital?
 YES (If Yes, complete this section.) **NO** (If No, proceed to Section III.)

15. Facility Name		16. Facility. Medicaid ID Number		17. Date Admitted to Facility	
18. Facility Address (Number & Street)		City	State	ZIP Code	

SECTION III- BENEFICIARY INFORMATION:

19. Beneficiary Name (Last, First, Middle Initial)			21. Beneficiary ID Number		
20. Beneficiary Address (Street Address and Apt. No.)			22. Social Security Number		23. Birth Date
City	State	ZIP Code	24. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		25. Home Phone Number () -
26. CSHCS Beneficiary? <input type="checkbox"/> YES <input type="checkbox"/> NO		27. Beneficiary LOC		28. Previous Hospice Enrollee? <input type="checkbox"/> YES <input type="checkbox"/> NO	
29. Estimated Remaining Life Span Months			29. Estimated Remaining Life Span Months		
30. Legal Parent or Guardian Name (Last, First, Middle Initial)			31. Diagnosis Code(s)		

REMARKS:

32.

By placing an "X" or a "✓" in this box, I certify that I have read (or they have been read to me) and understand the Conditions of Enrollment and Certification provisions on Page 2 of this form. Any questions I had about these provisions or my hospice care were answered by a hospice representative.

For ENROLLMENT Only

33. Beneficiary (or authorized representative) Signature	Date
34. Witness Signature	Date

For DISENROLLMENT Only

35. Beneficiary (or authorized representative) Signature	Date
36. Witness Signature	Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Department of Community Health is an equal opportunity employer, services and programs provider.

CONDITIONS OF ENROLLMENT:

Hospice services are an option of medical care that you may choose while you are in the terminal stages of your illness. Palliative at-home care is the basis for hospice care. If you do not have a family member or friend to care for you in your home, hospice care may be provided while you are a resident of an approved nursing facility (NF), home for the aged (HFA), adult foster care facility (AFC), licensed hospice long term care unit, boarding home, ventilator dependent care unit or hospice owned nursing facility. All Medicaid and any approved Children's Special Health Care Services (CSHCS) covered services for the terminal illness will be provided by the hospice. You must use your **mihealth card**, health plan card, or CSHCS Eligibility Letter to obtain care from your private physician or health plan for services not related to the terminal illness. You may elect to disenroll from the hospice at any time by signing the disenrollment form.

CERTIFICATION:

By signing this form, I certify that I voluntarily apply for hospice enrollment for myself or the person indicated in item number 19. The enrollment is effective on the date entered on item number 1 and will continue as long as the hospice continues operation and eligibility continues under the Medicaid Program or CSHCS approval. If the Medicaid Eligibility Verification System indicates a patient-pay amount, I understand that I must pay that amount, **each month**, to the hospice for my care. Any applicable patient-pay amount, insurance payment, and Medicaid reimbursement represents payment-in-full to the hospice. I understand and accept the conditions of enrollment stated above. I authorize any physician or hospital to release medical information to the hospice. I authorize the hospice to release medical information to the Michigan Department of Community Health.