

HOSPICE MEMBERSHIP NOTICE
Michigan Department of Health and Human Services

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. Hospice provider name		6. National provider ID		7. CHAMPS provider hospice ID		8. Control Number	
9. Hospice provider address				10. Hospice phone number		11. Hospice fax number	
				-		-	
12. Attending physician name and address				13. Physician national provider ID number			
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 a Nursing Facility or Ventilator Dependent Care Unit?

YES (If Yes, complete this section.)

NO (If No, proceed to Section III.)

15. Facility name			17. CHAMPS facility provider ID number		
16. Facility address (number and street)			18. Facility national provider ID		
City	State	ZIP code	19. Date admitted to facility		

SECTION III – BENEFICIARY INFORMATION

20. Beneficiary name (last, first, middle initial)			21. Beneficiary ID number		23. Social Security Number	
22. Beneficiary address (street address and apt. no.)			24. Birth date (mm/dd/yy)		25. Gender	
					<input type="checkbox"/> Male <input type="checkbox"/> Female	
City	State	ZIP code	26. Home phone number		30. Estimated remaining life span	
			-		-	
27. CSHCS beneficiary?		28. Beneficiary LOC		29. Previous hospice enrollee?		
				<input type="checkbox"/> YES (if yes, explain) <input type="checkbox"/> NO		
31. Legal parent or guardian name (last, first, middle initial)			32. Diagnosis code(s)			

SECTION IV – REMARKS

33.

SECTION V

34. 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

For DISENROLLMENT Only

35. Beneficiary (or authorized representative) signature		Date	37. Beneficiary (or authorized representative) signature		Date
36. Witness signature		Date	38. Witness signature		Date

<p>AUTHORITY: Title XIX of the Social Security Act COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.</p>	<p>The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.</p>
---	---

See Page 2

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), boarding home, OR ventilator dependent care unit. 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 20. 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. If eligibility verification 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 Health and Human Services.

COMPLETION INSTRUCTIONS

Document Description

The Hospice Membership Notice (DCH-1074) form is used by hospice agencies to notify the Michigan Department of Health and Human Services (MDHHS) of a Medicaid Fee-for-Service (FFS) eligible beneficiary's hospice enrollment, disenrollment; hospice agency transfer or to inform of a change in location of hospice services. The Community Health Automated Medicaid Provider System (CHAMPS) system is updated based on information reported on the DCH-1074. The following pertains to the completion of the Hospice Membership Notice.

DCH-1074 Location

The DCH 1074 is located in the Medicaid Provider Manual in the forms section.

Where to Submit the DCH-1074

Hospice agencies should fax the completed DCH-1074 to the MDHHS Enrollment Services Section at (517) 373-1437.

General Guidance

If the beneficiary is enrolled in a Medicaid Managed Health Plan do not submit the DCH-1074 to MDHHS. The hospice agency must instead contact the beneficiary's Medicaid Managed Health Plan to receive authorization for hospice services.

Entries should be typed or clearly printed.

Providers must retain a copy of the original DCH-1074 and all updates to the DCH-1074 in the beneficiary's record. The DCH-1074 should be submitted within five calendar days of the effective date of hospice election. Timely submission of the DCH-1074 is essential to ensure that the beneficiary's eligibility file contains the appropriate information including the hospice level of care (LOC) designation. Likewise, hospice disenrollment notices should be submitted within five calendar days. If the form is submitted and is incomplete or changes are required (e.g., the effective date is incorrect), the DCH-1074 will be returned to the hospice provider for correction and this will need to be resubmitted. When resubmitting the DCH-1074, providers should indicate that it is a revision.

When the DCH-1074 is accepted and processed, a LOC code 16 (hospice) will be entered into the CHAMPS eligibility screen for the beneficiary.

Selection of the DCH-1074 Purpose

The hospice agency must identify which function the form will serve by checking the appropriate box located at the top right hand corner of the Hospice Membership Notice and include an associated effective date. Choose enrollment application, enrollment update or disenrollment notice.

Initial Enrollment

The hospice provider must complete and submit the DCH-1074 as an enrollment application for a FFS Medicaid beneficiary who elects the hospice benefit. The Hospice provider must at a minimum read/communicate the *Conditions of Enrollment and Certification* on page 2 of the DCH-1074 in a language or manner that is understood by the beneficiary or authorized representative prior to having the beneficiary or beneficiary representative sign the form.

Disenrollment

The hospice must submit the DCH-1074 to inform MDHHS of the beneficiary's disenrollment from hospice. Disenrollment may be due to death, revocation of hospice by the beneficiary or beneficiary's representative, the beneficiary no longer qualifies for Medicaid or hospice, or the hospice elects to terminate the beneficiary's enrollment due to fraud, abuse or misconduct. The correct corresponding code (see below) must be documented. Providers must submit the completed form to MDHHS Enrollment Services.

Enrollment Updates: Hospice Agency Transfer or Change in Beneficiary's Service Location

If a beneficiary changes hospice agencies or the location of hospice services changes, a DCH-1074 must be submitted to MDHHS Enrollment Services with the enrollment update area checked. Use the remarks section to clarify the reason for the update and indicate the name of the transferring and accepting hospice (e.g. "beneficiary moved out of service area and is transferring from hospice A to hospice B effective mm/dd/yy.").

Service Coordination

At the time of hospice enrollment, the hospice provider must determine if the beneficiary is receiving services from other programs such as Home Help, MI Choice Waiver, or Private Duty Nursing (PDN). If another program is identified, this should be noted in the remarks section and the hospice provider must contact the other program(s) and develop a joint plan of care (POC) to coordinate services. If duplication of services is identified upon post-payment review, this could result in monetary recovery.

Beneficiaries Receiving Hospice and MI Choice Waiver Program Services

If the beneficiary is enrolled in hospice and subsequently becomes eligible for MI Choice Waiver services, the waiver agency must inform the hospice when they will begin providing services. The hospice must then resend the DCH-1074 to the Enrollment Services Section indicating the date prior to the begin date of waiver services in the REMARKS Section as the last date for level of care (LOC) 16. This will allow LOC 22 (MI Choice Waiver services) to be placed on the beneficiary's member file. Hospice may continue to provide and bill for services, however when submitting claims, the hospice must note the Benefit Plan ID of MI Choice in the REMARKS Section of the claim form in order to allow for correct claims processing.

The hospice should not submit a DCH-1074 to MDHHS if at the time of enrollment to hospice the eligibility response indicates the Benefit Plan ID of MI Choice for the date of service. The hospice must contact the waiver coordinator to discuss and coordinate the services required.

Enrollment, Enrollment Update and Disenrollment Information (check the appropriate box)

Item 1: For Enrollment Application; enter the effective date of the enrollment application. This is a mutually agreed upon date by the hospice and the beneficiary.

Item 2: For Enrollment Update; enter the effective date of the reported enrollment update. The update informs MDHHS of changes in hospice service location (e.g. the hospice beneficiary has moved from their home to a nursing facility for their routine hospice care) or the beneficiary has transferred to another hospice. If this box is checked, a narrative is required in the remarks field.

(By checking either the enrollment application box or enrollment update box and providing the required nursing facility information in items 15 thru 19, the hospice will receive payment for nursing facility room and board (which is passed on to the nursing facility). The effective date is the date the beneficiary enters the nursing facility.)

Item 3: For discharge or disenrollment enter the effective date. (A reason code must be entered under item 4.)

Item 4: For discharge or disenrollment from hospice, one of the following reason codes must be entered by the hospice:

2 = Deceased

3 = Beneficiary elected to disenroll. (Requires completion of item 37 and 38)

9 = Other (requires brief explanation in remarks, and completion of Items 37 and 38)

SECTION I - Provider Information

Item 5: Hospice Provider Name

Item 6: Hospice National Provider Identification (NPI) number

Item 7: Hospice Provider ID

Item 8: This control number is a hospice internal patient identifier and is for hospice use only.

Item 9: Hospice Provider Address

Item 10: Telephone Number of Hospice Staff Member Responsible for Submitting the DCH-1074

Item 11: Fax Number of the Hospice Provider.

Item 12: Attending Physician's Name and Address

Item 13: Attending Physician's NPI

Item 14: Select "yes" or "no" to indicate if the beneficiary is a waiver program participant

Section II - Facility Information

This section must be completed for beneficiaries who reside in or are admitted to a nursing facility or ventilator dependent care unit (VDCU) when hospice is elected. Indicate “yes” or “no” if this section applies. If the beneficiary is not residing in, or being admitted to a nursing facility or VDCU, skip Section II.

Item 15: Name of the nursing facility where the beneficiary resides or has been admitted for routine hospice care.

Item 16: Nursing Facility Address

Item 17: Nursing Facility Provider ID

Item 18: Nursing Facility NPI

Item 19: Date Admitted to the Nursing Facility

Section III – Beneficiary Information

Item 20: Beneficiary Name

Item 21: Medicaid Beneficiary ID Number

Item 22: Beneficiary Address

Item 23: Beneficiary Social Security Number

Item 24: Beneficiary Date of Birth (mm/dd/yyyy)

Item 25: Beneficiary's Gender

Item 26: Beneficiary Home Phone Number

Item 27: Select “yes” or “no” to indicate if the beneficiary has Children’s Special Healthcare Services (CSHCS)

Item 28: Beneficiary's LOC at the time of 1074 Submission (from CHAMPS)

Item 29: Previous Hospice Enrollee (select yes or no). If yes, explain in comments

Item 30: Estimated Remaining Life Span in months

Item 31: If applicable, the beneficiary's legal parent/ guardian or beneficiary representative's name (the person who is authorizing hospice enrollment by signing line Item 35).

Item 32: Diagnoses codes. The beneficiary's terminal diagnosis must be entered using the appropriate diagnosis code(s). A primary diagnosis code is required for hospice enrollment. The hospice should also enter secondary codes applicable to the hospice admission and conditions related to the terminal diagnosis.

Section IV – Remarks

Item 33: Remarks are used to explain information related to the beneficiary. For example, use of other community resources, transfer to another hospice provider, etc.

Section V - Enrollment Acknowledgement

Item 34: This box must be checked by the beneficiary, beneficiary’s representative, parent or legal guardian signifying that the *Conditions of Enrollment and Certification* have been explained and understood by the beneficiary, beneficiary’s representative, parent or legal guardian. The Hospice provider must at minimum read/communicate the *Conditions of Enrollment and Certification* in a language or manner that is understood by the recipient or authorized representative and answer any questions.

Item 35: Signature of beneficiary, beneficiary’s representative, parent or legal guardian and date. After the *Conditions of Enrollment and Certification* has been effectively communicated, the beneficiary or the beneficiary's legal parent or the beneficiary’s representative authorizing hospice enrollment must sign. (For disenrollment this item remains blank.)

Item 36: Witness Signature for hospice enrollment and date. This individual serves as a witness of the communicated *Conditions of Enrollment and Certification* and the enrollee’s or enrollee’s representative’s signature. (For disenrollment this item remains blank.)

Item 37: Signature of Beneficiary, beneficiary’s representative, parent or legal guardian must be completed for disenrollment and dated. (For enrollment this item remains blank.)

Item 38: Witness Signature for hospice disenrollment and date. (For enrollment this item remains blank.)