DEPARTMENT OF HUMAN SERVICES

# REVOCATION OF HOSPICE CARE

1 RECIPIENT NUMBER

2 RECIPIENT NAME ("PATIENT")

3 EFFECTIVE DATE

I hereby revoke my election of hospice care on the effective date noted above.

By signing this statement, I understand that, as long as I remain eligible for Medical Assistance, my rights to coverage of all other Medical Assistance services will resume. This revocation does not prevent me from re-electing hospice care as long as I remain eligible for this benefit.

4 SIGNATURE OF PATIENT

5 DATE

The Patient is unable to execute this Revocation of Hospice Care form for the following reason:

6

I hereby certify that I am authorized under the laws of the Commonwealth of Pennsylvania to execute this form on behalf of the Patient, as the Patient's legal representative. I understand and acknowledge all of the representations set forth in this Revocation of Hospice Care form.

7 SIGNATURE OF LEGAL REPRESENTATIVE

8 DATE

9 NAME OF LEGAL REPRESENTATIVE (PRINT)

10 RELATIONSHIP TO PATIENT

DHS COPY

HOSPICE

CAO

RECIPIENT