Hospice Certification #_____

NOTICE OF TERMINATION / REVOCATION

AMAVI Home Health & Hospice care services, Inc.
131 Sand Creek Rd. Suite K
Brentwood CA 94513

Patient Name:_____ MR #:_____ Date:_____

Check one: ☐ Termination (i.e., live discharge) ☐ Revocation

REASON FOR TERMINATION / REVOCATION

Please check the appropriate reason below (choose only one, Termination or Revocation)

☐ TERMINATION

Please check the appropriate reason below:

- ☐ Extended prognosis (i.e., prognosis is greater than 6 months)
- ☐ Other (specify):_____

☐ REVOCATION

Please check the appropriate reason below:

- ☐ I am choosing aggressive treatment of my terminal illness, inconsistent with the goals of palliative hospice care
- ☐ I am moving outside the hospice's geographical service area and do not choose care from another hospice at this time
- ☐ I am choosing to be treated at a facility that does not contract with this hospice
- ☐ Other (specify):_____

RESULTS OF TERMINATION/REVOCATION FOR MEDICARE BENEFICIARIES

I understand that by signing this revocation form:

1. I am no longer accessing my Medicare Hospice Benefit, effective on this date _____ at _____ ☐ am ☐ pm;
2. I lose the remaining days of Medicare Hospice coverage in the current benefit period;
3. I may re-elect my Medicare Hospice Benefit again at any time as long as I am medically eligible; and
4. I am eligible to resume my non-hospice Medicare benefits immediately upon the date and time listed in item #1 above.

Additional information and comments:

☐ Continued on another sheet

Patient or Authorized Representative (printed)		Signature	Date
Hospice Staff Name (printed)	Title	Signature	Date