Medical Authorization Form

This form is to be completed by a HOSPICE Representative ONLY.

The patients application will remain pending until this signed Medical Authorization and supporting documentation is submitted.

If you are referring a NON-HOSPICE patient, please return to our website and select the Physician Medical Authorization to complete.

Patient Name *

First Name

Last Name

Patient's Terminal Diagnosis *

Date of Diagnosis *

Date of Admission *

Current Life Expectancy in Months (If less than 1, enter 0). *

Name of Treatment Facility/Hospital that referred the patient for hospice services. *

Name of Hospice Representative *

First Name

Last Name

Name of Hospice Company *

Hospice Company's Address *

Street Address

Street Address Line 2

City

State

Zip Code

Office Phone Number *

Phone Number

Cell Phone Number *

Phone Number

Hospice Representative's Email Address *

example@example.com

Upon submission, please upload the patient's FACE Sheet. *

Message to the Hospice Representative: We rely heavily on your honesty and professional opinion about the patient's request and how we can best assist through our programs. After a completed application has been submitted and reviewed, there may be additional questions regarding what was assessed in the home firsthand. Conversations are never held in an intrusive manner and we do our best to be sensitive to the family's situation during this stressful time. We seek to foster a partnership with you to help better serve your patients.

I certify that I am the assigned Hospice Representative of the patient and acknowledge to the best of my ability that my patient has a **life expectancy of six months or less**. I confirm that all information provided above is accurate. I have read and understand the statement above and will do my best to partner with Project 4031 to provide any required additional information dependent on the request. I have discussed Project 4031's service capabilities with my patient and have deemed the request to the reasonable. I recognize that, dependent on the request, there are potential risks involved. I have discussed these possible risks and informed my patient that they will assume the full liability of all injuries, damages, or loss, regardless of severity that they may sustain as a result of said participation. To the best of my knowledge I believe my patient is an eligible candidate for assistance and I believe it will improve their quality of life.

○ **I agree to the terms above.** *

Signature of Hospice Representative *

Title of Signer *

Date *