

**KENTUCKY MEDICAID PROGRAM**

**Revocation of Medicaid Hospice Benefits**

I, \_\_\_\_\_ / \_\_\_\_\_, revoke the hospice benefit allowed  
(Patient Name/Maid #)

to me by Medicaid and rendered by \_\_\_\_\_  
(Hospice Agency)

\_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.  
(Provider #)

I understand that any remaining days of this election period will not be available to me.

I understand that I may elect hospice care at a later time.

I understand that as of the date of this revocation, if I am still eligible, my regular Medicaid benefits will be restored.

I understand, however, that based on this revocation, I may become ineligible for Medicaid benefits.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Witness' Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

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**FOR OFFICE USE ONLY**

Rationale of Revocation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_