

Representative Statement  
For Election of Hospice Benefits

I, \_\_\_\_\_, due to the physical/  
(Legal Representative)  
mental incapacity of \_\_\_\_\_ / \_\_\_\_\_ am authorized  
(Patient Name/MAID #)  
in accordance with state laws to execute, change or revoke the election  
of Medicaid Hospice Benefits on behalf of \_\_\_\_\_  
who has been certified as terminally ill. As the representative for  
\_\_\_\_\_, I will sign all necessary forms.

\_\_\_\_\_  
Signature, Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date