Government of the District of Columbia
Department of Health Care Finance
Hospice Termination Form



Date of Action _____

Name of Patient _____

Patient Social Security Number _XXX-XX-_____

Patient Medicaid Number _____

Name of Hospice _____

Reason for Termination

1. *No Longer in need of Hospice Care- Return to Community*
   Address: _____
   _____
2. *Admitted to Hospital*
   Name of Hospital: _____
3. *Transferred to Another Hospice*
   Name of Hospice _____
4. *Death*
   Date of Death_____
5. *Other*- Please Specify Reason for Termination_____

Signature _____ Date _____

Telephone Number _____

February 1, 2016