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