CHILDREN'S HOSPICE WAIVER APPLICATION

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 743 (6-2019)

Clear Fields

Child's Information

Name	Social Security Number	On Medicaid? ☐ Yes ☐ No		Medicaid ID
Address	City	State	ZIP Code	Telephone Number

Parent's Information

Mother's Name				Father's Name			
Address				Address (if different)			
City	State	ZIP Code	Telephone	City	State	ZIP Code	Telephone Number

Physician's Information

Name	Clinic/Hospital	Telephone Number
Life Limiting Diagnosis		

By signing, I/we give permission to children's hospice program manager to forward the physician's letter to the hospice agency of our choice, to assist in the determination of eligibility.

Signature	Date

Documentation

Letter from Primary Physician attached? ☐ Yes ☐ No - Being sent to department

Explain further if needed
Hospice Agency of Choice
Nurse Case Manager of Family's Choice

Mail Completed Form To:

ND Dept of Human Services
Medical Services Division
600 E Bouldevard Ave Dept 325
Bismarck ND 58505-0250

The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social sercurity numbers. Disclosure of the social secuirty number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.