CHILDREN'S HOSPICE WAIVER APPLICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 743 (2-2025)

Clear Fields

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

CHILD'S INFORMATION

Name		Telephone Number	
Social Security Number *	On Medicaid? ☐ Yes ☐ No	Green Card Number (if applicable)	
Address	City	State	ZIP Code

PARENT'S INFORMATION

Mother's Name		Telephone Number	
Address	City	State	ZIP Code
Father's Name		Telephone Number	
Address	City	State	ZIP Code

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.

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information.

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:

Dept of Health and Human Services
Medical Services Division
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0250

OR

Email Completed Form To:

kbarchenger@nd.gov