Hospice Care Patient Eligibility Assessment

Date: [Insert Date]

To Whom It May Concern,

This letter serves to confirm the eligibility of [Patient's Name], born on [DOB], for hospice care services. After thorough evaluation and assessment by our medical team, we have determined that [he/she/they] meets the necessary criteria as outlined by Medicare and state regulations.

Eligibility Criteria:

- Terminal illness with a life expectancy of six months or less if the disease follows its usual course.
- Patient has expressed a desire to forego curative treatment and focus on comfort care.
- Comprehensive assessment conducted, indicating a need for palliative care services.

We recommend initiating hospice care services to provide [Patient's Name] with the necessary support and comfort during this critical time.

Should you require further information or additional documentation, please do not hesitate to contact our office at [Phone Number] or [Email Address].

Sincerely,

[Your Name]
[Your Title]
[Hospice Care Facility Name]
[Address]
[Phone Number]
[Email Address]