M E D I C A I D R E F E R R A L – P A G E 1

TO: _____ **FROM:** _____ **DATE:** _____

I. REQUEST FOR MEDICAID ELIGIBILITY INFORMATION

(to be completed and signed by the PACE applicant/beneficiary)

I, _____*, have applied/reapplied for Medicaid. I authorize*
(Print your name)

_____*County Department of Social Services to release the*
(Print name of county)

information below to _____.
(Print name of PACE provider)

This authorization is valid for up to one year from the date signed. I understand that I may revoke this authorization at any time by submitting a written request to the County Department of Social Services or PACE provider. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

✓_____ / _____ _____
PACE Applicant/Recipient or Representative's Signature **Relationship to Recipient** **Date**

II. CONSUMER INFORMATION *(to be completed by County DSS Staff)*

☐ PACE Services Requested ☐ PACE Authorized ☐ PACE Authorization Ends ☐ Revision (***Check one***) **Effective:** _____

Name: _____ Medicaid ID #: _____ Sex: ☐ Female ☑ Male
Address: _____City _____ County _____ Zip _____
Phone: _____ Social Security #: _____ Date of Birth: _____
Responsible Person/Contact: _____ Phone: (Day) oh_____ (Night) _____

III. ELIGIBILITY INFORMATION *(to be completed by County DSS Staff)*

MEDICAID ELIGIBILITY STATUS

Caseworker Name: _____ Phone: _____ Email: _____
Status: ☐ Not a current recipient ☐ SSI Recipient ☐ Medicare/Medicaid dual eligible
☐ MAA/MAB/MAD/SA (***circle one***) Eligibility certification period _____

☐ Application Needed ☐ Application Received on _____ (*date*) ☐ Pending Application _____ (*date applied*)
☐ Denial/Ineligible for PACE services due to: _____

CURRENT PACE AUTHORIZATION STATUS

☐ PACE Approval Effective _____ PML Amount $_____ Next Review: _____

MEDICAID REVIEW COMPLETED

☐ Approved – Next Review: _____ ☐ Denied due to: _____
☐ PML Change: Revised Amount $_____ Effective: _____
☐ Comments: _____

P A C E R E F E R R A L - - P A G E 2

TO: _____ **FROM:** _____ **DATE:** _____

I. REQUEST FOR PACE INFORMATION (*to be completed and signed by the Medicaid applicant/beneficiary*)

I, _____*, have applied/reapplied for Medicaid. I authorize*
(Print your name)
_____ *to release the information*
(Print name of PACE provider)

below to _____*County Department of Social Services.*
(Print name of county)

This authorization is valid for up to one year from the date signed. I understand that I may revoke this authorization at any time by submitting a written request to the County Department of Social Services or PACE provider. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

✓_____ / _____ _____
Medicaid Applicant/Recipient or Representative's Signature **Relationship to Recipient** **Date**

II. CONSUMER INFORMATION *(to be completed by PACE Staff)*

☐ New Enrollment ☐ Disenrollment ☐ Withdrawal ☐ Revision ***(Check one)*** **Effective:** _____

Name: _____ Medicaid ID #: _____ Sex: ☐ Female ☑ Male
Address: _____City _____ County _____ Zip _____
Phone: _____ Social Security #: _____ Date of Birth: _____
Responsible Person/Contact: _____ Phone: (Day) _____ (Night) _____

III. PACE ENROLLMENT INFORMATION *(to be completed by PACE Staff)*

☐ Referred to DSS to Apply for Medicaid/PACE services ☐ Mail-In Application Taken ***(Please attach)*** ☐ Application Mailed on_____(date)

COMPLETE FOR NEW PACE APPLICANTS:
- ☐ Enrollment Approved Enrollment Date: _____
- ☐ Enrollment Withdrawn by Applicant Reason: _____ Date: _____
- ☐ Enrollment Denied by PACE Reason: _____ Date: _____

COMPLETE FOR CURRENT PACE PARTICIPANTS:
- ☐ Temporary Nursing Facility Placement Date: _____ Facility: _____ Est. Length of Stay: _____
- ☐ Permanent Nursing Facility Placement Date: _____ Facility: _____

DISENROLLMENT INFORMATION:
- ☐ Voluntary Disenrollment Effective Date: _____ Reason: _____
- ☐ Involuntary Disenrollment Effective Date: _____ State Approved: ☑ Yes ☐ No
- ☐ Death Date of Death: _____

Comments: _____

IV. LEVEL OF CARE INFORMATION *(to be completed by PACE Staff)*

Assessment Date: _____ NF Level of Care Approved ☐ Yes ☐ No **(*If Yes, please attach*)** Eff. Date: _____
Assessor's Name: _____ Agency: _____