PACE REFERRAL
REQUEST FOR A MEDICAID HEARING

Recipient Name: ____________________________ County: __________________________________

Address: __________________________________ Social Security #: _________________________

__________________________________ MID #: __________________________________

Phone #: __________________________________ ☐ Local Hearing ☐ State Hearing ☐ Judicial Review

Reason for Request: ____

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Is applicant/recipient assisted by legal counsel or other representative? ☐ Yes ☐ No If Yes, state name and address: ____

____ __________________________________
PACE Worker's Signature Date

PACE Instructions: Forward request to the department of social services (DSS). The date of the request for a hearing will be the date the referral is received by the DSS.

To be completed by DSS and forwarded to the PACE Center:

Hearing Date: __________________________________

Decision: ____

County DSS Action Required: ☐ Yes ☐ No If Yes, action required: ______________________________

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PACE Action Required: ☐ Yes ☐ No If Yes, action required: __________________________________

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____ __________________________________
DSS Worker's Signature Date