# PACE APPLICATION REPORT

**_____ County**

Please complete this form on all PACE applications at the time of disposition and fax to (919) 224-1070, Attention:  Medicaid Eligibility Unit.

1. PACE Applicant Name: _____ MID #: _____

2. Medicaid Eligibility Status:     MAA     MAB     MAD     Not a Current Recipient
   Medicare/Medicaid dual eligible     ☐ Yes     ☐ No
   SSI recipient     ☐ Yes     ☐ No

3. Applicant Referred by PACE Organization to apply for Medicaid?  Yes    No
   *If Yes, was a DHB-5106, PACE Referral completed by PACE?  Yes    No
   *If Yes, was a mail-in application completed by PACE:*     Yes      No

4. Applicant Referred by Medicaid for PACE:      Yes      No
   *If Yes, was a DHB-5106, Medicaid Referral sent by Medicaid?*  Yes   No *(Circle Answer)*
   *If No, how was referral made:*
   _____

5. Date of Medicaid/PACE Application: _____

6. Date PACE Enrollment Signed: _____

7. Date Notification of PACE Enrollment Received from PACE: _____

8. Disposition:     Approved          Denied          Sanction
   *If Approved*, date PACE authorization keyed in NC FAST: _____ and
   the PACE Authorization Effective Date: _____
   *If Denied*, reason for denial: _____
   *If Denied due to a sanction*, what is the penalty period? _____

9. Additional Information/Comments: _____
_____
_____
_____
_____

_____     _____     _____
DSS Worker's Name                    Date                Telephone Number