P A C E A P P L I C A T I O N R E P O R T

_____ County

Please complete this form on all PACE applications at the time of disposition and e-mail to Medicaid.businesssupport@dhhs.nc.gov.

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