

MEDICAID REFERRAL – PAGE 1

TO: _____ FROM: _____ DATE: _____

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

I, _____, have applied/reapplied for Medicaid. I authorize _____ to release the information requested on this form to the _____ County Department of Social Services.

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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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 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) (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 Pending Application 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:

III. LEVEL OF CARE INFORMATION (to be completed by County DSS Staff)

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

TO: _____ FROM: _____ DATE: _____

I. REQUEST FOR MEDICAID INFORMATION (to be completed and signed by the PACE applicant/recipient)

I, _____, have applied/reapplied for Medicaid. I authorize
(Print your name)
_____ to release the information requested on
(Print name of PACE provider)
the front of this form to the _____ 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.

✓ _____ / _____
PACE 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: _____

DISENMROLLMENT 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: _____