

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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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

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: _____