

**PACE REFERRAL
REQUEST FOR A MEDICAID HEARING**

Recipient Name: _____ County: _____

Address: _____ Social Security #: _____

_____ MID #: _____

Phone #: _____ Local Hearing State Hearing Judicial Review

Reason for Request: _____

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: _____

PACE Action Required: Yes No If Yes, action required: _____

DSS Worker's Signature

Date