

PACE APPLICATION REPORT

_____ **County**

Please complete this form on all PACE applications at the time of disposition and fax to (919) 715-0801, Attention: Medicaid Eligibility Unit.

1. PACE Applicant Name: _____ MID #: _____

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

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

4. Applicant Referred by Medicaid for PACE: Yes No (Circle Answer)
*If Yes, was a DMA-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 (Circle One)
*If Approved, date PACE authorization keyed in EIS: _____ 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