

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) REFERRAL

This is a referral for enrollment in the PACE Program. Enrollment is strictly voluntary. If you meet all of the eligibility requirements for enrollment, and you agree to obtain all of your health and health-related services through the PACE Program at _____, and you complete an application for Medicaid, you may be eligible for PACE Program services. **Please Print**

Applicant's Name: First _____ Last _____	Social Security Number ____ - ____ - _____
Street Address (Apartment #)	Date of Birth (Mo./Day/Yr.) ____ / ____ / _____
City, State, and Zip Code	Phone Number (____) _____ - _____
Caregiver's Name & Phone #: _____ (____) ____ - _____	County
Authorized Rep.'s Name & Phone#: _____ (____) ____ - _____	
Does Applicant have a Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No Full Name of Guardian: _____	Phone Number of Legal Guardian, if applicable (____) _____ - _____
Is there a Spouse living in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No Are there other dependents living in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name and Relationship of Dependent(s): Name _____ Relationship to Applicant _____ _____ _____	Referral Source: <input type="checkbox"/> PACE Site <input type="checkbox"/> CDHS <input type="checkbox"/> HSF <input type="checkbox"/> PASSPORT <input type="checkbox"/> Other _____

This Block Must Be Completed By the County Department of Human Services

Is the individual currently on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, is MAJ Open? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, has Institutional Budget been run? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spend-Down Amount, if Applicable: \$ _____/Mo. Patient Liability Amount, if Applicable: \$ _____/Mo.
MMIS Billing Number:	County:
CDHS Case Worker Name (Please Print) First _____ Last _____	Unique ID Number _____ Phone Number () _____ - _____
Name, Address, and Phone Number of Health Insurance Company	

If health and/or accident insurance or insurance settlement is available, include copies of health and accident/injury information forms ODHS 6612 and/or ODHS 6613.

Signature of Individual in Need of PACE Services, or Legal Guardian, or Authorized Representative	Date
Signature of Person Who Helped Complete Referral	Date
Signature of CDHS Case Worker	Date Referral Received by CDHS

AN ODHS 7100 OR ODHS 7200 COMMON APPLICATION FORM MUST BE ATTACHED TO THIS REFERRAL WHEN SUBMITTED TO CDHS
 Distribution Instructions by referral source: PACE Site— Original Referral form and Application Form to CDHS PACE Coordinator, copy of Referral to Applicant, copy of Referral to Applicant record at Site. HSF, PASSPORT, Other— Copy of Referral to applicant, Original Referral and Application to CDHS PACE Coordinator, Copy of Referral to PACE Site. CDHS—Both Referral and Application originals to CDHS PACE Coordinator, copy of Referral to Applicant, copy of Referral to PACE Site.