STATE OF KANSAS
DEPARTMENT OF HEALTH AND ENVIRONMENT
DIVISION OF HEALTH CARE FINANCE

NOTIFICATION OF PACE INFORMATION

Referral, Eligibility and Services Information

ES-3166
Rev 07-17

TO: _____ **FROM:** _____ Date submitted: _____

I. Consumer Information: ☐ New Enrollment ☐ Revised ☐ Disenrollment

Name: _____ Medicaid ID: _____ Sex: ☐ Female ☐ Male

Address: _____ City: _____ Cty: _____ Zip: _____

Phone: _____ SSN: _____ Date of Birth: _____

Responsible Person/Contact: _____ Home Phone: _____ Work Phone: _____

II. ELIGIBILITY INFORMATION: (to be completed by EES Specialist)

EES Specialist: _____ Phone: _____ Fax or E-Mail: _____

Customer Medicaid Status: **Case #:** _____

☐ SI Recipient ☐ Spendown ☐ QMB/LMB Recipient Approximate Participant Obligation: _____

☐ Not a current recipient ☐ Application needed Application Received on: _____

☐ Denial/Ineligible for PACE due to: _____

Current PACE Status:

☐ PACE Approved Effective: _____ Participant Obligation: _____ Next Review: _____

Review Completed: Approved Next Review: _____ ☐ Denied due to: _____

Participant Obligation change effective: _____ New Participant Obligation: _____

Additional Comments:

III. LEVEL OF CARE INFORMATION (to be completed by KDOA)

Annual Reassessment. ☐

Assessment Date: _____ LOC Score: _____ Threshold Met? ☐ Yes ☐ No

Assessors Name: _____ Agency: _____

☐ Deemed Eligible ☐ Ineligible ☐ Waived Eligible, special approval required, approved by: _____

KDOA Representative: _____ Date: _____

Services Currently being Received:

IV. PACE ENROLLMENT INFORMATION (to be completed by PACE Provider)

Financial App sent ☐

☐ Medicaid Referral ☐ Service Information PACE Provider: _____ Anticipated Enrollment Date: _____

Case Manager: _____ Phone: _____ Fax or E-mail: _____

COMPLETE FOR NEW PACE APPLICANTS:

Enrollment accepted: ☐ **Date of PACE Assignment:** _____

Enrollment denied by customer: ☐ Reason: _____

PACE Team denied enrollment: ☐ Reason: _____

COMPLETE FOR CURRENT PACE ENROLLEES:

Nursing Home Placement:

Temporary : ☐ Date: _____ Facility Name: _____ Est. Length of Stay: _____

Permanent: ☐ Date: _____ Facility Name: _____

Disenrollment information:

☐ Voluntary Disenrollment Effective Date: _____ Reason: _____

☐ Involuntary Disenrollment Effective Date: _____ ☐ State Approved

☐ Death Date of Death: _____

Comments:

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PACE REPRESENTATIVE SIGNATURE Date

EES SPECIALIST SIGNATURE Date

ATTACHMENTS ☐ YES ☐ NO