Iowa Department of Human Services

Program of All-Inclusive Care for the Elderly (PACE) Disenrollment

I. Disenrollment Information

Review Type	☐ Voluntary ☐ Involuntary ☐ Death (date)_____		
PACE Organization Name			
Contact Person		Telephone	
Person Requesting Disenrollment	☐ Participant ☐ Family/Spouse ☐ PACE Organization ☐ Assisted Living (AL) ☐ Nursing Facility (NF) ☐ Other (please specify)_____		

II. PACE Participant Information

Participant Full Name			
Medicaid ID Number		Date of Birth	
Date of Enrollment		Date of Admission to NF/AL	
Living Arrangement	☐ Alone ☐ Nursing Facility ☐ Assisted Living ☐ Family/Spouse ☐ Other (please specify)_____		

III. Criteria for Disenrollment *(Please select all that apply)*

CFR 460.162 and CFR 460.164

- ☐ The participant failed to pay, or to make satisfactory arrangements to pay, any premium due to the PACE Organization after a 30-day period.
- ☐ The participant engages in disruptive or threatening behavior.
- ☐ The participant moved out of the PACE program service area or is out of the service area for more than 30 consecutive days.
- ☐ The participant is deemed to no longer meet the state Medicaid nursing facility level of care requirements and is not deemed eligible.
- ☐ The PACE program agreement with the Centers for Medicare and Medicaid Services (CMS) and the state administering agency is not renewed or is terminated.
- ☐ The PACE Organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers.
- ☐ Other (voluntary disenrollment only)

IV. Statement of Reason for Disenrollment

Provide or attach a chronological summary of events supported by case file documentation. (See instructions on Page 3.)

V. Communication

Provide or attach a chronological summary of events supported by case file documentation. (See instructions on Page 3.)

VI. Remediation *(Action steps taken by PACE Organization)*

VII. Discharge Plan

Upon completion, please include the following via email to pace@dhs.state.ia.us:

- Completed PACE Disenrollment form 470-5532
- Current participant Care Plan
- Copy of PACE Organization's current Policy and Procedure for Disenrollment
- Copy of PACE Organization's current Disenrollment Policy and Procedure to reinstate the participant in other Medicare and Medicaid programs for which the participant is eligible

I confirm all information is a true and accurate description of the above PACE participant.

Completed by (Print Name)*				Title	
Telephone		Date		Email	

PLEASE NOTE: **After selecting SUBMIT, all required attachments must be included in the email to be sent to** pace@dhs.state.ia.us.
*** Printing your name under the section *"Completed by"* constitutes signature of confirmation.**

SUBMIT