



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

I. Disenrollment Information			
Review Type	<input type="checkbox"/> Voluntary	<input type="checkbox"/> Involuntary	<input type="checkbox"/> Death (date)_____
PACE Organization Name			
Contact Person		Telephone	
Person Requesting Disenrollment	<input type="checkbox"/> Participant <input type="checkbox"/> Family/Spouse <input type="checkbox"/> PACE Organization <input type="checkbox"/> Assisted Living (AL) <input type="checkbox"/> Nursing Facility (NF) <input type="checkbox"/> 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	<input type="checkbox"/> Alone <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Assisted Living <input type="checkbox"/> Family/Spouse <input type="checkbox"/> Other (please specify)_____		
III. Criteria for Disenrollment <i>(Please select all that apply)</i> CFR 460.162 and CFR 460.164			
<input type="checkbox"/> The participant failed to pay, or to make satisfactory arrangements to pay, any premium due to the PACE Organization after a 30-day period.			
<input type="checkbox"/> The participant engages in disruptive or threatening behavior.			
<input type="checkbox"/> The participant moved out of the PACE program service area or is out of the service area for more than 30 consecutive days.			
<input type="checkbox"/> The participant is deemed to no longer meet the state Medicaid nursing facility level of care requirements and is not deemed eligible.			
<input type="checkbox"/> The PACE program agreement with the Centers for Medicare and Medicaid Services (CMS) and the state administering agency is not renewed or is terminated.			
<input type="checkbox"/> The PACE Organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers.			
<input type="checkbox"/> 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 470-5030
- 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