Department ofHuman Services
Division of Aging Services
Office ofCommunity Choice Options

PACE ENROLLMENT REQUEST

To: Date:
OCCO Field Office

From:
PACE Provider

Phone Number

This is to advise you that the individual identified below has elected to enroll in the Program for All-Inclusive Care for the Elderly (PACE).

Participant Name:	Medicaid Number:
Street Address:	Social Security Number:
City, State, Zip Code:	Date of Birth:
CP2 Effective Date	Current MCO Enrollment:
Requested PACE Enrollment Date:	Clinical Eligibility Date:

Comments:

Name of PACE Administrator (Print)

OCCO SECTION ENROLLMENT REQUEST OUTCOME:	
Enrolled : ☐ Date of Enrollment:	Not Enrolled : ☐ Reason:
Name of OCCO Representative (Print)	Date: