

Department of Human Services
Division of Aging Services
Office of Community Choice Options

PACE ENROLLMENT REQUEST

To: _____ Date: _____
OCCO Field Office

From: _____
PACE Provider

Address

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:

Requested PACE Enrollment Date: _____

Please call this office at _____ should you have any questions.

Name of PACE Administrator (Print)	Signature
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OCCO SECTION	
ENROLLMENT REQUEST OUTCOME:	
Enrolled: <input type="checkbox"/> Date of Enrollment:	Not Enrolled: <input type="checkbox"/> Reason:
Name of OCCO Representative (Print):	Date: