BHSF Form 148-P
Issued 8/05
IV

PACE NOTIFICATION OF ENROLLMENT, STATUS CHANGE, OR DISENROLLMENT

Provider Name: **PACE GNO**	Telephone #:	Medicaid Provider Vendor #:

I. RECIPIENT INFORMATION

A. Recipient's Name:			SS#:		Date of Birth:
B. Recipient's Address: (City, State, Zip Code & Parish)			C. Responsible Party/Curator's Address: (City, State, Zip Code & Parish)		
Telephone #:	Race:	Sex:	Relationship:		Telephone #:
D. Medicaid Eligible: ☑ Yes ☑ No If **yes**, Medicaid ID#:					
E. Does the recipient wish to apply for Medicaid? ☑ Yes ☑ No					

II. ADMISSION INFORMATION

☑ PACE Enrollment Date: _____

Source of Enrollment: ☑ Home ☑ Hospital ☑ Nursing Home ☑ Other _____

Intended Payment Source: ☑ Private ☑ Medicare ☑ Medicare/Medicaid ☑ Medicaid
☑ VA Contract - Effective Date: _____

III. STATUS CHANGE INFORMATION

☑ Delay PACE Enrollment Enrollee Hospitalized Date: _____

☑ New PACE Enrollment Date : _____

IV. DISENROLLMENT INFORMATION

☑ Disenrolled on _____ (date) to _____. (place)

Reason for disenrollment:
☑ Voluntary ☑ Involuntary ☑ Death - Date of Death: _____

V. FACILITY PLACEMENT

☑ Placed in Nursing Facility on _____ (date)

Facility Name: _____

Type of placement: ☑ Temporary ☑ Permanent

_____ _____

Signature of Administrator or Authorized Representative **Date**