New England Building
503 South Kansas Avenue
Topeka, KS 66603-3404

Phone: (785) 296-4986
Fax: (785) 296-0256
kdads.wwwmail@ks.gov
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Program of All-Inclusive Care for the Elderly (PACE)
Participant Disenrollment Notice

PACE Organization:		Phone:
First Name:	MI:	Last Name:
Street Address:	City:	Zip Code:
Phone Number:	County of Residence:	
Social Security Number:	Date of Birth:	
Medicaid Number:	Medicare Number:	

Check one that applies:

☐ I am voluntarily disenrolling from the PACE program with this provider. I understand that I must utilize the program's services until the effective disenrollment date. I no longer wish to participate in this program for the following reason(s):

- ☐ Dissatisfaction with the quality of services. (I was informed of my right to file a Grievance)
- ☐ Dissatisfaction with the quantity of the services. (I was informed of my Appeal Rights)
- ☐ Prefer for own physician or medical specialty services out of provider network.
- ☐ Preference to move to a nursing facility or other long-term care facility outside of network.
- ☐ Financial reason; to avoid share of cost.
- ☐ Moved out of the service area.
- ☐ Enrollment in any other Medicare or Medicaid program or optional benefits including hospice care.
- ☐ Other: ____

☐ Client Death Date of Death: ______________________

☐ Participant involuntary disenrolled from PACE Program for the following reason(s):

- ☐ Did not follow the program requirements that were agreed to upon enrollment.
- ☐ Did not pay, after a 30-day grace period, or make satisfactory arrangements to pay premiums incurred from the PACE program.

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- ☐ Did not pay, after a 30-day grace period, or make satisfactory arrangements to pay any applicable Medicaid spend down liability or any amount due under the post-eligibility treatment of income process.
- ☐ Participant engaged in disruptive or threatening behavior, as defined in 42 CFR § 460.164(c).
- ☐ Participant's caregiver engaged in disruptive or threatening behavior, as defined in 42 CFR § 460.164(c).
- ☐ Participant moved out of the service area, or has been out of the service area, for more than 30 consecutive days without prior agreement from the PACE organization
- ☐ Participant no longer meets State Medicaid nursing facility level of care requirements and is no longer deemed eligible.
- ☐ Other: ____

Disenrollment Plan presented including referrals to: ______________________________

Effective Disenrollment Date: ________________

___________________________________ ___________________
Signature of Participant or Designee (req. for voluntary) Date

___________________________________ ___________________
Signature of PACE Staff Date

I, ______________________, have received and reviewed supporting documentation in support of the decision to involuntary disenroll me from the PACE program. I approve and accept the involuntary disenrollment.

___________________________________ ___________________
Signature of PACE Program Manager/or Designee Date