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

Kansas
Department for Aging
and Disability Services

Phone: (785) 296-4986
Fax: (785) 296-0256
kdads.wwwmail@ks.gov
www.kdads.ks.gov

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 from the PACE program. I approve and accept the involuntary disenrollment.

_____ _____
Signature of PACE Program Manager/or Designee Date