**WISCONSIN DEPARTMENT OF HEALTH SERVICES**

Division of Public Health

F-02483 (02/2024)

**PACE PROGRAM ENROLLMENT**

**INSTRUCTIONS AND IMPORTANT INFORMATION**

Completion of this form is voluntary; however, this form must be completed if you are interested in enrolling in the PACE program. If you want to apply for the PACE program, you must contact your local Aging and Disability Resource Center (ADRC) or if you are a tribal member, you may also contact your tribal aging and disability resource specialist (ADRS). Contact information for local ADRCs or Tribal ADRS can be found at [www.dhs.wisconsin.gov/adrc/consumer/index.htm](https://www.dhs.wisconsin.gov/adrc/consumer/index.htm).

**HOW TO USE THIS FORM**

1. Read the Important Information section and all the instructions before signing the form. If you need information in another language or format, please contact your local ADRC or Tribal ADRS.
2. Only the individual, their legal guardian, conservator, or activated power of attorney, can sign this form.

**IMPORTANT INFORMATION**

* Signing this form does not guarantee you will be eligible for the PACE program.
* After you sign this form, you can choose not to enroll. Enrollment in PACE is voluntary and you may disenroll at any time, however your Medicare benefits will remain with the PACE plan until the last day of the month in which you request disenrollment from the program.
* Changes in your health or financial situation may affect your eligibility for the PACE program. If such a change occurs, talk with your PACE organization care manager or Tribal case manager, if applicable.
* To enroll in PACE, you may be, but are not required to be (1) entitled to Medicare Part A; (2) enrolled under Medicare Part B; or (3) eligible for Medicaid.

**SIGNING THIS FORM**

I understand that my signature (or the signature of my legal guardian, conservator or activated power of attorney) on this form means I have read and understand the contents of this form, including information about date of enrollment and assurance of choice below. I certify that all my answers are complete to the best of my knowledge. I understand that if I intentionally hide information or provide false information on this form, I may be disenrolled from the program. I understand that my signature authorizes the ADRC or Tribal ADRS to release my information to:

* The PACE organization
* Another ADRC or Tribal ADRS
* Income maintenance agencies
* The tribe of affiliation, if provided
* Medicaid
* Medicare
* Service providers and their authorized representatives for the purpose of providing my care.

**REQUESTED DATE OF ENROLLMENT**

You may choose the date you would like to enroll in the program. However, enrollment cannot occur before the date:

* The ADRC or Tribal ADRS receives this form signed.
* You meet all functional and financial eligibility requirements.

**ASSURANCE OF CHOICE**

The primary purpose of the PACE program is to help you get the services you need to live in your own home or community whenever possible.

**PERSONAL INFORMATION**

Under Wis. Stat. § 49.45(4), your personally identifiable information is kept confidential and is only used for the direct administration of the PACE program.

**INFORMATION REGARDING PACE**

PACE is a Wisconsin Medicaid and Medicare managed care program and certain eligibility requirements apply. If you are enrolled in Medicare and you want to enroll in PACE, you must enroll in the PACE Medicare plan. Your Medicare PACE program benefits will start the first day of the month following the month in which you are determined eligible for PACE.

If you are currently enrolled in Medicare, your current plan will continue to provide your Medicare benefits until you become eligible to enroll in the PACE plan.

To enroll in PACE, you must live in the PACE organization’s service area, be at least 55 years old, require a nursing home level of care, and be able to live safely in a community setting at the time of enrollment.

**ADDITIONAL INSTRUCTIONS**

**Section I**

* “County of Residence” means the county in which you physically live.
* “County of Responsibility” means the county that has responsibility to provide mental health or other services.
* “Permanent Street Address” means the address of the residence in which you physically live.

**Section II**

This section will be completed if you have a legal guardian, conservator, activated power of attorney, or Medicaid authorized representative.

**Section III**

Please provide emergency contact information of a friend or relative whom we can contact in case of an emergency.

**Section IV**

This section will be completed, if applicable.

**Section V**

Your signature or the signature of your legal guardian, conservator, or activated power of attorney is required. If you sign with a mark, two witness signatures are required. If you are physically unable to sign, you may direct an adult to sign the form in front of two witnesses. The person who signs on your behalf should indicate that they are signing at the direction of the applicant.

The ADRC or Tribal ADRS must retain the originally signed enrollment form, or an electronically scanned copy of the signed form, for ten years in the event of a records request.

**PACE PROGRAM – ENROLLMENT**

**CIP**

**INSTRUCTIONS**: Before signing this form, read all instructions.

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| **SECTION I –PERSONAL INFORMATION** | | | | | | | | | | | | | | | | | | |
| Member Name (First, MI, Last) | | | | | | | | | | | | | | | Date of Birth | | | |
| Current Marital Status (Check one box only)  Single  Married  Widowed | | | | | | | If Currently Married, Name of Spouse (First, MI, Last) | | | | | | | | | | | |
| Mailing Address | | | City | | | | | | | | | State | | | | Zip Code | | |
| Phone Number | County of Residence | | | | | | | | | | | County of Responsibility | | | | | | |
| American Indian or Alaskan Native  Yes  No | | | | | | | | | American Indian/Alaskan Native Affiliation | | | | | | | | | |
| Email Address | | | | | | | | | | | | | | | | | | |
| Permanent Street Address (If different than above) | | | | City | | | | | | | | State | | | | Zip Code | | |
| Facility Name—Check Type:  NH  ICF-IID  CBRF  AFH  RCAC | | | | | | | | | | | | Date of NH or ICF-IID Admission | | | | | | |
| Facility Street Address (If different from above) | | | | | City | | | | | | | State | | | | | Zip Code | |
| **SECTION II – ALTERNATIVE ENROLLMENT AUTHORITY** | | | | | | | | | | | | | | | | | | |
| Do you have a Legal Guardian?  Yes  No  Type:  Guardian of Person  Guardian of Estate  Guardian of Person and Estate | | | | | | | | | | | | | | | | | | |
| Name of Guardian (First, MI, Last) | | | | | | | | Phone Number | | | | | | County of Residence | | | | |
| Mailing Address (street, city, state, zip code) | | | | | | | | | | | | | | | | | | |
| Do you have another Legal Guardian?  Yes  No  Type:  Guardian of Person  Guardian of Estate  Guardian of Person and Estate | | | | | | | | | | | | | | | | | | |
| Name of Guardian (First, MI, Last) | | | | | | | | Phone Number | | | | | | County of Residence | | | | |
| Mailing Address (street, city, state, zip code) | | | | | | | | | | | | | | | | | | |
| Do you have an Activated Power of Attorney for Finance and Property (POAF)?  Yes  No | | | | | | | | | | | | | | | | | | |
| Name of POAF (First, MI, Last) | | | | | | | | Phone Number | | | | | | County of Residence | | | | |
| Mailing Address (street, city, state, zip code) | | | | | | | | | | | | | | | | | | |
| Do you have an Activated Power of Attorney for Health Care (POAHC)?  Yes—Date Activated:        No | | | | | | | | | | | | | | | | | | |
| Name of POAHC (First, MI, Last) | | | | | | | | Phone Number | | | | | | County of Residence | | | | |
| Mailing Address (street, city, state, zip code) | | | | | | | | | | | | | | | | | | |
| Do you have a Conservator?  Yes—Date conservator ordered        No | | | | | | | | | | | | | | | | | | |
| Name of Conservator (First, MI, Last) | | | | | | | | Phone Number | | | | | | County of Residence | | | | |
| Mailing Address (street, city, state, zip code) | | | | | | | | | | | | | | | | | | |
| Do you have a Medicaid Authorized Representative as Designated on DHS form [F‑10126A](https://www.dhs.wisconsin.gov/forms/f10126a.pdf) or [F‑10126B](https://www.dhs.wisconsin.gov/forms/f10126b.pdf)?  Yes—Date:        No | | | | | | | | | | | | | | | | | | |
| Name of Medicaid Authorized Representative (First, MI, Last) | | | | | | | | Phone Number | | | | | | County of Residence | | | | |
| Mailing Address (street, city, state, zip code) | | | | | | | | | | | | | | | | | | |
| **SECTION III –ADDITIONAL CONTACT INFORMATION** | | | | | | | | | | | | | | | | | | |
| List the name of a friend or relative whom we can contact in case of an emergency. | | | | | | | | | | | | | | | | | | |
| Name of Contact (First, MI, Last) | | Daytime Phone Number | | | | | | | | Evening Phone Number | | | | | Relationship to You | | | |
| **SECTION IV – INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | |
| Do you currently have medical/health insurance coverage such as employer-provided health insurance, private insurance, VA benefits, TRICARE or federal employee health benefits coverage? Yes  No | | | | | | | | | | | | | | | | | | |
| Name and Address of Insurance Company | | | | | | | | | | | | | Policy or Identification Number | | | | | |
| Group Number | | | | | |
| Do you currently have prescription drug coverage?  Yes  No | | | | | | | | | | | | | | | | | | |
| Name of Coverage | | | | | | Policy or Identification Number | | | | | | | | | | | | Group Number |
| Do you receive Social Security Benefits?  Yes  No | | | | | | | | | | | | | | | | | | |
| Do you receive Railroad Retirement Board (RRB)?  Yes  No | | | | | | | | | | | | | | | | | | |
| **If you are eligible for Medicare**: | | | | | | | | | | | Is Entitled To: | | | | | | | |
| Beneficiary Name (First, MI, Last): | | | | | | | | | | | Effective Date: (mm/dd/yyyy) | | | | | | | |
| Medicare Beneficiary Identifier (MBI): | | | | | | | | | | | **HOSPITAL (PART A)** | | | | | | | |
|  | | | | | | | | | | | **MEDICAL (PART B)** | | | | | | | |
| **Please Read This Important Information** | | | | | | | | | | | | | | | | | | | |
| **If you currently have health coverage from an employer or union, joining PACE could affect your employer or union health benefits. You could lose your employer or union health coverage if you join PACE.** Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If you don’t know who to contact, your benefits administrator or the office that answers questions about your coverage can help. | | | | | | | | | | | | | | | | | | | |

**SECTION V – ENROLLMENT CHOICE AND SIGNATURE**

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| **Read and Sign Below** | | | | | | | | | | | |
| Requested Date of Enrollment: | | | | | | | | | | | |
| PACE Plan Selected:  PACE - Community Care Health Plan, Inc. | | | | | | | | | | | |
| **By completing this enrollment application, I agree to the following:**  A PACE Plan is a Medicare plan and has a contract with the Federal government.  I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. I will continue to receive my Medicare benefits from my current Medicare plan until the last day of the month in which I submit this form. It is my responsibility to inform the ADRC or Tribal ADRS of my coverage at the time of enrollment and inform the PACE organization at any future time of any prescription drug coverage that I have or may get in the future. The selected plan serves a specific service area. If I move out of the area that the selected plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of the selected plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the PACE Member Handbook and Enrollment Agreement from the selected plan when I get it to know which rules, I must follow to get coverage with this Medicare Advantage or Medicare plan. I understand that people with Medicare are not usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I understand that beginning on the date the selected plan coverage begins; I must get all my health care from the selected plan except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the selected plan and other services contained in my selected plan’s PACE Member Handbook and Enrollment Agreement will be covered.  **WITHOUT AUTHORIZATION,** **NEITHER MEDICARE NOR THE SELECTED PLAN WILL PAY FOR THE SERVICES.**  **Release of Information:** By joining this Medicare health plan, I acknowledge that the selected plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that the selected plan will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that (1) this person is authorized under state law to complete this enrollment and (2) documentation of this authority is available upon request by the selected plan or by Medicare.  I, the undersigned, do hereby state my intent, and do hereby agree, to enroll into the program.  I understand that my Medicaid enrollment start date will be       and my Medicare enrollment will start the first of the month following submission of this form. I will continue to receive my Medicare benefits from my current plan until I am eligible to enroll into the PACE plan I have selected above. | | | | | | | | | | | |
| **I, the undersigned, do hereby state my intent and do hereby agree to enroll into the PACE program.** | | | | | | | | | | | |
| **SIGNATURE –** Individual | | | | | | | | | | | Date Signed |
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| **SIGNATURE –** Legal Guardian, Conservator, or Activated Power of Attorney | | | | | | | | | | | Date Signed |
|  | | | | | | | | | | |  |
| **SIGNATURE –** Legal Guardian, Conservator, or Activated Power of Attorney | | | | | | | | | | | Date Signed |
|  | | | | | | | | | | |  |
| **SIGNATURE** – Witness (if applicable) | | | | | | | | | | | Date Signed |
|  | | | | | | | | | | |  |
| **SIGNATURE** – Witness (if applicable) | | | | | | | | | | | Date Signed |
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| **For ADRC or Tribal ADRS Office Use Only** | | | | | | | | | | | |
| ADRC or Tribe: | | | | | County: | | | | | | |
| ADRC or Tribal ADRS Worker: | | | | | | | | | Phone Number: | | |
| Email Address: | | | | | | | | | | | |
| Actual Date of Medicaid Enrollment : | | | | | | Date of Medicare Enrollment: | | | | | |
| Enrollment Date Information:  Actual Date of Enrollment:  Enrollment date pending: Urgent Services  Enrollment date pending: Pre-Release Agreement  Enrollment date pending: Transfer to new agency with move. | | | | | | | Program:  PACE | | | Verify HMO End Date if applicable: | |
| Enrollment Status in FHiC:  Enrollment date in FHiC  Enrollment date not in FHiC: pending MA or IRIS entry in system. MCO does not update LTCFS until enrollment is verified in FHiC. | | | | | | | | | | | |
| Medicaid Recipient  Yes  No  Medicaid ID No:  Language for CARES Notice:  English  Spanish | | Level of Care  Check the assigned NH LOC in the left column and then check the appropriate DD LOC in the right column. A maximum of two boxes should be checked.   |  |  | | --- | --- | | Choose 1 | Choose 1 | | NH-ISN  NH-SNF  NH-ICF | DD1A  DD1B  DD2  DD3  NDD | | | | | | | | | Target Group:  FE  ID/DD  PD | |
| **For PACE Office Use Only**  Plan ID Number: | | | | Name of Staff Member (if assisted in enrollment) | | | | | | | |
| Effective Date of Medicare Coverage | | | Medicaid Provider No. | | | | | Actual Date of Medicaid Enrollment | | | |
| Distribution of completed form: | Individual, Guardian, Conservator, or Activated Power of Attorney  Selected MCO  Income Maintenance, if applicable  Tribe, if applicable | | | | | | | | | | |