Program of All-Inclusive Care for the Elderly (PACE) Disenrollment

Purpose:

PACE organizations use form 470-5030 to notify Iowa Medicaid Enterprise (IME) of all participant disenrollments, including voluntary, involuntary, and deaths.

Instructions:

Form 470-5030 is a fillable PDF. Before using this form, save it to your hard drive. Use the saved version to report all disenrollments. After the form is completed and saved, upload the form and all required documents through the Iowa Medicaid Portal Access (IMPA). For proper submission in IMPA, select "PACE Documents" from the dropdown options.

For Voluntary and Involuntary Disenrollments:

Sections 1 – 9 of this form *must be completed*. The following documents are required:

- ☐ PACE participant's current Care Plan
- ☐ PACE organization's current Policy and Procedure for Disenrollment
- ☐ Case file documentation to validate the PACE participant's understanding of a possible delay in services, such as when applying for the waiver

For Disenrollment Due to Death:

Sections 1, 2, 5, and 9 *must be completed*.

1. PACE Participant Information			
Participant Full Name			
Medicaid ID Number		Date of Birth	
Living Arrangement	☐ Alone ☐ Nursing Facility (NF) ☐ Assisted Living (AL) ☐ Family/Spouse ☐ Other (please specify)_____		
Date of PACE Enrollment		Date of Admission to NF/AL	
2. Disenrollment Type			
☐ Voluntary ☐ Involuntary ☐ Death (date of death)_____			
3. Disenrollment Requestor			
☐ Participant ☐ Family/Spouse ☐ PACE Organization ☐ Other_____			
4. Disenrollment Criteria *(select all that apply)* *CFR 460.162 and CFR 460.164*			
☐ Failure to pay ☐ Disruptive or threatening behaviors ☐ Other (explain in #5)	☐ No longer in service area ☐ Level of care not met		

5. Disenrollment Reason
*Summarize a chronological list of events leading to the disenrollment or death.**

6. Communication
*Summarize chronologically communication that occurred between the Participant and the Organization leading to the disenrollment.**

7. Remediation
*Summarize action steps taken to prevent or intervene in the disenrollment.**

8. Discharge Plan

*If a discharge plan is projected, include a summary with the anticipated disenrollment date, transitional services, Medicaid, Medicare and Part D reinstatement plans. Include a list of the new medical providers and pharmacy.**

9. PACE Contact Information

Name			
Email			
Phone Number			
PACE Organization's Name			
Disenrollment form completed by		Date	

☐ Check the box to confirm that you have notified the Income Maintenance Worker of a voluntary disenrollment or death.

***** *If needed, upload additional documentation through IMPA.*