

Department of Human Services  
 Division of Aging Services  
 Office of Community Choice Options

|                                     |
|-------------------------------------|
| <input type="checkbox"/> <b>SSI</b> |
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To:  Northern OCCO Office  
 Southern OCCO Office  
 CWA / Board of Social Services (*CP-23 not sent to CWA if on SSI*)

Date: \_\_\_\_\_

From: \_\_\_\_\_  
 PACE Administrator and Provider Name

Address \_\_\_\_\_

Phone \_\_\_\_\_

This notice is to advise you that the individual identified below wishes to/has been disenrolled from the PACE program. Please prepare and submit the appropriate Medicaid Status File input documents in accordance with related Operational Procedures.

|                        |  |                         |
|------------------------|--|-------------------------|
| Name:                  | Medicaid Number:   | Social Security Number: |
| Street Address:        | Disenrollment Date:  |                         |
| City, State, Zip Code: | Participant Receives SSI Benefits?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                         |

**Reason(s) for Disenrollment:**

- Participant is deceased.      Date of Death: \_\_\_\_\_
- Participant no longer meets the clinical eligibility criteria for nursing facility level of care under the New Jersey Medicaid Program in accordance with N.J.A.C. 8:85-2.1 and the participant has not filed for (or exhausted) his/her fair hearing rights.
- The services required by the participant to be adequately cared for are not available in the PACE program.
- Participant has moved out of the PACE program service area or is out of the service area for more than 30 days, without the PACE organization agreeing to a longer absence due to extenuating circumstances.
- Participant voluntarily withdraws from the PACE program.  
**Important:** The PACE provider must submit to OCCO a completed CP-18 PACE Participant Withdrawal form, which identifies the reason for the withdrawal and includes the participant's signature, when a voluntary withdrawal is requested. If the participant chooses not to sign the form, it may be submitted without his/her signature with a notation indicating participant's refusal to sign.
- Participant is involuntarily withdrawn from the PACE program.
- Other: \_\_\_\_\_

**Clinical Eligibility Status:**

Date of most recently authorized NF LOC assessment:  
 OCCO reassessment needed for:  
 PACE participant with Deemed Continued Eligibility wishing to enroll in a program requiring NF LOC eligibility, e.g., MLTSS or JACC  
 PACE participant wishing to enter a Special Care Nursing Facility (SCNF)

|                                    |           |
|------------------------------------|-----------|
| Name of PACE Administrator (Print) | Signature |
|------------------------------------|-----------|

| <b>OCCO SECTION</b>  |   |
|--|---|
| <b>DISENROLLMENT REQUEST OUTCOME:</b>                        |   |
| Disenrolled: <input type="checkbox"/> Date of Disenrollment: | Not Disenrolled: <input type="checkbox"/> Reason: |
| Name of OCCO Representative (Print):                         | Date:   |

c:  Participant     Participant Representative     PACE Organization     OCCO File