COLORADO
Department of Health Care Policy & Financing

Programs of All-Inclusive Care for the Elderly (PACE)

Involuntary Disenrollment Request Form

Directions

1. If a PACE organization plans to involuntarily disenroll a participant, the organization must submit an Involuntary Disenrollment Request form to the Department of Health Care Policy & Financing (HCPF).

2. Do not leave any questions/cells blank. Enter “NA'' if a response is not applicable.

3. Submit the request, and the required supporting documents, to the organization’s SharePoint page, which is managed by HCPF. **SharePoint Path**: Reports & Requests/ Involuntary Disenrollments/[Center Name, if applicable]/[Participant Name]

4. At the same time the request is submitted, a PACE organization must notify HCPF via the general PACE email - hcpf_pace@state.co.us. To avoid encryption:

    - Title the email: Involuntary Disenrollment Request for [PACE Center Name].
    - Include the following message in the body of the email: [PACE Center Name] uploaded an Involuntary Disenrollment Request to SharePoint on [Date].
    - Avoid attachments containing personally identifiable information.

Table 1. General Information.	
PACE Organization	
PACE Center	
Participant (First and Last Name)	
Participant Date of Birth	
Participant Health First Colorado ID	
Participant Enrollment Date	
PACE Representative Signature and Title	
Date	

Table 2. Involuntary Disenrollment Reasons. Select the most appropriate reason(s).			
Check Box	**Reason #**	**Disenrollment Reason**	**Required Documents**
☐	1	The participant, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any premium due the PACE organization.	The written notice issued to the participant, including the amount due and how arrangements can be made to pay the amount due.
☐	2	The participant, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any applicable Medicaid spend-down liability or any amount due under the post-eligibility treatment of income process.	The written notice issued to the participant, including the amount due and how arrangements can be made to pay the amount due.
☐	3a	The participant engages in disruptive or threatening behavior that jeopardizes his or her health or safety, or the safety of others.	1. A summary of the disruptive or threatening behavior. 2. A medical record entry documenting notification to the police or Adult Protective Services (APS), if applicable.
☐	3b	A participant's caregiver engages in disruptive or threatening behavior.	1. A summary of the disruptive or threatening behavior that jeopardizes the participant's health or safety, or the safety of the caregiver or others. 2. A medical record entry documenting notification to the police or Adult Protective Services, if applicable.
☐	4	A participant with decision-making capacity who consistently does not comply with his or her individual	1. A summary of the participant's decisions not to comply with his or her plan of care or the terms of the PACE enrollment agreement.

Table 2. Involuntary Disenrollment Reasons. Select the most appropriate reason(s).			
Check Box	**Reason #**	**Disenrollment Reason**	**Required Documents**
		plan of care or the terms of the PACE enrollment agreement.	2. Documentation of the participant's decision-making capacity.
☐	5	The participant repeatedly does not comply with medical advice and repeatedly fails to keep appointments.	A summary of the participant's repeated choices not to comply with medical advice and repeated failure to keep appointments.
☐	6	The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.	A summary of the organization's attempts to locate the participant. For example: visiting the participant's last known address, requesting a welfare check by police, calling shelters, etc.
☐	7	The participant is determined to no longer meet the State Medicaid nursing facility level of care requirements and is not deemed eligible.	A summary of the differences between the initial Long-Term Services and Supports assessment and the annual reassessment (continued stay review).
☐	8	The PACE program agreement with the Centers for Medicare and Medicaid Services and the State administering agency is not renewed or is terminated.	HCPF will issue guidance at the time of nonrenewal or termination.
☐	9	The PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers.	A copy of the license or contract that was lost.

Table 3. Contact Summary.	
Question	**PACE Organization Response**
1. What efforts did the PACE organization take to remedy the situation? Include the date(s) the organization referred the situation to the PACE Ombudsman.	

Table 3. Contact Summary.	
Question	**PACE Organization Response**
2. What contact has the PACE organization had with the participant during the past 60 days? Include both furnished services and attempts to furnish services. For example: 7/3/23 - Center visit. 7/5/23 - Home care visit. 7/11/23 - Podiatry appointment. 7/12/23 - Home care visit. 7/17/23 - Center visit. 7/13/23 - Dental appointment. 7/19/23 - Home care visit. 7/26/23 - Clinic visit. 8/2/23 - Home care attempted visit. No answer. 8/2/23 - SW left voicemail. Call not returned. 8/9/23 - Home care attempted visit. No answer. 8/9/23 - SW called police and requested a welfare check. Police entered the participant's apartment. It appeared empty. 8/10/23 - SW left voicemail. Call not returned. 8/16/23 - Home care left voicemail. Call not returned. 8/23/23 - Home care left message. Call not returned. 8/30/23 - Participant called SW. He moved to New Mexico in July but he does not want to disenroll.	

Table 3. Contact Summary.	
Question	**PACE Organization Response**
3a. What date did the PACE organization most recently visit the participant?	
3b. What was the reason for the visit?	
3c. Was the visit performed in person or via telehealth?	

Table 4. Required Supporting Documentation. Check each box to indicate the corresponding document was submitted to HCPF.	
Checkbox	**Required Supporting Document**
☐	The participant's current plan of care.
☐	The participant's medical record for the past 60 days.
☐	The required documents for each reason selected in Table 2.

Note: HCPF may request additional information if this form is incomplete or if a required supporting document is not provided.