THIS BOOKLET BELONGS TO _____

CENTER _____

TELEPHONE NUMBER _____

ADDRESS _____

CENTER MANAGER _____

PHYSICIAN _____

SOCIAL WORKER _____

FOR 24 HOUR EMERGENCY SERVICES

ON-CALL PHYSICIAN TELEPHONE NUMBER ( )

EMERGENCY TELEPHONE NUMBER **911**

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

{PACE Organization Name}

MEMBER ENROLLMENT AGREEMENT

TERMS AND CONDITIONS

Effective {Date}

{PACE Organization Name}
Health Plan Administration
{Street Address}
{City, State, Zip Code}
{Telephone Number}
For the Hearing Impaired
TTY/TDD: ( )

Table of Contents

CHAPTER 1
WELCOME TO {PACE PROGRAM NAME}

{PACE Organization} is a health care services plan designed just for people age 55 and older who have ongoing health care needs. We are very pleased to welcome you as a participant. Since we enroll only individuals, dependents are not covered when you enroll.

Please keep this booklet. Your signed copy of the {PACE Organization} Enrollment Agreement form, along with these terms and conditions, will be your enrollment agreement, a legally binding contract between you and {PACE Organization}.

This document should be read carefully and completely. Individuals with special health care needs should read carefully those sections that apply to them. You can find a Summary of Benefits and Coverage Table containing the major provisions of the {PACE Organization} at the end of this chapter. {PACE Organization} has an agreement with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) that is subject to renewal on a periodic basis, and if the agreements are not renewed the program will be terminated.

If you would like further information about the benefits of the {PACE Organization}, please feel free to contact us at {PACE telephone number}. In this agreement, {PACE Organization} is sometimes called "we" and you are sometimes called the "participant" or "member". The term "participant" is most often used at {PACE Organization}. *Some of the terms used in this document may not be familiar to you. Please refer to the "Definitions" section in the back (Chapter 13) for explanations of various terms used.*

Our philosophy at {PACE Organization} is to help you remain as independent as possible, living in your own community and home. We offer a complete program of health and health-related services and focus on *preventive* measures to maintain your well-being.
One unique feature of {PACE Organization} is our personal approach to health care and services. We make sure that you and our health

care staff all know each other well, so we can work together effectively on your behalf. We do not replace the care of your family and friends. Rather, we collaborate with you, your family and friends to provide the care you need. Your suggestions and comments are always encouraged and welcomed.

{PACE Organization} operates 24 hours a day, seven days a week, 365 days a year. To treat the multiple chronic health care problems of our participants, our health care professionals assess and evaluate changes, provide timely intervention and encourage participants to help themselves. Based on your needs, we provide medical, nursing and nutrition services; rehabilitation therapy; in-home services and training; pharmaceuticals; podiatry; audiology; and vision, dental, mental health, and any other service approved by the interdisciplinary team (IDT). On an inpatient basis, we provide acute and skilled nursing care in contracted facilities. *(See Chapter 4 for a more detailed description of covered benefits.)*

Please examine this Enrollment Agreement carefully. Enrollment in the {PACE Organization} is voluntary. If you are not interested in enrolling in our program, you may return the Enrollment Agreement to us without signing. If you do sign and enroll with us, your benefits under {PACE Organization} continue until you choose to disenroll from the program or you no longer meet the conditions of enrollment. *(See Chapter 10 for information on termination of benefits.)*

Upon signing and enrolling in {PACE Organization}, you will receive the following items:

- A copy of the Enrollment Agreement
- A copy of the {PACE Organization} Member Enrollment Agreement Terms and Conditions (this document)
- A {PACE Organization} Membership card
- A sticker with our emergency telephone numbers to post in your home

Summary of Benefits and Coverage Table

The following table is intended to help you compare coverage benefits and is a summary only. There are no co-payments for PACE services.

Please read this entire booklet, which constitutes your Enrollment Agreement with {PACE Organization}, for a detailed description of coverage benefits and limitations.

Services must be either pre-approved or obtained from specified doctors, hospitals, pharmacies and other health care providers who contract with {PACE Organization}.

Prior authorization is never required for Emergency, Preventive, or Sensitive Services. *Please refer to Chapter 4, Benefits and Coverage.*

CATEGORY	SERVICES AND LIMITATIONS
Deductibles	None
Lifetime Maximums	None
Professional Services	• Physician services including primary care providers and medical specialists, routine physicals, preventive health care, sensitive services, outpatient surgical services and outpatient mental health. • Basic dental coverage (routine, Preventive Services including exam, X-rays and cleanings). Cosmetic dentistry is not included. • Vision care. Prescription eyeglasses and corrective lenses after cataract surgery. • Audiology services. Hearing exams and hearing aids. • Routine podiatry. • Medical social services/case management. • Rehabilitation therapy. Includes physical, occupational and speech therapies.

CATEGORY	SERVICES AND LIMITATIONS
Outpatient Service	Coverage for surgical services, mental health, diagnostic X-ray and laboratory service.
Hospitalization Services	Coverage for semi-private room and board and all medically necessary services including general medical and nursing services, psychiatric services, operating room fees, diagnostic or therapeutic services, laboratory services, X-ray, dressings, casts, anesthesia, blood and blood products, drugs and biologicals. Not covered are private rooms or private duty nursing, unless medically necessary, and non-medical items.
Emergency Health Coverage	Coverage for emergency services. {PACE Organization} does not cover emergency services outside the United States except for emergency services requiring hospitalization in Canada or Mexico.
Ambulance Services	
Prescription Drug Coverage	Coverage for medications from the PACE organization formulary when prescribed by a physician.
Durable Medical Equipment	
Mental Health Services	
Chemical Dependency Services	

CATEGORY	SERVICES AND LIMITATIONS
Home Health Services	
Other	• Medicare covered skilled nursing facility. Coverage provided for semi-private rooms only.

	• Home care services. • Day center services (including nutrition, hot meals, escort and transportation). • Necessary materials, supplies and services for management of diabetes mellitus. • End of Life Care.

Please note: All services and benefits are determined through the plan of care (or treatment plan) at the discretion of the IDT.

CHAPTER 2
SPECIAL FEATURES OF {PACE Organization}

Our health care services plan has several unique features:

1. Expertise in Caring

Since {insert applicable year here}, {PACE Organization} has specialized in caring for older people with health problems. Our successful approach focuses on developing customized care plans addressing specific health and health-related issues for each participant. Our dedicated, highly skilled providers both plan and provide care, so the care you receive is comprehensive and coordinated.

2. The Interdisciplinary Team

Your care is planned and provided by a team of specialists, working together with you. Your team includes a physician, possibly a nurse practitioner, registered nurses, a home care nurse, social workers, physical therapist, occupational therapist, a dietician and others who assist you, such as health workers, home health aides and drivers of our vans. Each team member's special expertise is employed to assess your health care needs. Other staff may be called upon if necessary. Together a plan of care is developed just for you.

3. Facilities

You will receive many of your health care services at our center—where your team is. *Our teams and center(s) is (are) located at the following addresses in (name of city):*

{Insert address(es) here}

A number of factors including your preference, your home location, and your special needs will determine which center you attend. We provide transportation for you to come to the center. How often you come to the center will depend upon your care plan.

{PACE Organization} offers you access to medical care through our physicians and center on a 24-hour basis, 365 days of the year.

4. Choice of Physicians and Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOUR HEALTH CARE MAY BE OBTAINED. Because care is provided at {PACE Organization} through an IDT, the Primary Care Physician (PCP) you choose is a member of your IDT. You will be assigned other providers for your team. Your Physician is responsible for all of your primary health care needs and, with the help of your IDT, arranges for other medical services that you may need. Participants have the option to seek gynecological physician services directly from a participating gynecologist.

When necessary, services are provided in your home, a hospital or nursing home. We have contracts with physician consultants (such as cardiologists, urologists and orthopedists), pharmacies, laboratories and X-ray services, as well as with hospitals and nursing homes. Should you need such care, your team will continue working with you to monitor these services, your health and your ongoing needs.

If you wish to have the names, locations and hours of our contracting hospitals, nursing homes and other providers, you may request this information from the {Contract's Administrator and/or Provider Services Department} at {telephone number} or {TTY telephone number for the hearing impaired}.

5. Authorization and Management of Care

You will know each member of the team very well, for they will all work closely with you to help you remain as healthy and independent as possible. Before you can receive any service from {PACE Organization}, the IDT must approve the service. However, prior authorization is never required for Emergency, Preventive, or Sensitive Services.

At least every six months—more frequently if you are having problems—your team assesses your needs and adjusts services if necessary. You and/or your family may request an assessment. If your situation changes, the IDT adjusts your services, based on your care plan assessment and other needs.

6. Medicare / Medi-Cal Relationship

The benefits under this Enrollment Agreement are made possible through an agreement {PACE Organization} has with Medicare (the Centers for Medicare and Medicaid Services of the Department of Health and Human Services) and Medi-Cal (DHCS). When you sign this Enrollment Agreement, you are agreeing to accept benefits from {PACE Organization}, in place of the usual Medicare and Medi-Cal benefits. {PACE Organization} will provide services based on your needs - the same benefits to which you are entitled under Medicare and Medi-Cal, plus more.

For additional information concerning Medicare-covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California.

7. No Pre-set Limits to Care

{PACE Organization} has no pre-set limit to services. There are no limits or restriction to the number of hospital or nursing home days that are covered if your {PACE Organization} physician determines that they are medically necessary. Home care is authorized and provided to you on a frequency and duration based on the evaluation of your needs by the team's clinical experts.

8. "Lock-in" Provision

When you enroll with {PACE Organization}, we will be your sole service provider and you agree to receive medical services ***exclusively*** from our organization, except in the case of an emergency or for urgently needed services. You will have access to all the care you need through our staff or through arrangements that {PACE Organization} makes with contract providers, but **you will no longer be able to obtain services from other doctors or medical providers under the traditional fee-for-service Medicare and Medi-Cal system.** Enrollment in {PACE Organization} results in disenrollment from any other Medicare or Medi-Cal pre-payment plan or optional benefit.

Electing enrollment in any other Medicare or Medi-cal prepayment plan or optional benefit, including the hospice benefit, after enrolling in {PACE Organization} is considered a voluntary disenrollment from {PACE Organization}. (Please note that any services you use before your enrollment will not be paid for by {PACE Organization} unless these are specifically authorized.)

CHAPTER 3
ELIGIBILITY

You are eligible to enroll in {PACE Organization} if you:

- Reside in {PACE Program's} service area, which includes {insert appropriate zip codes or other geographical parameters here}.
- Are 55 years of age or older.
- Require the State's nursing facility level of care, as assessed by our IDT. A "Skilled Nursing Facility" is a level-of-care designation of the need for continuous 24-hour availability of skilled nursing. An "Intermediate Care Facility," is a level-of-care designation of the need for 24-hour supervised care during the day on weekdays.
- Are able to live in the community without jeopardizing the health and safety of yourself and others.

You must also be:

- Certified by the DHCS' Long-Term Care Division (LTCD) as having met these level-of-care requirements. Because {PACE Organization} serves only older individuals who meet the State's level-of-care requirements for coverage of nursing facility services, an outside review must confirm that your health situation, in fact, qualifies you for our care.
- The DHCS' LTCD provides this review before you sign the {PACE Organization} Enrollment Agreement based on a review of the documents prepared by the members of the IDT who have assessed your health.

CHAPTER 4
BENEFITS AND COVERAGE

Please see Chapter 5 to learn how to receive care if you have a medical emergency or other urgent need for care.

What Do I Do if I Need Care?

All you need to do is call your center as listed on the inside cover of this booklet at any time.

Our plan provides ready access to a whole array of professionals and health care services. Upon enrollment you will be assigned a PCP at the center where you will receive services.

All benefits are covered by {PACE Organization} and will be provided according to your needs as assessed by your IDT, in accordance with professionally recognized standards. If you would like more specific information about how we authorize or deny health care services, please request this from the Social Worker.

Benefits include:

Services in the Center and the Community

- Primary care clinic visits (with {PACE Organization} physician, nurse practitioner and/or nurse)
- Routine physicals and preventive health evaluations and care (including pap smears, mammograms, immunizations, and all generally accepted cancer screening tests). These services do not require prior authorization.
- Sensitive Services, which are services related to sexually transmitted diseases and HIV testing. These services do not require prior authorization.
- Consultation with medical specialists
- Kidney dialysis
- Outpatient surgical services
- Outpatient mental health
- Medical social services/case management

- Health education and counseling
- Rehabilitation therapy (physical, occupational and speech)
- Personal care
- Recreational therapy
- Social and cultural activities {intergenerational (if applicable)}
- Nutritional counseling and hot meals
- Transportation, including escort
- Ambulance service
- X-rays
- Laboratory procedures
- Emergency coverage anywhere in the United States and its territories
- Durable medical equipment
- Prosthetic and orthotic appliances
- Routine podiatry
- Prescribed drugs and medicines
- Vision care (prescription eyeglasses, corrective lenses after cataract surgery)
- Hearing exams and hearing aids
- Dental care from the {PACE Organization} dentist, with the goal of restoring participant oral function to a condition which will help maintain optimal nutritional and health status. Dental services include Preventive Care (initial and yearly examinations, radiographs, prophylaxis and oral hygiene instructions); Basic Care (fillings and extractions); and Major Care (treatment which is determined by the condition of the mouth, for example, the amount of remaining supporting bone, the participant's ability to comply with instruction, and the participant's motivation to pursue oral health care). Major Care includes temporary crowns, full or partial dentures and root canals. Not included under dental care is: cosmetic dentistry.
- Diagnosis and treatment of male erectile dysfunction provided that the care is from {PACE Organization} staff physician or a physician specialist under contract to {PACE Organization}, and that such care is deemed medically necessary. The Plan does not cover treatment, including medication, devices and surgery, which is deemed harmful to the participant or which is deemed

to be for cosmetic or recreational purposes and not medically necessary.
- Mastectomy, lumpectomy, lymph node dissection, prosthetic devices and reconstructive surgery.
- Necessary materials, supplies and services for the management of diabetes mellitus.

Home Services

- Home Care
    - Personal care (i.e., grooming, dressing, assistance in using the bathroom)
    - Homemaker/chore services
    - Rehabilitation maintenance
    - Evaluation of home environment

- Home Health
    - Skilled nursing services
    - Physician visits (at discretion of physician)
    - Medical social services
    - Home health aide service

Hospital Inpatient Care

- Semi-private room and board
- General medical and nursing services
- Psychiatric services
- Meals
- Prescribed drugs, medicines and biologicals
- Diagnostic or therapeutic items and services
- Laboratory tests, X-rays and other diagnostic procedures
- Medical/Surgical, Intensive Care, Coronary Care Unit, as necessary
- Kidney dialysis
- Dressings, casts, supplies
- Operating room and recovery room
- Oxygen and anesthesia
- Organ and bone marrow transplants (non-experimental and non-investigative)
- Use of appliances, such as a wheelchair

- Rehabilitation services, such as physical, occupational, speech and respiratory therapy
- Radiation therapy
- Blood, blood plasma, blood factors and blood derivatives
- Medical social services and discharge planning

{PACE Organization} does not cover private room and private duty nursing unless medically necessary, nor any non-medical items for which there is an additional charge, such as telephone charges or television rental.

Skilled Nursing Facility

- Semi-private room and board
- Physician and nursing services
- Custodial care
- All meals
- Personal care and assistance
- Prescribed drugs and biologicals
- Necessary medical supplies and appliances, such as a wheelchair
- Physical, occupational, speech and respiratory therapy
- Medical social services

End of Life Care

{PACE Program's} comfort care program is available to care for the terminally ill. If needed, your Physician and other clinical experts on your IDT will work with you and your family to provide these services directly or through contracts with local hospice providers. If you want to receive the Medicare hospice benefit, you will need to disenroll from our program and enroll in a Medicare-certified Hospice provider.

CHAPTER 5
EMERGENCY SERVICES AND URGENT CARE

{PACE Organization} provides emergency care 24 hours per day, 7 days per week, and 365 days per year. An **Emergency Medical Condition** means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Serious jeopardy to the health of the participant;
(2) Serious impairment to bodily functions;
(3) Serious dysfunction of any bodily organ or part.

Emergency Services include inpatient or outpatient services furnished immediately in or outside the service area because of an Emergency Medical Condition.

Call "911" if you reasonably believe that you have an Emergency Medical Condition which requires an emergency response and/or ambulance transport services. Shock, unconsciousness, difficulty breathing, symptoms of a heart attack, severe pain or a serious fall are all examples of Emergency Medical Conditions that require an emergency response.

After you have used the "911" emergency response system, you or your family must notify {PACE Organization} as soon as reasonably possible in order to maximize the continuity of your medical care. {PACE Organization} physicians who are familiar with your medical history will work with the emergency service providers in following up with your care and transferring your care to a {PACE Organization} contracted provider when your medical condition is stabilized.

Preparing To Go Out of the {PACE Organization} Service Area

Before you leave the {PACE Organization} service area to go out of town, please notify your IDT through your {PACE Organization} Social Worker. Your Social Worker will explain what to do if you become ill while you are away from your {PACE Organization} Physician. Make sure that you keep your {PACE Organization} membership card with you at all times, especially when traveling out of the service area. Your card identifies you as a {PACE Organization} participant and provides information to care providers (emergency rooms and hospitals) about your health care coverage and how to reach us, if necessary.

Emergencies and Urgent Care When You Are Out of the Service Area

{PACE Organization} covers both Emergency Services and Urgent Care when you are temporarily out of our service area but still in the United States or its territories. Urgent Care includes inpatient or outpatient services that are necessary to prevent serious deterioration of your health resulting from an unforeseen illness or injury for which treatment cannot be delayed until you return to our service area.

If you use Emergency Services or Urgent Care when out of the service area (for example, ambulance or inpatient services), you must notify {PACE Organization} within 48 hours or as soon as reasonably possible. If you are hospitalized, we have the right to arrange a transfer when your medical condition is stabilized, to a {PACE Organization} contracted hospital or another hospital designated by us. We may also transfer your care to a {PACE Organization} physician.

{PACE Organization} will pay for all medically necessary health care services provided to a participant which are necessary to maintain the participant's stabilized condition up to the time that {PACE Organization} arranges the participant's transfer or the participant is discharged.

{PACE Organization} must approve any routine medical services (i.e. medical services that do <u>not</u> constitute a medical emergency or other urgent need for care) when you are out of the service area. For authorization of any non-emergency, out-of-the-area services, you

must call {PACE Organization} at {PACE Program telephone number} and speak with your nurse, social worker or PCP.

Reimbursement Provisions

If you have paid for Emergency Services or Urgent Care you received when you were outside our service area but still in the United States, {PACE Organization} will reimburse you. Request a receipt from the facility or physician involved at the time you pay. This receipt must show: the physician's name, your health problem, date of treatment and release, as well as charges. Please send a copy of this receipt to your {PACE Organization} social worker within 30 business days.

Please note that if you receive any medical care or covered services as described in this document outside of the United States, {PACE Organization} will not be responsible for the charges.

For Your Reference:

{PACE Organization} EMERGENCY PLAN

POST IN A CONVENIENT PLACE

Date:

Participant's Name:

{PACE Organization} Day Health Center's Hours: { business days and hours}

{PACE Organization} Primary Care Physician: {Telephone and TTY numbers}

Health Care Wishes: ☐Do Not Resuscitate ☐Basic Life Support ☐Full Code

Before and after business hours and on weekends and holidays {include days and hours of operation}:

Call the {PACE Organization} After-Hours Operator at {PACE Program's After-Hours Operator's telephone number}. Say that you are a {PACE Organization} participant and ask for an on-call nurse for:

Call "911" in the event of an emergency.

Remember, an **emergency** is described as "a medical condition manifesting itself with symptoms of sufficient severity (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in serious jeopardy to health, serious impairment of bodily functions or serious dysfunction of an organ or body part." Examples of emergencies include unconsciousness, severe bleeding, and/or extreme chest pain not relieved by your usual medications.

CHAPTER 6
EXCLUSIONS AND LIMITATIONS ON BENEFITS

Please see Chapter 5 to learn how to receive care if you have a medical emergency or other urgent need for care. Except for Emergency Services and Urgent Care received outside our service area, Preventive, and Sensitive Services, all care requires authorization in advance by the appropriate member of the Interdisciplinary Team.

The following general and specific exclusions are in addition to any exclusions or limitations described in *Chapter 4* for particular benefits.

Covered Benefits Do Not Include:

- Any service not authorized by the physician or other qualified decision maker on the IDT, even if it is listed as a covered benefit, except Emergency, Urgent, Preventive, and Sensitive Services. If a {PACE Organization} provider requests prior approval to provide health care services and the IDT decision maker, Director or Medical Director denies, defers or modifies the request, you will be notified in writing of the reason for this denial and information on how to appeal this decision, in accordance with California and federal law.
- Prescription drugs and over-the-counter drugs not prescribed by a {PACE Organization} physician except when prescribed as part of Emergency Services or Urgent Care provided to you.
- Cosmetic surgery, unless the physician on your IDT determines that it is medically necessary for improved functioning of or to correct a malformed part of the body resulting from an accidental injury, trauma, infection, tumor or disease, or to restore and achieve symmetry after a mastectomy.
- Experimental or investigational medical, surgical or other health procedures not generally available.
- Gender alteration procedures.

- Family planning, including sterilization operations or procedures.
- Care in a government hospital (VA, federal/state hospitals), except for Emergency Services and Urgent Care.
- Services in any county hospital for the treatment of tuberculosis or chronic medically uncomplicated drug dependency or alcoholism.
- Short-Doyle/Medi-Cal Services
- In an inpatient facility, private room and private duty nursing services (unless medically necessary), and non-medical items for personal convenience, such as telephone charges and radio or television rental, unless specifically authorized by the IDT as part of your Plan of Care.
- Any services rendered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.
- The cost of labor and materials to modify your home environment, unless authorized by the occupational therapist and physician on your IDT.
- If you are out of {PACE Organization} service area for more than 30 days, {PACE Organization} may disenroll you unless other prior arrangements have been approved by the Director or Medical Director, upon recommendation of the IDT.
- {PACE Organization} will make every reasonable effort to provide a safe and secure environment at the center. However, we strongly advise participants and their families to leave valuables at home. {PACE Organization} is not responsible for safeguarding personal belongings.

CHAPTER 7
YOUR RIGHTS AND RESPONSIBILITIES

{PACE Organization} Participant Bill of Rights

At {PACE Organization}, we are dedicated to providing you with quality health care services so that you may remain as independent as possible. Our staff seeks to affirm the dignity and worth of each Participant by assuring the following rights:

Respect and Non-Discrimination

You have the right to be treated with dignity and respect at all times, to have all of your care kept private, and to get compassionate, considerate care.

You have the right to:

- Be treated in a respectful manner that honors your dignity and privacy.
- Receive care from professionally trained staff.
- Know the names and responsibilities of the people providing your care.
- Know that decisions regarding your care will be made in an ethical manner.
- Receive comprehensive health care provided in a safe and clean environment and in an accessible manner.
- Be free from harm, including unnecessary physical or chemical restraints or isolation, excessive medication, physical or mental abuse or neglect, and hazardous procedures.
- Be encouraged to use your rights in the PACE program.
- Receive reasonable access to a telephone at the center, both to make and receive confidential calls, or to have such calls made for you if necessary.
- Not have to do work or services for the PACE Program.
- Not be discriminated against in the delivery of PACE services based on race, ethnicity, national origin, religion, sex, age, sexual orientation, mental or physical disability or source of payment.

Information Disclosure

You have the right to get accurate, easy-to-understand information and have someone help you make informed health care decisions.

You have the right to:

- Be fully informed, in writing, of your rights and responsibilities and all rules and regulations governing participation in {PACE Organization}.
- Be fully informed, in writing, of the services offered by {PACE Organization}, including services provided by contractors instead of {PACE Organization} staff. You must be given this information before enrollment, at enrollment, and at the time your needs necessitate the disclosure and delivery of such information, in order for you to make an informed choice.
- A full explanation of the Enrollment Agreement and an opportunity to discuss it.
- Have an interpreter or a bilingual provider available to you if your primary language is not English.
- Examine the results of the most recent federal or state review of {PACE Organization} and how {PACE Organization} plans to correct any problems that are found at inspection.

Confidentiality

You have the right to talk with health care providers in private and have your personal health care information kept private as protected under state and federal laws.

You have the right to:

- Speak with health care providers in private and have all the information, both paper and electronic, related to your care kept confidential within required regulations. Be assured that your written consent will be obtained for the release of medical or personal information or photographs or images to persons not otherwise authorized under law to receive it. You have the right

to limit what information is released and to whom it is released to.

- Be assured that your health record will remain confidential.
- Review and copy your medical records and request amendments to those records and have them explained to you.
- Be assured of confidentiality when accessing Sensitive Services such as Sexually Transmitted Disease (STD) and HIV testing.

If you have any questions, you may call the Office for Civil Rights toll-free at 1-800-368-1019. TTY users should call 1-800-537-7697.

Choosing Your Provider

You have the right to:

- Choose your own primary care provider and specialists from the {PACE Organization} provider panel.
- Request a qualified specialist for women's health services or preventive women's health services.
- Initiate the disenrollment process at any time.

Emergency Care

You have the right to:

- Receive health care services in an emergency without prior approval from the {PACE Organization} Interdisciplinary Team.

Treatment Decisions

You have the right to:

- Participate in the development and implementation of your care plan. If you cannot fully participate in your treatment decision you may designate a health spokesperson to act on your behalf.
- Have all treatment options explained to you in a language you understand and acknowledge this explanation in writing.

- Be fully informed of your health status and make your own health care decisions.
- Refuse treatment or medications and be informed how this may affect your health.
- Request and receive complete information about your health and functional status by the {PACE Organization} Interdisciplinary Team.
- Request a reassessment by the {PACE Organization} Interdisciplinary Team at any time.
- Receive reasonable advance notice, in writing, if you are to be transferred to another treatment setting for medical reasons or for your welfare or the welfare of other Participants. Any such actions will be documented in your health record.
- Have our staff explain advance directives to you and to establish one on your behalf, if you desire.

Exercising Your Rights

You have the right to:

- Assistance to exercise civil, legal and participant rights, including {PACE Organization} grievance process, the Medi-Cal State hearing process and the Medicare and Medi-Cal appeals processes.
- Voice your complaints and recommend changes in policies and services to our staff and to outside representatives of your choice. There will be no restraint, interference, coercion, discrimination or reprisal by our staff if you do so.
- Appeal any treatment decision made by {PACE Organization} or our contractors through our appeals process and request a State hearing.
- Leave the program at any time.

If you feel any of your rights have been violated or you are dissatisfied and want to file a grievance or an appeal, please report this immediately to your social worker or call our office during regular business hours at

{PACE Program telephone number } *or our toll free line at {PACE Program telephone number}.*

If you would like to talk to someone outside of {PACE Organization} about your concerns you may contact 1-800-MEDICARE (1-800-633-4227) or 1-888-452-8609 (Department of Health Care Services Office of the Ombudsman)

Please refer to other sections of your {PACE Organization} *Member Enrollment Agreement Terms and Conditions* booklet for details about {PACE Organization} as your sole provider; a description of {PACE Organization} services and how they are obtained; how you may obtain emergency and urgently needed services outside {PACE Organization}'s network; the grievance and appeals procedure; conditions for disenrollment; and a description of premiums, if any, and payment of these.

Participant Responsibilities

We believe that you and your caregiver play crucial roles in the delivery of your care. To assure that you remain as healthy and independent as possible, please establish an open line of communication with those participating in your care and be accountable for the following responsibilities:

You have the responsibility to:

- Cooperate with the Interdisciplinary Team in implementing your care plan.
- Accept the consequences of refusing treatment recommended by the Interdisciplinary Team.
- Provide the Interdisciplinary Team with a complete and accurate medical history.
- Utilize only those services authorized by {PACE Organization}.
- Take all prescribed medications as directed.
- Call the {PACE Organization} physician for direction in an urgent situation.

- Notify {PACE Organization} within 48 hours or as soon as reasonably possible if you require emergency services out of the service area.
- Notify {PACE Organization} in writing when you wish to initiate the disenrollment process.
- Notify {PACE Organization} of a move or lengthy stay outside of the service area.
- Pay required monthly fees as appropriate.
- Treat our staff with respect and consideration.
- Not ask staff to perform tasks that they are prohibited from doing by PACE or agency regulations.
- Voice any concerns or dissatisfaction you may have with your care.

CHAPTER 8
PARTICIPANT GRIEVANCE AND APPEALS PROCESS

All of us at {PACE Organization} share responsibility for your care and your satisfaction with the services you receive. Our grievance procedures are designed to enable you or your representative to express any concerns or dissatisfaction you have so that we can address them in a timely and efficient manner. You also have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

The information in this Chapter describes our grievance and appeals processes. You will receive written information of the grievance and appeals processes when you enroll and annually after that. At any time you wish to file a grievance or an appeal, we are available to assist you. If you do not speak English, a bilingual staff member or translation services will be available to assist you.

You will not be discriminated against because a grievance or appeal has been filed. {PACE Organization} will continue to provide you with all the required services during the grievance or appeals process. The confidentiality of your grievance or appeal will be maintained throughout the grievance or appeal process and information pertaining to your grievance or appeal will only be released to authorized individuals.

Grievance Procedure

Definition: A grievance is defined as a complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of participant care. A grievance may include, but is not limited to:

- The quality of services a PACE participant receives in the home, at the PACE Center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility);

- Waiting times on the telephone, in the waiting room or exam room;
- Behavior of any of the care providers or program staff;
- Adequacy of center facilities;
- Quality of the food provided;
- Transportation services; and
- A violation of a participant's rights

Filing of Grievances

The information below describes the grievance process for you or your representative to follow should you or your representative wish to file a grievance.

1. You can verbally discuss your grievance either in person or by telephone with PACE program staff of the center you attend. The staff person will make sure that you are provided with written information on the grievance process and that your grievance is documented on the Grievance Report form. You will need to provide complete information of your grievance so the appropriate staff person can help to resolve your grievance in a timely and efficient manner. If you wish to submit your grievance in writing, please send your written grievance to: {Insert designated individual, PACE Program Administration Office, address, etc.}

   You may also contact our {insert designated individual /appropriate department} at {PACE telephone number} [if applicable, add "or our toll-free telephone number] to request a Grievance Report form and receive assistance in filing a grievance. For the hearing impaired (TTY/TDD), please call {insert telephone number}. Our {insert designated individual/appropriate department} will provide you with written information on the grievance process. [If applicable, insert "You may also access our website at {insert website here} to receive information about the grievance process"].

2. The staff member who receives your grievance will help you document your grievance (if your grievance is not already documented) and coordinate investigation and action. All information related to your grievance will be held in strict confidence.

3. You will be sent a written acknowledgement of receipt of your grievance within five (5) calendar days. Investigation of your grievance will begin immediately to find solutions and take appropriate action.

4. The {PACE Organization} staff will make every attempt to resolve your grievance within thirty (30) calendar days of receipt of your grievance and you will receive a written letter with the resolution. If you are not satisfied with that resolution, you and/or your representative have the right to pursue further action.

5. In the event resolution is not reached within thirty (30) calendar days, you or your representative will be notified in writing of the status and estimated completion date of the grievance solution.

Expedited Review of Grievances

1. If you feel your grievance involves a serious or imminent threat to your health, including, but not limited to potential loss of life, limb or major bodily function, severe pain or violation of your participant rights, we will expedite the review process to a decision within 72 hours of receiving your written grievance and request for expedition. In this case, you will be immediately informed by telephone of: (a) the receipt of your request for expedited review, and (b) your right to notify the Department of Social Services of your grievance through the State hearing process.

Resolution of Grievances

1. Upon {PACE Organization} completion of the investigation and reaching a final resolution of your grievance, you will receive written notification that will provide you with a written report describing the reason for your grievance, a summary of actions taken to resolve your grievance, and options to pursue if you are not satisfied with the resolution of your grievance.

Grievance Review Options

If after completing the grievance process or after participating in the process for at least thirty (30) calendar days, and you or your representative are still dissatisfied, you or representative may pursue the options described below. *Note:* If you feel that waiting thirty (30) calendar days represents a serious health threat, you and/or your representative need not complete the entire grievance process nor wait thirty (30) calendar days to pursue the options described below.

1. If you are covered by Medi-Cal only or by Medi-Cal and Medicare, you are entitled to pursue your grievance with the DHCS, by contacting or writing to:

Ombudsman Unit
Medi-Cal Managed Care Division
Department of Health Care Services
P.O. Box 997413, Mail Station 4412
Sacramento, CA 95899-7413
Telephone: 1-888-452-8609
TTY: 1-800-735-2922

State Hearing Process: At any time during the grievance process, per California State law, you may also request a State hearing from the California Department of Social Services by contacting or writing to:

California Department of Social Services
State Hearing Division

P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Fax: (916) 229-4410
TTY: 1-800-952-8349

If you want a State hearing, you must ask for it within 90 days from the date of receiving the letter for resolved grievance. You or your representative may speak at the State hearing or have someone else speak on your behalf, including a relative, friend or an attorney. You may also be able to get free legal help. You or your representative will be provided a list of Legal Services offices in {specify county (ies)} at the time you file a grievance.

{If your organization holds a Home Health Agency license, then insert the following}:

Home Health Hotline: If you have a question or concern regarding {PACE Organization's} home health services, we recommend that you first discuss the matter with your {insert appropriate contacts here, i.e. Home Health Nurse, Social Worker or Center Manager}. However, please be informed that the State of California has established a confidential toll-free telephone number to receive questions or complaints about home health services. The telephone number is: {insert applicable L&C Office (will vary depending on location) number and TYY/TDD number, as available}, Monday through Friday, from 9:00 a.m. to 5:00 p.m.

Appeals Process

Definition: An appeal is a participant's action taken with respect to the PACE organization's decision not to cover, or not to pay for a service, including denials, reductions or termination of services.

When {PACE Organization} decides not to cover or pay for a service you want, you may take action to change our decision. The action you take—whether verbally or in writing— is called an "**appeal**." You have the right to appeal any decision about our failure to approve, furnish,

arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information on the appeals process when you enroll and annually after that. You will also receive this information and necessary appeals forms whenever {PACE Organization} denies, defers or modifies a request for a service or request for payment.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited. Both of these processes are described below.

If you request a **standard appeal**, your appeal must be filed within one-hundred-and eighty (180) calendar days of when your request for service or payment of service was denied, deferred or modified. This is the date which appears on the Notice of Action for Service or Payment Request. (The 180-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. If the treating physician asks for an expedited appeal for you, or supports you in asking for one, we will automatically make a decision on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after we receive your request for an appeal. We may extend this time frame up to fourteen (14) days if you ask for the extension or if we justify to the Department of Health Care Services the need for more information and how the delay benefits you.

If you ask for an **expedited appeal** without support from a treating physician, we will decide if your health condition requires us to make a decision on an expedited basis. If we decide to deny you an **expedited appeal**, we will let you know within seventy-two (72) hours. If this happens, your appeal will be considered a standard appeal.

Note: For {PACE Organization} participants the {PACE Organization} will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If our initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If you or your representative has requested a service or payment for a service and {PACE Organization} denies, defers or modifies the request, you may appeal the decision. A written "*Notice of Action of Service or Payment Request*" (NOA) will be provided to you and/or your representative which will explain the reason for the denial, deferral or modification of your service request or request for payment.
2. You can make your appeal either verbally, in person or by telephone, or in writing with PACE Program staff of the center you attend. The staff person will make sure that you are provided with written information on the appeals process, and that your appeal is documented on the appropriate form. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review, either in person or in writing to us at the address listed below. If more information is needed, you will be contacted by {designated individual or staff title} who will assist you in obtaining the missing information.
3. If you wish to make your appeal by telephone, you may contact our {designated individual} at {insert telephone number and hours and days of service available at number} [If applicable, add "or our toll-free number at {telephone}"] to request an appeal form and/or to receive assistance in filing an appeal. For

the hearing impaired (TTY/TDD), please call {insert PACE program telephone number}.

4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

   [Designated Individual]

   [PACE Organization Administrative Office]

   [Address]

   [City, State, Zip]

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) working days for a standard appeal. For and expedited appeal, we will notify you or your representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received.

6. The reconsideration of {PACE Organization} decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team. We will insure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.

7. Upon {PACE Organization} completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, {PACE Organization} will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below:

The Decision on Your Appeal:

If we decide fully in your favor on a **standard appeal** for a request for **service**, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we received your request for an appeal. **If we decide fully in your favor** on a request for **payment**, we are required to make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

If we do not decide fully in your favor on a **standard appeal** or if we fail to provide you with a decision within thirty (30) calendar days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program **(see Additional Appeal Rights, below).** We also are required to notify you as soon as we make a decision and also to notify the federal Centers for Medicare and Medicaid Services and the Long-Term Care Division, DHCS. We will inform you in writing of your **external** appeal rights under the Medicare or Medi-Cal Program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

If we decide fully in your favor on an **expedited appeal**, we are required to obtain the service or provide you the service as quickly as your health condition requires, but no later than seventy-two (72) hours after we received your request for an **appeal**.

If we do not decide fully in your favor on an **expedited appeal** or fail to notify you within seventy-two (72) hours, you have the right to pursue an external appeal process under either Medicare or Medicaid (**see Additional Appeal Rights**). We are required to notify you as soon as we make a decision that is not fully in your favor and also to notify the Centers for Medicare and Medicaid Services and the Long-Term Care Division, DHCS. We will let you know in writing of your **external appeal** rights through the Medicare or Medi-Cal Program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

Additional Appeal Rights under Medi-Cal and Medicare

If we do not decide in your favor on your appeal or fail to provide you a decision within the required timeframe, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program.

The **Medicare program** contracts with an "Independent Review Organization" to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The **Medi-Cal program** conducts their next level of appeal through the State hearing process. If you are enrolled in Medi-Cal, you can appeal if {PACE Organization} wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service. However, you may have to pay for the service(s) if the decision is not in your favor.

If you are enrolled in both **Medicare and Medi-Cal**, we will help you choose which appeals process you should follow. We also will send your appeal on to appropriate external program for review.

If you are not sure which program you are enrolled in, ask us. The Medicare and Medi-Cal external appeal processes are described below.

Medi-Cal External Appeals Process

If you are enrolled in both **Medicare and Medi-Cal OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a State hearing through:

California Department of Social Services
State Hearings Division

P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Fax: (916) 229-4410
TTY: 1-800-952-8349

If you choose to request a State hearing, you must ask for it within ninety (90) days from the date of receiving the Notice of Action (NOA) for Service or Payment Request from {PACE Organization}.

You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend or attorney. You may also be able to get free legal help. We will provide you with a list of Legal Services offices in [specify county (ies)] at the time that we deny, modify or defer a service or payment of a service.

If the Administrative Law Judge's (ALJ) decision is in your favor of your appeal, {PACE Organization} will follow the judge's instruction as to the timeframe for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ's decision is not in your favor of your appeal, for either a standard or an expedited appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.

Medicare External Appeals Process

If you are **enrolled in both Medicare and Medi-Cal OR Medicare only**, and choose to appeal our decision using Medicare's external appeals process, we will send your appeal to the current contracted Medicare appeals entity to impartially review your appeal. The current contracted Medicare appeals entity will contact us with the results of their review. The current contracted Medicare appeals entity will either maintain our original decision or change our decision and rule in your favor.

Expedited and Standard Appeals Process

You can request an **expedited** external appeal if you believe your health would be jeopardized by not receiving a specific service. In an expedited external review, we will send your appeal to the current contracted Medicare appeals entity as quickly as your health requires. The current contracted Medicare appeals entity must give us a decision within 72 hours after they receive the appeal from us. The current contracted Medicare appeals entity may ask for more time to review the appeal, but they must give us their decision within fourteen (14) calendar days.

You can request a **standard** external appeal if we deny your request for non-urgent services or do not pay for a service. For a standard external appeal, you will receive a decision on your appeal no later than thirty (30) calendar days after you request the appeal.

If the current contracted Medicare appeals entity**'s decision is in your favor for a standard appeal:**
If you have requested a service that you have not received, we will provide you with the service you asked for as quickly as your health condition requires;

-OR-

If you have requested payment for a service that you have already received, we will pay for the service within sixty (60) calendar days for either a standard or expedited.

If the current contracted Medicare appeals entity's decision is **not** in your favor for either a standard or expedited appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.

For more information regarding the appeals process or to request forms, please {insert telephone number and TTY/TDD numbers} {hours and days of operation} or contact {PACE Organization} {Quality Assurance Coordinator or designee} at {address}.

CHAPTER 9
MONTHLY FEES

{PACE Organization} sets its fees on an annual basis and has the right to change its fees with a 30-day written notice.

Prepayment Fees

Your payment responsibility will depend upon your eligibility for Medicare, Medi-Cal and Medi-Cal's Medically Needy Only (MNO) programs:

1. If you are eligible for Medi-Cal or a combination of Medi-Cal and Medicare, you will pay nothing to {PACE Organization} for the benefits and services described in CHAPTER 4, including prescription drugs.

2. If you qualify for Medicare and Medi-Cal's Medically Needy Only (MNO) program, you are not liable for any premiums but will be responsible for paying your MNO share of cost.

3. If you are eligible only for Medicare, you will be charged a monthly premium. Because this premium does not include the cost of Medicare prescription drug coverage, you will be responsible for an additional monthly premium for Medicare prescription drug coverage. This monthly premium may be reduced if you qualify for a low-income subsidy.

4. If you are not eligible for Medi-Cal or Medicare, you will be charged the full monthly premium. This premium will include the cost of prescription drugs.

Please refer to your signed Enrollment Agreement for the amount you will be charged. If you have a monthly responsibility for payment of a premium or prescription drug coverage, the Enrollment Representative will explain this to you. We will also discuss your payment with you at the enrollment conference and write the amount on your Enrollment Agreement before you are asked to sign it. If you are charged both premiums, you may pay them together or you may contact your Social

Worker for additional payment options. We will notify you in writing of any change in your monthly premium at least 30 days before the change takes effect.

Your usual monthly Medicare Part B premium will continue to be deducted from your Social Security check.

Prescription Drug Coverage Late Enrollment Penalty

Please be aware that if you are eligible for Medicare prescription drug coverage and are enrolling in {PACE Organization} after going without Medicare prescription coverage or coverage that was as least as good as Medicare drug coverage for 63 or more consecutive days, you may have to pay a higher monthly amount for Medicare prescription drug coverage. You may contact your {PACE Organization} social worker for more information about whether this applies to you.

If you are required to pay a monthly premium or a premium for prescription drug coverage, you will receive an invoice. You must pay this amount by the first day of the month after you sign the Enrollment Agreement and on the first day of each subsequent month. Payment may be made by check or money order to:

{PACE Organization address here}
Attention: Accounting Department

Late Charges

Monthly payments are due on the first day of each month. If you have not paid this premium by the tenth day of the month, you may be assessed a late fee of $20.00, in accordance with applicable law. Late charges do not apply to participants with Medi-Cal coverage.

Termination for Non-Payment

If you pay a monthly premium, your monthly invoice will remind you that you are required to pay your monthly fee by the first day of each month. If you have not paid your monthly premium by the tenth day of the month, {PACE Organization} may terminate your coverage. If this occurs, {PACE Organization} will mail you a written Cancellation Notice on the tenth day of the month, informing you that your

Enrollment Agreement will be terminated if you still have not paid the premium due (the monthly premium and late charge) by the cancellation date given in the Cancellation Notice. The cancellation date will be at least fifteen (15) days after {PACE Organization} mails you the Cancellation Notice. The Cancellation Notice will also inform you that, if you pay the required amount within a thirty (30)-day grace period after {PACE Organization} gives you the Cancellation Notice you will be reinstated with no break in coverage. You are obligated to pay the premium for any month in which you use {PACE Organization} services. If your benefits are terminated and you wish to re-enroll, please refer to CHAPTERS 10 and 11 regarding {PACE Organization} termination policy and renewal provisions.

Other Charges: None. There are no co-payments or deductibles for authorized services.

CHAPTER 10
COVERAGE AND TERMINATION OF BENEFITS

Your enrollment in {PACE Organization} is effective the first day of the calendar month following the date you sign the "Enrollment Agreement." For example, if you sign the Enrollment Agreement on March 14, your enrollment will be effective on April 1. Please note that you may not enroll in {PACE Organization} at a Social Security office.

- The {PACE Organization} will complete the initial assessments and plan of care for you. The DHCS' LTCD will make the final determination of clinical eligibility. If you are determined eligible by DHCS' LTCD, the {PACE Organization} will then initiate the enrollment process.

- If you are eligible for Medi-Cal, your official enrollment with the DHCS as a {PACE Organization} participant is subject to a 15 to 45-day enrollment processing period after the date you sign the {PACE Organization} Enrollment Agreement.

- If you do not meet the financial eligibility requirements for Medi-Cal, you may pay privately for your care (see CHAPTER 9).

After signing the Enrollment Agreement, your benefits under {PACE Organization} continue indefinitely unless you choose to disenroll from the program ("voluntary disenrollment") or you no longer meet the conditions of enrollment ("involuntary disenrollment"). The effective date of termination is midnight of the last day of a month (except termination for failure to pay a required fee, see CHAPTER 9).

{PACE Organization} will work to transition you back into traditional Medi-Cal and/or Medicare services as quickly as possible. Medical records will be forwarded as requested and authorized by the participant or designated representative and referrals to other resources in the community will be made to assure continuity of care.

You are required to continue to use {PACE Organization's} services and to pay the monthly fee, if applicable, until termination becomes effective. If you should require care before your reinstatement occurs, {PACE Organization} will pay for the service to which you are entitled by Medicare or Medi-Cal.

Voluntary Disenrollment

If you wish to cancel your benefits by disenrolling, you should discuss this with your social worker. You may disenroll from {PACE Organization} without cause at any time. You will need to sign a "Disenrollment Form". This form will indicate that you will no longer be entitled to services through {PACE Organization} after midnight on the last day of the month. Please note that you may not disenroll from {PACE Organization} at a Social Security office.

Involuntary Disenrollment

We may terminate your enrollment with {PACE Organization} if:

- You move out of the {PACE Organization} service area {include zip codes or other identifying information here} or are out of the service area for more than 30 days without prior approval (see CHAPTER 6).

- You engage in disruptive or threatening behavior, i.e. your behavior jeopardizes the health or safety of yourself or others or you consistently refuse to comply with the terms of your Plan of Care or Enrollment Agreement, when you have decision-making capacity. Disenrollment under these circumstances is subject to prior approval by the DHCS and will be sought in the event that you display disruptive interference with care planning or threatening behavior which interferes with the quality of PACE services provided to you and other PACE Participants.

- You are determined to no longer meet the Medi-Cal Nursing Home level of care criteria and are not deemed eligible.

- You fail to pay or fail to make satisfactory arrangements to pay any premium due to {PACE Organization} within the 30-day period specified in any Cancellation Notice (see CHAPTER 9).

- The agreement between {PACE Organization}, the Centers for Medicare and Medicaid Services and the DHCS is not renewed or is terminated.

- {PACE Organization} is unable to offer health care services due to the loss of our State licenses or contracts with outside providers.

All rights to benefits will stop at midnight on the last day of the month following a voluntary or involuntary disenrollment (except in the case of termination due to failure to pay fees owed, see CHAPTER 9). We will coordinate the disenrollment date between Medicare and Medi-Cal, if you are eligible for both programs. You are required to use {PACE Organization} services (except for Emergency Services and Urgent Care provided outside our service area) until termination becomes effective.

If you are hospitalized or undergoing a course of treatment at the time your disenrollment becomes effective, {PACE Organization} has the responsibility for service provision until you are reinstated with Medicare and Medi-Cal benefits (according to your entitlement and eligibility).

CHAPTER 11
RENEWAL PROVISIONS

Your coverage by {PACE Organization} is continuous indefinitely (with no need for renewal). However, your coverage will be terminated if: (1) you fail to pay or fail to make satisfactory arrangements to pay any amount due {PACE Organization} after the 30-day grace period (see CHAPTER 9), (2) you voluntarily disenroll (see CHAPTER 10), or (3) you are involuntarily disenrolled due to one of the other conditions specified in CHAPTER 10.

If you choose to leave {PACE Organization} ("disenroll voluntarily"), you may be re-enrolled. To be re-enrolled, you must reapply, meet the eligibility requirements and complete our assessment process.

If you are disenrolled due to failure to pay the monthly fee (see CHAPTER 9), you can re-enroll simply by paying the monthly fee provided you make this payment before the end of the 30-day grace period (see CHAPTER 9). In this case, you will be reinstated with no break in coverage.

CHAPTER 12
GENERAL PROVISIONS

Authorization to Obtain Medical Records

By accepting coverage under this Enrollment Agreement, you authorize {PACE Organization} to obtain and use your medical records and information from any and all health care facilities and providers who have treated you in the past. This will include information and records concerning treatment and care you received before the effective date of this Enrollment Agreement.

Access to your own medical record is permitted in accordance with California law. This information will be stored in a secured manner that will protect your privacy and be kept for the time period required by law.

Authorization to Take and Use Photographs

By accepting coverage under this Enrollment Agreement, you authorize {PACE Organization} to make and use photographs, video tapes, digital or other images for the purpose of medical care, identification, payment for services or internal operation of {PACE Organization}. Images will only be released or used outside {PACE Organization} upon your authorization.

Changes to Enrollment Agreement

Changes to this Enrollment Agreement may be made if they are approved by the Centers for Medicare and Medicaid Services and the DHCS. We will give you at least a 30-day advance written notice of any such change, and you will be deemed to have contractually agreed to such change.

Confidentiality of Medical Records Policy

The personal and medical information collected by {PACE Organization} adheres to a confidentiality policy to prevent disclosure of your personal and medical information other than as needed for your care. You may request a copy of our confidentiality policy by

calling {insert appropriate PACE Program designee and telephone number here}.

Continuation of Services on Termination
If this Enrollment Agreement terminates for any reason, you will be reinstated back into the traditional Medicare and Medi-Cal programs, according to your eligibility. {PACE Organization} will work to transition you back into the traditional Medicare and/or Medi-Cal programs so your care is not jeopardized.

Cooperation in Assessments
So we can determine the best services for you, your full cooperation is required in providing medical and financial information to us.

Non-discrimination
{PACE Organization} shall not unlawfully discriminate against participants in the rendering of service on the basis of race, age, religion, color, national origin, ancestry, sex, marital status, sexual orientation or disability. {PACE Organization} shall not discriminate against participants in the provision of service on the basis of having or not having an Advance Health Care Directive.

Notice
Any notice which we give you under this Enrollment Agreement will be mailed to you at your address as it appears on our records. It is your responsibility to notify us promptly of any change to your address. When you give us any notice, please mail it to:

{PACE Organization address here}
Attention: {contact person or department here}

Notice of Certain Events
If you may be materially and adversely affected, we shall give you reasonable notice of any termination, breach of Enrollment Agreement or inability to perform by hospitals, physicians or any other person with whom we have a contract to provide services. We will give you a 30-day written notice if we plan to terminate a contract with a medical group or individual practice association from whom you are receiving

treatment. In addition, we will arrange for the provision of any interrupted service by another provider.

Organ and Tissue Donation

Donating organs and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your {PACE Organization} PCP. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization helps coordinate the donation.

Our Relationship to {PACE Organization} Providers

{PACE Organization} providers other than {PACE Organization} staff are independent organizations and are related to us by contract only. These providers are not our employees or agents. {PACE Organization} providers maintain a relationship with you and are solely responsible for any of their acts or omissions, including malpractice or negligence. Nothing in this Enrollment Agreement changes the obligation you have to any provider who renders care to you to abide by the rules, regulations and other policies established by the provider.

Participation in Public Policy of Plan

{NOTE: The following is a suggested structure only. Please modify as you see fit to best meet the needs of your organization.}

The Board of Directors of {PACE Organization} has a standing committee, known as the {enter name of committee here}, which reports to the board every quarter and advises the board on issues related to the actions of {PACE Organization} and our staff to assure participant comfort, dignity and convenience. The committee has nine members, at least five of whom are participants enrolled in {PACE Organization}. In addition, at least one committee member is a {PACE Organization} board member and at least one committee member is a provider. All members of the committee are appointed by the board, but are nominated by the committee itself. The committee elects its own co-chairs, at least one of whom must be a participant. Any

material changes in our health care services plan are communicated to participants at least annually.

Recovery from Third Party Liability

If you are injured or suffer an ailment or disease due to an act or omission of a third party giving rise to a claim of legal liability against the third party, {PACE Organization} must report such instances to the DHCS. If you are a Medi-Cal beneficiary, any proceeds which you collect, pursuant to the injury, ailment or disease, are assigned to the DHCS.

Reduction of Benefits

We may not decrease in any manner the benefits stated in this Enrollment Agreement, except after a period of at least a 30-day written notice. The 30-day period will begin on the date postmarked on the envelope.

Reimbursement from Insurance

If you are covered by private or other insurance, including but not limited to motor vehicle, liability, health care or long-term care insurance, {PACE Organization} is authorized to seek reimbursement from that insurance if it covers your injury, illness or condition. (Instances of tort liability of a third party are excluded.) We will directly bill these insurers for the services and benefits we provide (and upon receipt of reimbursement reduce any payment responsibility you may have to {PACE Organization}. You must cooperate and assist us by giving us information about your insurance and completing and signing all claim forms and other documents we need to bill the insurers. If you fail to do so, you, yourself, will have to make your full monthly payment. (See CHAPTER 9 for payment responsibility.)

Safety

To provide a safe environment, {PACE Program's} Safety Policy includes mandatory use of quick release wheelchair seat belts for all participants while in transit, either in a vehicle or from one program area to another.

Second Opinion Policy

You may request a second medical opinion, as may others on your behalf, including your family, your PCP and the IDT. If you desire a second opinion you should notify your PCP or nurse practitioner. {PACE Organization} will issue a decision on second opinions within 72 hours. The timeline is available upon request by calling {insert telephone number here} or contacting {insert name and address of appropriate entity here}.

Tuberculosis Testing

A tuberculosis (TB) skin test(s) or chest X-ray is required upon enrollment. {PACE Organization} will provide treatment if the TB test is positive.

Payment for Unauthorized Services

You will be responsible to pay for unauthorized services, except for Emergency Services and Urgent Care (see "Reimbursement Provisions" in CHAPTER 5).

Payment for Services under this Enrollment Agreement

Payment for services provided under this Enrollment Agreement will be made by {PACE Organization} to the provider. You cannot be required to pay anything that is owed by {PACE Organization} to the selected providers.

CHAPTER 13
DEFINITIONS

Benefits and coverage are the health and health-related services we provide through this Enrollment Agreement. These services take the place of the benefits you would otherwise receive through Medicare and/or Medi-Cal. Their provision is made possible through an agreement between {PACE Organization}, Medicare (Centers for Medicare and Medicaid Services of the Department of Health and Human Services) and Medi-Cal (Department of Health Care Services). This Enrollment Agreement gives you the same benefits you would receive under Medicare and Medi-Cal plus many additional benefits. To receive any benefits under this Enrollment Agreement, you must meet the conditions described in this Enrollment Agreement.

Enrollment Agreement means the agreement between you and {PACE Organization} which establishes the terms and conditions and describes the benefits available to you. This Enrollment Agreement remains in effect until Disenrollment and/or Termination take place.

Contracted provider means a health facility, health care professional or agency that has contracted with {PACE Organization} to provide health and health-related services to {PACE Organization} participant.

Coverage decision means the approval or denial of health services by {PACE Organization} substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of our Enrollment Agreement with you.

Credentialed refers to the requirement that all practitioners (physicians, psychologists, dentists and podiatrists) who serve {PACE Organization} participants must undergo a formal process that includes thorough background checks to verify their education, training and experience and confirm competence.

Department of Health Care Services (DHCS) means the single State Department responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California), California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health-related programs.

Disputed health care service means any health care service eligible for payment under your Enrollment Agreement with {PACE Organization} that has been denied, modified or delayed by a decision of {PACE Organization} in whole or in part due to the finding that a service is not medically necessary. A decision regarding a "disputed health care service" relates to the practice of medicine and is not a coverage decision.

Eligible for nursing home care means that your health status, as evaluated by the {PACE Organization} Interdisciplinary Team, meets the State of California's criteria for placement in either an Intermediate care facility (ICF), or a Skilled Nursing Facility (SNF). {PACE Organization's} goal, however, is to help you to stay in the community as long as possible, even if you are eligible for nursing home care.

Emergency Medical Condition and **Emergency Services** are defined in CHAPTER 5.

Exclusion means any service or benefit that is not included in this Enrollment Agreement. For example, non-emergency services received without authorization from the {PACE Organization's} Interdisciplinary Team of qualified clinical professionals are excluded from coverage. You would have to pay for any unauthorized services.

Experimental and Investigational service means a service that is not seen as safe and effective treatment by generally accepted medical standards (even if it has been authorized by law for use in testing or other studies in humans); or has not been approved by the government to treat a condition.

Family means your spouse, "significant other," children and relatives; the definition of "family" may also be expanded to include close friends or any other person you choose to involve in your care.

Health services are services such as medical care, diagnostic tests, medical equipment, appliances, drugs, prosthetic and orthopedic devices, nutritional counseling, nursing, social services, therapies, dentistry, optometry, podiatry and audiology. Health services may be provided in a {PACE Organization} center or clinic, in your home, or in professional offices of contracted specialists or other providers, hospitals or nursing homes under contract with {PACE Organization}.

Health-related services are those services which help {PACE Organization} provide health services and enable you to maintain your independence. Such services include personal care, homemaker/chore service, attendant care, recreational therapy, escorts, translation services, transportation, home-delivered meals and assistance with housing problems.

Home health care refers to two categories of services—supportive and skilled services. Based on individualized Plans of Care, supportive services are provided to participants in their homes and may include household services and related chores such as laundering, meal assistance, cleaning and shopping, as well as assistance with bathing and dressing as needed. Skilled services may be provided by the program's social workers, nurses, occupational therapists and on-call medical staff.

Hospital services are those services which are generally and customarily provided by acute general hospitals.

Interdisciplinary Team (IDT) means {PACE Organization's} team of service providers, facilitated by a program manager, and consisting of a Primary Care Provider (PCP), registered nurse(s), master's-level social worker (MSW), personal care attendant, home care coordinator, driver, physical, recreational and occupational therapists and a dietitian. {Note: The preceding list includes required, core members. Please insert any additional members.} Members of the IDT will assess

your medical, functional and psychosocial status and develop a Plan of Care which identifies the services needed. Many of the services are provided and monitored by this team. All services you receive must be authorized by your physician or other qualified clinical professionals on the IDT. Periodic reassessment of your needs will be done by the team and changes in your treatment plan may occur.

Life threatening means diseases or conditions where the likelihood of death is high unless the course of the disease or condition is interrupted.

Medically necessary means medical or surgical treatments provided to a participant by a participating provider of the Plan which are: (a) appropriate for the symptoms and diagnosis or treatment of a condition, illness or injury; (b) in accordance with accepted medical and surgical practices and standards prevailing at the time of treatment; and (c) not for the convenience of a participant or a participating provider of the Plan.

Monthly fee means the amount you must pay each month in advance to {PACE Organization} to receive benefits under this Enrollment Agreement.

Nursing home means a health facility licensed as either an Intermediate Care Facility or a Skilled Nursing Facility by the Department of Health Care Services.

Out-of-area is any area beyond {PACE Organization's} service area. (See below for definition of service area).

PACE is the acronym for the **P**rogram of **A**ll-Inclusive **C**are for the **E**lderly. PACE is the comprehensive service plan which integrates acute and long-term care for older people with serious health problems. Payments for services are on a monthly capitation basis, combining both state and federal dollars through Medicare and Medi-Cal. Individuals not eligible for these programs pay privately. PACE arranges for participants to come to the {PACE Organization} Center to receive individualized care from doctors, nurses and other health

and social service providers. The goal is to help participants stay independent in the community for as long as safely possible.

{PACE Organization} Physician is a doctor who is either employed by {PACE Organization} or has a contract with {PACE Organization} to provide medical services to participants.

Representative means a person who is acting on behalf of or assisting a PACE participant, and may include, but is not limited to, a family member, a friend, a PACE employee, or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

Sensitive Services means those services related to sexually transmitted diseases (STD's) and HIV testing.

Service area means the geographical location that {PACE Organization} serves. This area includes {insert appropriate zip codes or other geographic parameters here.}

Urgent care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (for example, sore throats, fever, minor lacerations and some broken bones). Urgent care includes inpatient or outpatient services from an unforeseen illness or injury for which treatment cannot be delayed until you return to our service area.

APPENDIX I

This Appendix explains your rights to make health care decisions and how you can plan what should be done in the event that you cannot speak for yourself. A federal law requires us to give you this information. We hope this information will help increase your control over the medical treatment you receive.

Who Decides About My Treatment?

Your doctors will give you information and advice about treatment. You have the right to choose. You may say "Yes" to treatments you want. You may say "No" to treatments you don't want. You are entitled to say "No" to a treatment you don't want even if that treatment might keep you alive longer. If you have a conservator, you still may make your own health care decisions. This only changes if and when a judge decides that your conservator will also make your health care decisions on your behalf.

How Do I Know What I Want?

Your doctor must tell you about your medical condition and about what different treatments can do for you. Many treatments have "side effects." Your doctor must offer you information about serious problems that medical treatment may cause.

Often, more than one treatment might help you—and people have different ideas about which is best. Your doctor can tell you which treatments are available to you and which treatments may be most effective for you. Your doctor can also discuss whether the benefits of treatment are likely to outweigh potential drawbacks. However, your doctor can't choose for you. That choice depends on what is important to you.

What If I Am Too Sick To Decide?

If you are unable to make treatment decisions, your doctor will ask your closest available relative, friend or the person you have personally identified to the doctor as the one you want to speak for you to help decide what is best for you. That works most of the time. But sometimes everyone doesn't agree about what you want to happen if

you cannot speak for yourself. There are several ways you can prepare in advance for someone you choose to speak for you. Under California Law, these are called Advance Health Care Directives.

An Advance Health Care Directive lets you write down the name of the person you want to make health care decisions for you when you are unable to do so. This part of an Advance Health Care Directive is called a Durable Power of Attorney for Health Care. The person you choose is called the "agent." There are Advance Health Care Directive forms you can use, or you can write down your own version as long as you follow a few basic guidelines.

Who Can Write An Advance Health Care Directive?

You can if you are 18 or older and of sound mind. You do not need a lawyer to make or fill out an Advance Health Care Directive.

Who Can I Name To Make Medical Treatment Decisions When I'm Unable To Do So?

When you make your Advance Health Care Directive, you can choose an adult relative or friend whom you trust. That person will then be able to speak for you in the event that you're too sick to make your own decisions.

How Does This Person Know What I Would Want?

Talk to the family member or friend whom you are considering to be your agent about what you would want. Make sure they feel comfortable with your wishes and able to carry them out on your behalf. You may write down your treatment wishes in the Advance Health Care Directive. You may include when you would or wouldn't want medical treatment. Talk to your doctor about what you want and give your doctor a copy of the form. Give another copy to the person named as your agent. Take a copy with you when you go into a hospital or other treatment facility.

Sometimes treatment decisions are hard to make and it truly helps your family and doctors if they know what you want. The Advance Health Care Directive also gives your health care team legal protection when they follow your decisions.

What If I Do Not Have Anybody To Make Decisions For Me?

If you do not want to choose someone, or do not have anybody to name as your agent, you may just write down your wishes about treatment. This is still an Advance Health Care Directive. There is a place on the standard form to write your wishes or you may write them on your own piece of paper. If you use the form, simply leave the Power of Attorney for Health Care section blank.

Writing down your wishes this way tells your doctor what to do in the event that you can no longer speak for yourself. You may write that you do not want any treatment that would only prolong your dying or you may write that you *do* want life-prolonging care. You may provide more detail about the type and timing of the treatment you would want. (Whatever you write, you would still receive care to keep you comfortable.)

The doctor must follow your wishes about your treatment unless you have requested something illegal or against accepted medical standards. If your doctor does not want to follow your wishes for another reason, your doctor must turn your care over to another doctor who will follow your wishes. Your doctors are also legally protected when they follow your wishes.

May I Just Tell My Doctor Who I Want Making Decisions For Me?

Yes, as long as you personally tell your doctor the name of the person you want making these health care decisions. Your doctor will write what you said in your medical chart. The person you named will be called your "surrogate." Your surrogate will be able to make decisions based on your treatment wishes, but only for 60 days or until your specific treatment is done.

What If I Change My Mind?

You may change your mind or revoke your Advance Health Care Directive at any time as long as you communicate your wishes.

Do I Have To Fill Out One Of These Forms?

No, you do not have to fill out any of these forms if you do not want to. You may just talk to your doctors and ask them to write down in your medical chart what you have said; and you may talk with your family. But people will be clearer about your treatment wishes if you write them down. And your wishes are more likely to be followed if you write them down.

Will I Still Be Treated If I Do Not Fill Out These Forms Or Do Not Talk To My Doctor About What I Want?

Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make medical decisions, someone else will have to make them for you. Remember that:

- A Durable Power of Attorney for Health Care lets you name someone to make treatment decisions for you. That person can make most medical decisions—not just those about life-sustaining treatment—when you can't speak for yourself.

- If you do not have someone you want to name to make decisions when you cannot, you may also use an Advance Health Care Directive to just say when you would and would not want particular types of treatment.

- If you already have a "Living Will" or Durable Power of Attorney for Health Care, it is still legal and you do not need to make a new Advance Health Care Directive unless you wish to do so.

SIGNATURE PAGE

A. Effective Dates of Enrollment

Your enrollment is effective:	
Your {PACE organization} Center is located	
The telephone number is	
You will attend the {PACE organization} Center on	

Your driver will pick you up at approximately:

_____

(*While we plan to be on time, we will do our best to let you know if we will be later than expected.*)

Your driver will take you home at approximately:

_____

B. Enrollment Agreement Signature Sheet/Family Conference Packet

Name of Applicant:

_____

Date of Birth: _____ **Sex**: _____

Permanent Address:

_____

_____

Mailing Address (if different from Permanent Address):

_____

_____

Medicare Beneficiary Status:

☐ **Part A** ☐ **Part B** ☐ **Part D** ☐ **ALL** ☐ **NONE**

Medicare Number:

_____

Medi-Cal Recipient Status:

_____

Medi-Cal Number:

_____

Other Health Insurance Information (other insurance coverage, current Prescription Drug Plan, etc.):

Primary Language:

_____

Secondary Language:

_____

IN WITNESS WHEREOF, I _____ agree to enroll in the services of {PACE organization}. I have received a copy of the member enrollment agreement and talked with a {PACE organization} staff member about my enrollment benefits. I understand that once I enroll in {PACE organization}, I am to receive all my health care benefits from {PACE organization}.

A {PACE organization} staff member has reviewed the following information with me and/or my caregiver:

- **Introduction and Program Description**
- **The Mission Statement of {PACE organization}**
- **Eligibility requirements for participation in {PACE organization}**
- **The process of enrolling in {PACE organization}**
- **Health Care Power of Attorney and Advanced Directives**

Benefits and Coverage information, which include:

- **Effective Dates of Enrollment and a sample of the Enrollment Conference Checklist (which is located in the Enrollment agreement)**
- **A description of the kind of benefits and coverage I receive with {PACE organization}.**
- **Information about the {PACE organization} Center that I will attend, including location, hours, and what to do when the weather is bad.**
- **Information about the PACE Interdisciplinary Team that will care for me.**
- **{PACE organization} Employees**
- **{PACE organization} Contract Providers.**
- **Financing - Monthly Payment Information, including what I may have to pay, if anything. Also, I understand what {PACE organization} will not pay for.**
- **Notification that a participant with Medi-Cal may be liable for any applicable spend-down liability and any amounts due under the post-eligibility treatment of income process**
- **Information about long-term care facilities, and how they may be used for my care.**
- **Emergency and Urgent Care coverage.**
- **Information about what should be done if I am hurt in an accident.**
- **A copy of the Participant Rights - Bill of Rights.**

- **My responsibilities as a Participant of {PACE organization} and the responsibilities of my caregiver.**
- **Information about the {PACE organization} Participant Council.**
- **Information about the {PACE organization} Grievance process.**
- **Information about the {PACE organization} Appeal process.**
- **Information about the Medi-Cal and Medicare appeals processes.**
- **Information about stopping my {PACE organization} benefits.**
- **Information about re-applying to {PACE organization}.**
- **A Confidentiality Statement.**
- **Definitions of terms in the agreement booklet.**
- **Notice that you may not enroll or disenroll from {PACE organization} at a Social Security office.**

I have received copies of the above information and have been allowed to ask questions and my questions have been answered. I understand the {PACE organization} program and wish to become a Participant.

I understand that enrollment in {PACE organization} will result in automatic disenrollment from any other Medicare or Medi-Cal prepayment plan. I also understand that enrollment in any other Medicare or Medi-Cal prepayment plan or optional benefit, including the hospice benefit, subsequent to enrolling in {PACE organization} will subject me to voluntary disenrollment from {PACE organization}.

I understand that if I move out of the service area or am absent from the service area for a period of time longer than thirty (30) days, I must notify {PACE organization}.

I agree to accept my health services from {PACE organization} instead of other programs sponsored by Medicare and/or Medi-Cal and that my effective date of enrollment is:

_____

I understand that I am authorizing the disclosure and exchange of my personal information between the Centers for Medicare and Medicaid Services (CMS) and its agents, the DHCS and {PACE organization}.

_____	_____	_____
Name of Participant	Signature of Participant	Date
_____	_____	_____
Name of Witness	Signature of Witness	Date
_____	_____	_____
Name of Designated Representative*	Signature of Designated Representative*	Date
_____		_____
Signature of Authorized {PACE organization} Representative		Date

* Signature other than that of the Participant or immediate family member will be accompanied by the appropriate documentation in accordance with State law and {PACE organization} policies & procedures.

Your Enrollment/Family Conference Packet

Checklist

Enclosed in this packet are important items you will receive as a {PACE organization} Participant. Please read and follow these directions carefully so that if an emergency happens, you, your family, and any health care facility will know exactly what to do.

☐ Your {PACE organization} CARD is the small white card. It identifies you as a Participant of {PACE organization} and must be shown when you need to use the hospital. Written on this card are your name, address, Social Security number, Medi-Cal number, the {PACE organization} phone number, and your medical record number. Keep this card with your Medi-Cal and Medicare cards.

☐ The YELLOW EMERGENCY STICKER is the long, bright yellow sticker. The sticker shows the numbers to dial in case of an emergency. This sticker needs to be placed on or near your telephone so it will be handy when you need it most.

☐ The MEDICARE STICKER is the small, white sticker. Apply this sticker to the back of your Medicare Card. Your Medicare Card is the small card that has Social Security written at the top and is in red, white, and blue. Please place the sticker on the back of the card and present this card anytime you receive an authorized service.

☐ The EMERGENCY PLAN is the detailed sheet that you sign which has instructions on "what to do" in case of an emergency. This also outlines the health care wishes, you have chosen (Basic Life Support, or, Do Not Resuscitate (DNR), or Full Code). You will receive an original or copy of the yellow DNR form to post in your home if you have chosen that course for your care.

In addition, this packet contains:

- Your copy of the **ENROLLMENT AGREEMENT AND SIGNATURE SHEET**. This must be signed before you can receive {PACE organization} services.
- Your signed **ACKNOWLEDGEMENT OF THE CARE PLAN** that your Interdisciplinary Team designed for you.
- **Your {PACE organization} Center** information which includes your scheduled days of attendance and pick-up and return times
- **Your Interdisciplinary Team** information including the names of team members. Any future changes in your Interdisciplinary Team will be communicated to you.
- **{PACE organization} Contract Providers** list. Any future changes in {PACE organization} contract providers will be communicated to you.
- Information about the **{PACE organization} PARTICIPANT COUNCIL**.
- A **CONFIDENTIALITY STATEMENT**.
- **CONSENT** forms for **immunizations** and **marketing**
- Information about what you will need to bring to the {PACE organization} Center on your days of attendance and a sample calendar of activities**.**