ALABAMA MEDICAID AGENCY
WAIVER and PACE MEDICAL / SLOT CONFIRMATION FORM

Client's Name _____

Client's Address _____

_____

Social Security Number _____

Operating Agency _____

Name of Waiver _____

Waiver Slot Available Yes ____ No ____ Date _____

Level of Care Approved Yes ____ No ____ Date _____

Disability Determination Required *Yes ____ No ____ Onset Disability _____

Waiver Transitional Medicaid Transitioning from Nursing Facility? Yes ____ No _____

Date of Discharge from Nursing Facility _____

Start Date of Waiver Services _____

Name/Address of Nursing Facility _____

_____

Transferring from Another Waiver? Yes ____ No ____ Date of Transfer _____

Name of Waiver Transferring from _____

****

PACE SERVICES

Transitioning from Nursing Facility to PACE Program? Yes _____ No _____

Name/Address of Nursing Facility transitioning from: _____

_____

Date of Discharge from Nursing Facility: _____

Name of PACE Provider: _____

Start Date of PACE Services: _____

Transitioning from Waiver to PACE Program? Yes _____ No _____

Name of Waiver transitioning from: _____

Date of Discharge from Waiver: _____

Name of PACE Provider: _____

Start Date of PACE Services: _____

Transitioning from one PACE Provider to another PACE Provider? Yes _____ No ____

Name of PACE Provider transitioning from: _____

End Date for above PACE Provider: _____

Name of new PACE Provider: _____

Start Date for new PACE Provider: _____

Entering Nursing Facility while enrolled in PACE Program? Yes _____ No _____

Date entering Nursing Facility: _____

Request that Patient Liability be established: Yes _____ No _____

Anticipated date of discharge, if known: _____

Leaving Nursing Facility while enrolled in PACE Program? Yes _____ No _____

Date discharged from Nursing Facility: _____

Request that Patient Income be re-established: Yes _____ No _____

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Signature and Title of Reviewer: _____

Phone Number of Reviewer (_____) _____

Name and Fax Number for Award/Denial Notification _____

Case Manager:_____ Phone Number:_____

District Office _____ _____

Phone Number of District Office (_____) _____

Date Application Mailed to District Office _____

NOTE: LTC ADMISSION NOTIFICATION FORM SHOULD NOT BE TRANSMITTED UNTIL FINANCIAL ELIGIBILITY IS ESTABLISHED.

*If this is an adoption subsidy recipient, a disability determination is required. Please route packet directly to AMA Medical and Quality Review Services Unit. All other disability determinations should be sent to the appropriate District Office.