



New Jersey Department of Human Services
NOTICE OF PROGRAM ENROLLMENT

To: \_\_\_\_\_ Date: \_\_\_\_\_
CWA/Board of Social Services/Office of Community Choice Options (OCCO), if on SSI

From: \_\_\_\_\_
[ ] OCCO Field Office Manager [ ] PACE Provider

Address

This is to advise you that the individual identified below has been enrolled in the noted Medicaid Waiver Program or PACE. Please prepare and submit the appropriate Medicaid Status File input documents in accordance with related Operational Procedures.

Participant Name: Medicaid Number:
Street Address: Social Security Number:
City, State, Zip Code: Date of Birth:

ENROLLMENT DATE: \_\_\_\_\_ [ ] Fast Track
Check One:
Program of Enrollment Special Program Code
[ ] GO - Global Options..... (32)
[ ] PACE ..... N/A
[ ] Other: ..... ( )

Care Management/PACE Site: \_\_\_\_\_

SPECIAL CONSIDERATIONS FOR OFFICE OF COMMUNITY CHOICE OPTIONS (OCCO)
Does this client have a Medicaid Managed Health Care (HMO): [ ] Yes\* [ ] No
\*If so, date of disenrollment from HMO:
Does this client have Supplemental Security Income (SSI): [ ] Yes\*\* [ ] No
\*If so, indicate the date that the Special Program Code was entered:

Please call this office at \_\_\_\_\_, if you have any questions.

Name of OCCO FOM or PACE Administrator (Print) Signature

- c: [ ] Participant
[ ] Contact Person
[ ] Care Management Site
[ ] AL/AFC Provider
[ ] PACE Provider Organization
[ ] OCCO File