New Jersey Department of Human Services
Division of Aging Services
PO Box 807
Trenton, NJ 08625-0807

PACE PARTICIPANT VOLUNTARY WITHDRAWAL

To: ☐ Northern OCCO Office
☐ Southern OCCO Office

Date: _____

From: _____ Phone: _____
(Print Participant Name)

_____ _____
(Address) (City, State, Zip Code)

Medicaid Number: _____ Social Security Number: _____

I am no longer interested in receiving PACE services. I have decided to withdraw for the reason/s indicated:

- ☐ The services offered by the program do not meet my needs.
- ☐ I want to receive services in an appropriate institutional setting of my choice (an assisted living facility, an adult family care home, a nursing home or a hospice service) that does not contract with my PACE program.
- ☐ I wish to be enrolled in another program. I understand that I will continue to receive services through the PACE program until disenrollment occurs.
- ☐ Other: _____

I have been counseled on the benefits for which I may be eligible and which meet my needs. I understand that I may reapply for the PACE program at any time by contacting the PACE provider directly.

_____ _____
(Participant Signature) (Date)

_____ _____
(Witness Signature) (Date)