

# PACE Referral Form



Organization Name: \_\_\_\_\_

Name of person completing form: \_\_\_\_\_

Your contact information for follow up: \_\_\_\_\_

On this date, (mm/dd/yyyy) \_\_\_\_\_, the following individual has authorized me to forward along his/her contact information to and requests to be contacted by the CalOptima Health PACE Intake staff to learn more about the CalOptima Health PACE program:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Cell/other: \_\_\_\_\_

E-mail: \_\_\_\_\_

This individual is a (please check one):

- Prospective PACE participant
- Family member/caregiver
- Referral source (organization name) \_\_\_\_\_
- other: \_\_\_\_\_

Preferred language: \_\_\_\_\_

Preferred method of contact: \_\_\_\_\_

Please fax your referral to: **714-954-2210** or scan and email to: **PACEintake@caloptima.org**.

Please direct any further questions to the PACE general line at **714-468-1100** or to the PACE Intake Department

Intake Team	Direct Line
Arlene Martinez	714-824-1269
Gaby Sanchez	714-380-2865
Andy Tran	714-602-0598
Martha Vargas	714-309-3430