Comagine Health

Oregon Behavioral Health Support Program

Request for Oregon Behavioral Health Personal Care Attendant (BH PCA) Services

Form CH-010: BH PCA Referral

This form may be used to refer an individual for OBHSP Behavioral Health Personal Care Attendant (BH PCA) services (reference **OAR 410-172-0790**). To be eligible for BH PCA services, an individual must demonstrate the need for assistance from a qualified provider due to a disabling behavioral health condition. Please fill out all the fields and include documentation that might assist in determining eligibility. If you are completing this form for yourself, please complete to the best of your knowledge/ability.

Please send completed requests to Comagine Health via one of the following methods:

Fax: 877-575-8309

Secure email:
BHPCAsupport@comagine.org

Mail: Comagine Health – OBHSP
650 NE Holladay St., Suite 1700
Portland, OR 97232

Please include a copy of the following supporting documentation if applicable (*denotes required):

- ☐ Mental health diagnosis (any documentation that states the consumer has a mental health diagnosis)
- ☐ Any available documentation demonstrating the need for assistance with personal care services (i.e. mental health assessment, treatment plan, therapy/case manager progress notes, physician/medical doctor notes etc.)
- ☐ Legal guardianship paperwork (if applicable)*

Please acknowledge the following:

- ☐ The individual does not receive in-home care support through DD or APD programs.
- ☐ The individual does not currently live in an assisted living facility, group home, or other congregate care setting.
- ☐ The individual is capable of making their own behavioral health care decisions as defined by OAR 410-172-0600 and 410-172-0775.

    - ☐ If the individual is not capable of doing so, an authorized representative has been identified:

      Name and contact information:

☐ The individual is capable of performing the essential responsibilities of the PCA employer-employee relationship as defined by OAR 410-172-0600 and 410-172-0775.

☐ If the individual is not capable of doing so, a consumer-employer representative has been identified:

Name and contact information:

Individual Information:

Individual Name:

DOB: Medicaid ID: SSN:

Phone: Email:

Physical Address:

Diagnosis (DSM 5/ICM 10 [if known]):

Legal guardian Information:

☐ Individual does not have a legal guardian.

Guardian Name:

Relationship to Individual:

Phone: Email:

Physical Address:

Mailing address (if different than physical address):

Provider Information:

Mental Health Provider or Referring Agency Name: _____

Provider or Agency Direct Contact Name & Title: _____

Provider or Agency Phone: _____ Email: _____

Address: _____

Fax: _____

PCA Provider Information:
PCAs cannot be a spouse, legal guardian or authorized representative. If a PCA has not been identified, Comagine Health can provide resources to support the process of finding and hiring a PCA. Comagine Health cannot assign a PCA to an individual seeking services. If a prospective PCA has been identified but is not officially registered as a PCA, Comagine Health can provide guidance about completing this process. Please contact **888-416-3184** and ask for a member of the PCA team for support.

☐ **PCA has not yet been identified. (If no PCA has been identified, skip to the next page.)**

PCA Name (First, Middle Initial, Last): _____

DOB: _____ SSN: _____

Phone: _____ Email (required): _____

Physical/mailing address: _____

Provider Number: _____

PCA provider eligibility verification:

☐ Authorized to work in the US.

☐ The PCA is not the individual's spouse, authorized representative or other legally responsible representative.

☐ Approved notice of final fitness determination (submitting approval notice email is acceptable).

Date of approval: _____ *(must be within the past 2 years)*

This referral is being submitted by:

- ☐ The community mental health provider
- ☐ The individual
- ☐ The individual's legal guardian
- ☐ Other (please include contact information):

Reason for referral:

By signing below, I acknowledge that I have reviewed this application with the individual and they have consented to this referral. If this is a self-referral, by signing below, I acknowledge that I consent to these services.

Signature	Printed Name & Title/Relationship to Individual	Date

Please provide ALL information listed above to Comagine Health BH PCA Team for a timely determination of program eligibility.

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