

Oregon Independent and Qualified Agent (IQA) and Related Services

Plan of Care Authorization

Plan of Care Request for Behavioral Health Residential or Personal Care Services

Form CH-006: PA-BH-Res-PCS

Please submit this form to request an initial determination, change in condition assessment and annual redetermination for 1915(i) Home and Community Based Services (HCBS). Comagine Health is responsible for notifying providers 60 days prior to the end date of the current service authorization and request annual redetermination documentation.

SRTF Medical Necessity/Medical Appropriateness approval is required prior to Plan of Care Authorization.

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

Fax: 877-575-8309

Secure email:

ORBHSupport@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/Behavioral Health Assessment signed by Qualified Mental Health Professional (QMHP) within one year of service start date for current authorization*
- ☐ Residential Care Plan and/or Treatment Plan which must address all the BH individual's service needs dated within one year of the authorization start date*
- ☐ Progress Notes *AFH, RTH, RTF (60 days from submission)
- ☐ Progress Notes *SRTF (most recent 90 days)
- ☐ Progress Notes*Change in Condition/Status (30+ days)
- ☐ Legal Guardianship/Authorized Representative Documentation (if applicable)
- ☐ Risk Management Plan (for identified risks i.e., suicide, choking, fall, elopement, etc.)

☐ Conditional Release/Community Evaluation for individuals involved with Psychiatric Security Review Board (PSRB)

☐ APD/DD license (for all APD/DD placements)

☐ Incident Reports (if applicable)

☐ Nursing Delegation Form(s) CH-011 and supporting documentation (if applicable)

☐ Signed Consent for Release of Information and Participation in the Oregon Behavioral Health Support Program (signed by legal guardian/authorized representative if applicable)

Individual/Member Information

Last Name: _____ First Name: _____

Date of Birth: _____ Primary ICD-10 Diagnosis Code: _____

Medicaid ID (prime number): _____

Current Legal Status (select one):

☐ Voluntary ☐ Voluntary by Guardian ☐ Civil Commitment ☐ PSRB ☐ 370 Aid and Assist

Legal Guardian/Authorized Representative Information (if applicable):

Name: _____

Relationship to Individual: _____

Address: _____

Phone: _____

Email Address: _____

Request Information:

This request is for (select one):

☐ Initial Request (Referral accepted upon admission)

☐ Annual Redetermination (Referral accepted 60 days prior to end of current eligibility/authorization)

☐ Change in Condition Request (Requires a significant change in acuity lasting 30+ days)

Original Admission Date for the current placement setting (if applicable): _____

Managed Care Enrollment Status:

☐ Coordinated Care Organization (CCO): _____

☐ Fee-for-service (FFS)

Requesting/Submitting Provider or Individual:

Name: _____

MCD Number (if applicable): _____ Phone Number: _____

Email Address: _____ Fax Number: _____

Referring Provider/County of Responsibility (if different than requesting/submitting provider)

Name: _____

MCD Number: _____ Phone Number: _____

Email Address: _____ Fax Number: _____

Treating/Rendering Provider (N/A if independent living and no current provider):

Name: _____

MCD Number: _____ Phone Number: _____

Email Address: _____ Fax Number: _____

Procedure Code (select one):

- ☐ T1020 Person Care Services, in OHA licensed Residential Treatment Program, per diem

Placement Setting (select one):

- ☐ Residential Treatment Home (RTH)
- ☐ Residential Treatment Facility (RTF)
- ☐ Young Adults in Transition RTH
- ☐ Young Adults in Transition RTF
- ☐ Secure Residential Treatment Facility

- ☐ S5141 Habilitation Services, Adult Foster Home, per month.

Placement Setting (select one):

- ☐ Behavioral Health (BH) Adult Foster Home (AFH)
- ☐ Aging and People with Disabilities (APD) AFH
- ☐ APD Residential Care Facility (RCF)
- ☐ APD Assisted Living Facility (ALF)
- ☐ Intellectual / Developmental Disabilities (I/DD) AFH
- ☐ I/DD Group Home (GH)

- ☐ Not Applicable (N/A)

Placement Setting (select one):

- ☐ Independent Living
- ☐ Psychiatric Acute Care Hospital
- ☐ Oregon State Hospital (OSH)

Modifiers (select all that apply):

- ☐ HK Fee-for-service (FFS) / residential facility-based rate – requires prior authorization
- ☐ HE Mental health residential program, 5 - 16 residents (when billed with T1020)
- ☐ HW 1915(i) Home and Community Based Services (HCBS)
- ☐ TG Mental health Secure Residential Treatment Facility (SRTF) or home (when billed with T1020)
- ☐ N/A

Requested Dates of Service (N/A for independent living/Psychiatric acute care/OSH):

From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

Care Coordinator/s, if assigned (Ex. ENCC, CCO/FFS Care Coordinator, Residential Specialist)

Name: _____

Role: _____ Phone Number: _____

Email Address: _____

Name: _____

Role: _____ Phone Number: _____

Email Address: _____