Comagine Health

Oregon Behavioral Health Support Program CH-002

Discharge Notification for Behavioral Health Services

Review the information at the top of the page regarding when to utilize this form. This form must be completed in its entirety.



650 NE Holladay St, Suite 1700
Portland, Oregon
Phone: 888-416-3184
Fax: 877-575-8309

Comagine Health
www.comagine.org/obhsp

Oregon Behavioral Health Support Program

Form CH-002: Discharge Notification for Behavioral Health Services

Please complete and submit this form to Comagine Health whenever an individual moves out of an adult foster care or residential treatment program for behavioral health services. Do not complete this form when an individual goes away for a brief time (e.g., a family visit, hospitalization, or respite).

Please tell us about the individual who is moving out of the residential program. For the primary provider contact, tell us the name and telephone number of the best person to contact with questions related to this discharge. This is typically the case manager, program manager, or county residential specialist.

Please submit prior authorization (PA) requests via MMIS.

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

Fax: 1-877-575-8309 Secure email: ORBHSupport@comagine.org Mail: Comagine Health – OBHSP
650 NE Holladay St., Suite 1700
Portland, OR 97232

Individual and Program Information

Individual name: _____ Medicaid ID: _____

Individual phone number: _____ Individual Diagnosis (DSM 5 or ICD 10): _____

Legal Guardian Name: _____

Relationship to Individual: _____ Legal Guardian Phone:_____

Legal Guardian Address: _____

(Please attach Guardian documentation, if applicable)

Residential provider name: _____ Provider number: _____

Primary provider contact (name): _____ Phone number: _____

Level of care (select one):

- ☐ Adult foster home
- ☐ Residential treatment home
- ☐ Residential treatment facility
- ☐ Secure residential treatment facility

Comagine Health

- List the consumer's full name and Medicaid ID as it appears in their Medicaid profile.
- List the consumer's Diagnosis (DSM 5 or ICD 10)





If the consumer has a Legal Guardian, please indicate their information here

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List the provider's name and phone number



Check the box that indicates the consumer's placement at discharge

Comagine Health

Review the information in this section to determine the date of discharge

Check the box that indicates the reason the consumer discharged

If evicted, houseless, left without notice, or other is selected, please provide the reason/explanation

Please provide all known information for discharge location and/or point of contact

Comagine Health

Discharge Information

The date of discharge is the last billable day that the individual was in your program.

- A billable day is when the individual was in the home at midnight that night.
- If a person moves out before midnight, then last billable day is the day prior to move-out day.

Date of discharge: _____

Reason for discharge (select only one reason that best describes why the individual has left):

- ☐ Admitted for long-term hospitalization (please complete Discharge to information below)
- ☐ Deceased
- ☐ Evicted (please complete Discharge to information below)
  - Reason for Eviction: _____
- ☐ Homeless
  - Please Explain: _____
- ☐ Left without notice
  - Please Explain: _____
- ☐ Transitioned to a lower level of residential care (please complete Discharge to information below)
- ☐ Transitioned to independent setting (please complete Discharge to information below)
- ☐ Transitioned to supportive housing (please complete Discharge to information below)
- ☐ Other
  - Reason for discharge: _____

Discharge to Information

Discharge to location: _____

Location name: _____

Address: _____

Contact person: _____ Contact phone #: _____

Save as | Print | Clear form

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Comagine Health

Once the form is complete, please submit by email, fax, or mail.

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Mail: 650 NE Holladay St. Suite 1700, Portland, OR 97232