Comagine Health

Oregon Behavioral Support Program CH-012

OSH Initial Determination for 1915i services for Forensic Status Individuals

This form is only for those who are residing at Oregon State Hospital. Please contact the forensic patient's OSH social worker for information on 1915(i) assessment referral

All required documentation must be included before the referral can be processed

Comagine Health

Oregon Behavioral Health Support Program

Request for OSH Initial Determination for 1915(i) Services for Forensic Status Individuals

Form CH-012

*Please submit this form to request an initial determination for 1915i services at least **14 days** prior to scheduling a 1915(i) assessment.*

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

Fax: 877-575-8309

Secure email: OSHTeam@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):

- ☐ Psychosocial Assessment signed by Qualified Metal Health Professional (QMHP) within one year of service start date for current authorization *
- ☐ Treatment Plan which must address all the BH consumer's service needs dated within one year of the authorization start date *
- ☐ RN ADL/Functional Needs Assessment *
- ☐ Clinical Hospital Level of Care Assessment *
- ☐ Legal Guardianship Paperwork (if applicable) *
- ☐ Progress Notes (most recent 60 days, psychiatry, nursing, group, etc.) *
- ☐ Risk Management Plan (for identified risks i.e., suicide, choking, fall, elopement, etc.)
- ☐ Community Living Assessment Referral (if applicable)
- ☐ Seclusion Reports (if applicable)

Individual/Member Information

Last Name: _____ First Name: _____

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

Medicaid ID (prime number if known): _____

Legal Status: ☐ 370 Aid and Assist ☐ PSRB

Guardian Information

Legal Guardian Name: _____

Relationship to Individual: _____

Legal Guardian Address: _____

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Form CH-012: OSH
Revised June 27, 2022

This form and supporting documentation is submitted by OSH team members

Complete all sections of this form, if there are areas that don't apply to the patient, please enter N/A

Comagine Health

Legal Guardian Phone: _____

Legal Guardian Email Address: _____

Request Information

☐ 1915(i) assessment ☐ Pre-1915(i) assessment APD/DD rate screening (*excludes DD AFH)*

Level of Care (select one, if known): ☐ AFH ☐ RTH ☐ RTF ☐ SRTF ☐ DD AFH ☐ DD Group Home

☐ APD AFH ☐ APD RCF ☐ APD Assisted Living Facility (ALF) ☐ Independent Living

The IQA is required to check-in with the consumer and the provider within 30 days of discharge from OSH. Upon review, if the consumer's service needs or status has changed since discharge, the IQA will conduct a re-assessment, which may result in a rate adjustment.

Expected Admission Date to Residential Program (MM/DD/YYYY) if known: _____

ENCC Name: _____ Phone Number: _____

ENCC Email: _____

Aid & Assist or PSRB Liaison/Coordinator Name: _____ Phone Number: _____

Aid & Assist Liaison/Coordinator Email: _____

OSH Social Worker Name: _____ Phone Number: _____

OSH Social Worker Email: _____

Resource Coordinator Name: _____ Phone Number: _____

Resource Coordinator Email: _____

Other Treatment Team Members:

Name: _____ Title: _____

Email: _____ Phone Number: _____

Name: _____ Title: _____

Email: _____ Phone Number: _____

Is the individual/guardian aware this referral is being submitted on their behalf? ☐ Yes ☐ No

If No, please explain: _____

SIGNATURES

By signing below, the staff completing the form have reviewed the above services and recommend them for this member.

_____	_____	_____
Signature	Name and Title	Date

Provider/Staff Submitting Form

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1915(i) assessment review will be completed for all behavioral health patients once admitted to a community placement or by referral if living independently

Include any other member of the treatment team

An answer to this question is required. If "no," an explanation must be provided

Signature is required to process referral

Comagine Health

Comagine Health

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

Email: ORBHSupport@comagine.org

Fax: 877-575-8309

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