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

Request for Oregon Mental Health Benefits – Qualification Determination

Form CH-001: Benefit Referral

This form may be used to refer an individual for OBHSP Services, including 1915(i), non-1915(i), non-Medicaid, or State Plan Personal Care (SPPC PC 20) services. If you are not sure which program you qualify for, please fill out all the fields and include documentation that might assist in making the eligibility determination.

Required documentation for each program is listed. If you are not eligible for 1915(i) or non-1915(i) services, you will be evaluated for SPPC services.

Please submit prior authorization (PA) requests via MMIS.

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

Fax from (name): _____

Date: _____ Number of pages: _____

Residential Facility Name: _____

Facility Address: _____

Facility Phone: _____ Facility Fax #: _____

Facility Contact Person: _____

Level of Care: ☐ RTH/RTF ☐ AFH ☐ SRTF ☐ TAY ☐ Home ☐ Other

Mental Health Provider or Referring Agency: _____

Provider or Referring Agency Address: _____

Provider or Referring Agency Phone: _____ Provider or Agency Fax: _____

Provider or Referring Agency Contact Person:

_____

Individual Name: _____ Individual DOB: _____

Individual Medicaid ID: _____ Individual Phone: _____

Individual Address: _____

Individual Diagnosis (DSM 5/ICD 10) _____

Legal Guardian Name: _____

Relationship to Individual: _____

Legal Guardian Address: _____

Legal Guardian Phone: _____

Please attach guardian documentation, if applicable.

Please designate which program, if known, this referral is for:

☐ 1915(i) Initial Referral

☐ Non-1915(i) Initial Referral

☐ Non-Medicaid Initial Referral

☐ State Plan Personal Care (SPPC PC 20)

☐ Unknown/Other

Please provide ALL information listed below to Comagine Health OBHSP in order for a timely determination of program qualification. All records must be received before a determination can be completed. Please double check all items are included before transmission.

Save as Print Clear form

Required Documentation

1915(i):

- Admission assessment including DSM – 5 Diagnoses
- Most recent Mental Health Assessment and Treatment Plan
- Most recent Care Plan for ADLs if different from Treatment Plan
- Documentation of daily care provided for the past week
- Physician notes
- Any additional clinical information supporting the need for 1915(i) HCBS
- For initial eligibility determination, an LSI may be provided by the facility/program (LSI-AFH-CH-004 or LSI-Res-CH-005)

Non-1915(i):

- Admission assessment including DSM – 5 Diagnoses

- Most recent Mental Health Assessment and Treatment Plan
- Most recent Care Plan for ADLs if different from Treatment Plan
- Documentation of daily care provided for the past week
- Physician notes
- Any additional clinical information supporting the need for non-1915(i) services
- For initial eligibility determination, an LSI may be provided by the facility/program (LSI-AFH-CH-004 or LSI-Res-CH-005)
- For SRTF, documentation that supports:
    - The individual does not require 24-hour hospital care and treatment.
    - The individual requires highly structured environmental supports and supervision seven days a week and 24 hours a day in order to participate successfully in a program of habilitative and rehabilitative activities.
    - Due to a mental illness and as evidenced by clinical documentation from the last 90 days or from an Authority-approved and standardized risk assessment conducted within the past year, the individual presents a risk in one of the following areas:
        - Clear intention or specific acts of bodily harm to others.
        - Suicidal ideation with intent, or self-harm posing significant risk of serious injury.
        - Inability to care for basic needs that results in exacerbation or development of a significant health condition, or the individual's mental health symptoms impact judgment and awareness to the degree that the individual may place themselves at risk of imminent harm.
        - Due to the symptoms of a mental illness, there is significant risk that the individual will not remain in a place of service for the time needed to receive the services and supports necessary to stabilize the symptoms of a mental illness that pose a threat to the individual's safety and well-being.

Non-Medicaid:

- Admission assessment including DSM – 5 Diagnoses
- Most recent Mental Health Assessment and Treatment Plan
- Most recent Care Plan for ADLs if different from Treatment Plan
- Documentation of daily care provided for the past week
- Physician notes
- Any additional clinical information supporting the need for requested services
- For initial eligibility determination, an LSI may be provided by the facility/program (LSI-AFH-CH-004 or LSI-Res-CH-005)

State Plan Personal Care Services (SPPC PC 20):

- Any available documentation demonstrating the need for assistance with personal care and supportive services
- If available, please include the following completed DHS forms:
    - Form 531 - SPPC: 20-Hour Service Plan
    - Form 531A - Medicaid Personal Care Assessment
      Form 549 - Mental Health PC 20 Program Employee/Provider(s) Information