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

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 #: _____

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