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 Behavioral Health Personal Care Attendant (BH PCA) Services

Form CH-010: BH PCA Referral

This form may be used to refer an individual for OBHSP Behavioral Health Personal Care Attendant (BH PCA) services (reference **OAR 410-172-0790**). To be eligible for Behavioral Health Personal Care Attendant services, an individual must demonstrate the need for assistance from a qualified provider due to a disabling behavioral health condition with personal care services and meet the eligibility criteria. Please fill out all the fields and include documentation that might assist in determining eligibility. If you are completing this form for yourself, please complete to the best of your knowledge/ability.

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: _____

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:

_____

Provider or Provider or Referring Agency Contact Email: _____

_____ _____ _____

Referring Provider Signature Name and Title Date

Individual Name: _____ Individual DOB: _____

Individual Medicaid ID: _____ Individual Phone: _____

Individual Email Address: _____

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:

☐ Behavioral Health Personal Care Attendant (BH PCA)

☐ Unknown/Other

PCA Provider Information

If you have selected a PCA provider, please input the PCA Provider information below:

Last name: _____ First name: _____ MI: _____

Phone number: _____ Date of birth: _____ SSN: _____

Mailing address: _____

City, State, ZIP: _____

Provider number: _____

PCA provider eligibility verification

☐ 1) Authorized to work in the US.

☐ 2) The PCA provider is not the individual's spouse or another legally responsible relative.

☐ 3) Approved Notice of Final Fitness Determination (submitting Approval Notice email is acceptable).

Date of approval: _____ *(must be within the past two years)*

☐ 4) List any physical, environmental, financial, and/or medical restrictions:

_____

_____

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.

Required Documentation

- Most recent progress notes
- Mental health diagnosis
- Any available documentation demonstrating the need for assistance with personal care and supportive services

If you do not have these records, Comagine can obtain these for you**. Please fill out and submit a Release of Information (ROI)**.

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