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-009: SRTF Criteria Checklist (Based on OAR 410-172-0720(7))

Please submit prior authorization 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

Please complete this form to request an authorization for the individuals who will be transitioning to an SRTF. The Independent and Qualified Agent (IQA) will review this request and process it for the individual staying at the identified facility.

Date:

Individual's Name:

Individual's Birthdate:

Medicaid Number:

Individual's Current Living Situation:

For admission to SRTF, the following are required: 1a, 2b, and 2c.

1. Does the individual require *less than* 24 hours a day of acute hospital care and treatment?
   a. ☐ Yes – go to question #2
   b. ☐ No – **Stop, Deny**

2. The individual requires highly structured environmental supports and supervision 24 hours a day, 7 days a week in order to participate successfully in a program of habilitative and rehabilitative activities.
   a. ☐ No – **Stop, Deny**
   b. ☐ Yes – Attach or enter evidence, then go to Question 3
   c. Evidence: (required)

3. Due to a mental illness, and as evidenced by clinical documentation from the last 90 days, or from an OHA-approved and evidence-based risk assessment, risk is present in one of the following areas: *Need one of these: a, or b, or c; requires proof.*
    a. ☐ Clear intention or specific acts of bodily harm to others
    b. ☐ Suicidal ideation or self-injury requiring significant medical intervention
    c. ☐ Inability to care for basic needs that results in exacerbation or development of a significant health condition, or the individual's mental health
    d. ☐ Impact judgement and awareness to the degree that the individual may place themselves at risk of imminent harm

4. Due to the symptoms of a mental illness, there is significant risk that the person will not remain in a place of service for the time needed to receive the services and supports necessary to resolve the symptoms of a mental illness that pose a threat to the person's safety and well-being. (Requires Proof)
    a. ☐ No – Stop, Deny
    b. ☐ Yes – Provide evidence
    c. Evidence (required)

The following situations require a Class I SRTF.
Documentation proof is required. If documentation is present, then the SRTF admission or stay is approved.

1. The individual is under an involuntary medication order.
   Proof: A current involuntary medication order.
   Reference to the order in chart notes in NOT adequate proof.

2. The individual has orders for seclusion and/or restraints, if needed.
   Proof: A current order for seclusion and/or restraint.
   Reference to the order in chart notes is NOT adequate proof.

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