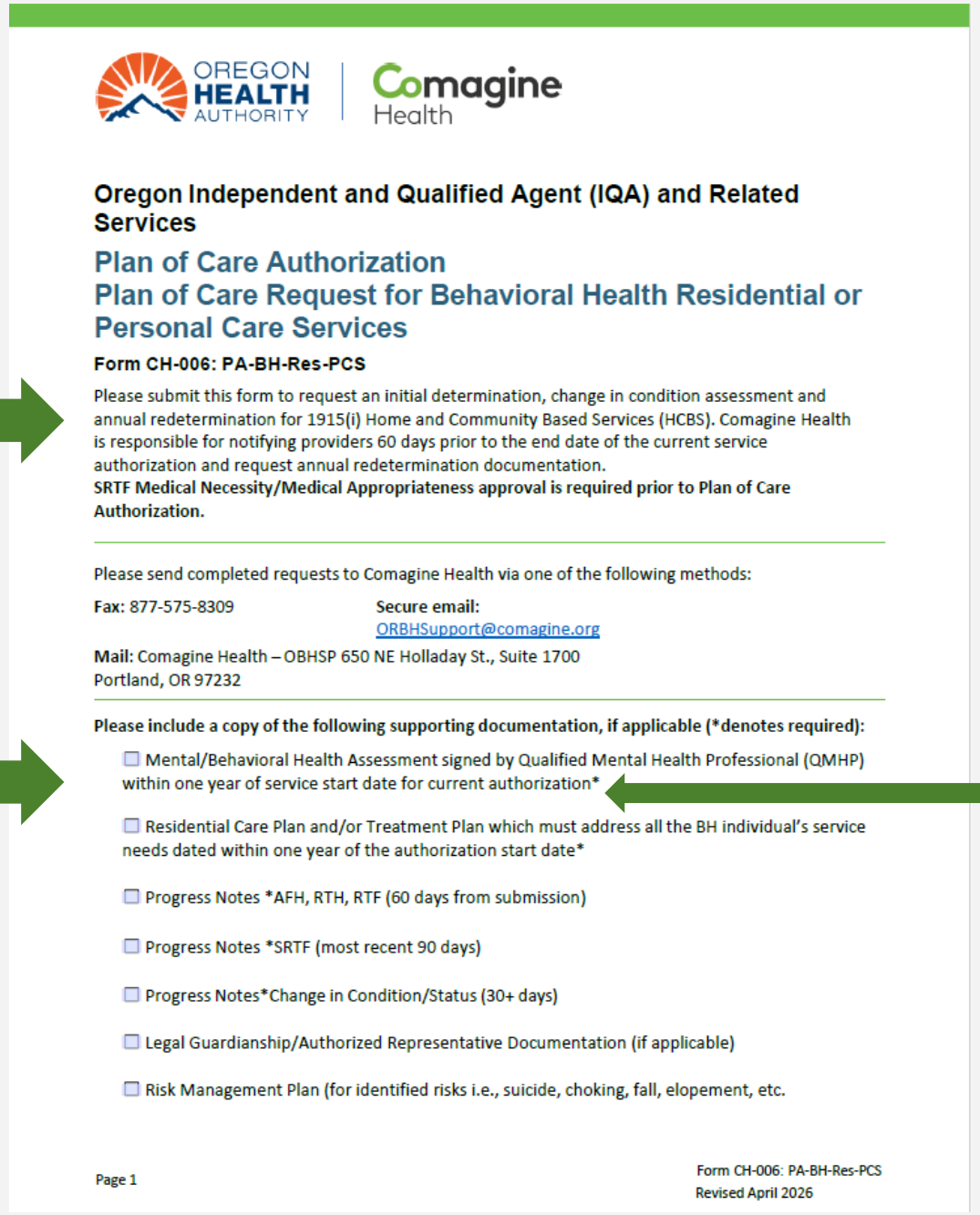
Comagine™ HEALTH

Oregon Behavioral Health Support Program CH-006

Plan of Care Request

Review the information at the top of the page. This form must be completed in its entirety.

Check boxes for applicable supporting documentation that is being submitted along with the referral form (CH-006).



OREGON HEALTH AUTHORITY | Comagine Health

Oregon Independent and Qualified Agent (IQA) and Related Services

Plan of Care Authorization
Plan of Care Request for Behavioral Health Residential or Personal Care Services

Form CH-006: PA-BH-Res-PCS

Please submit this form to request an initial determination, change in condition assessment and annual redetermination for 1915(i) Home and Community Based Services (HCBS). Comagine Health is responsible for notifying providers 60 days prior to the end date of the current service authorization and request annual redetermination documentation.
SRTF Medical Necessity/Medical Appropriateness approval is required prior to Plan of Care Authorization.

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 include a copy of the following supporting documentation, if applicable (*denotes required):

- ☐ Mental/Behavioral Health Assessment signed by Qualified Mental Health Professional (QMHP) within one year of service start date for current authorization*
- ☐ Residential Care Plan and/or Treatment Plan which must address all the BH individual's service needs dated within one year of the authorization start date*
- ☐ Progress Notes *AFH, RTH, RTF (60 days from submission)
- ☐ Progress Notes *SRTF (most recent 90 days)
- ☐ Progress Notes*Change in Condition/Status (30+ days)
- ☐ Legal Guardianship/Authorized Representative Documentation (if applicable)
- ☐ Risk Management Plan (for identified risks i.e., suicide, choking, fall, elopement, etc.

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Form CH-006: PA-BH-Res-PCS
Revised April 2026

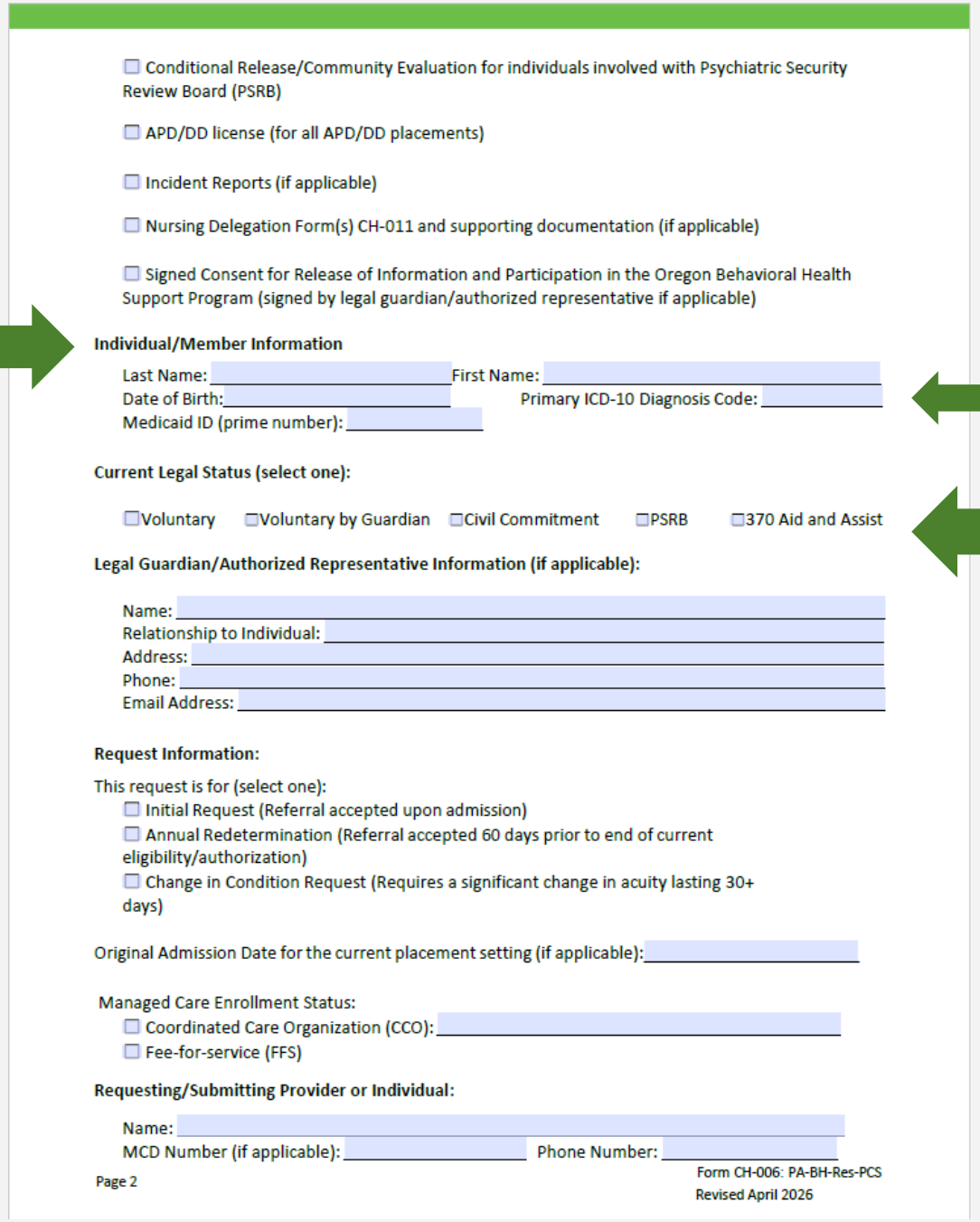
The CH-006 form is required to request an initial determination, change in condition assessment and annual redetermination for 1915(i) services.

Supporting documentation with an asterisk is required. Missing required documentation may result in a delay of processing the request.

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Individual's information must match their Medicaid Profile. A new form will be requested if there are any discrepancies.

If the individual has a Legal Guardian or Authorized Representative, please indicate their information here and submit a copy of the Legal Guardianship or Authorized Representative paperwork with the referral.



☐ Conditional Release/Community Evaluation for individuals involved with Psychiatric Security Review Board (PSRB)

☐ APD/DD license (for all APD/DD placements)

☐ Incident Reports (if applicable)

☐ Nursing Delegation Form(s) CH-011 and supporting documentation (if applicable)

☐ Signed Consent for Release of Information and Participation in the Oregon Behavioral Health Support Program (signed by legal guardian/authorized representative if applicable)

Individual/Member Information

Last Name: _____ First Name: _____
Date of Birth: _____ Primary ICD-10 Diagnosis Code: _____
Medicaid ID (prime number): _____

Current Legal Status (select one):

☐ Voluntary ☐ Voluntary by Guardian ☐ Civil Commitment ☐ PSRB ☐ 370 Aid and Assist

Legal Guardian/Authorized Representative Information (if applicable):

Name: _____
Relationship to Individual: _____
Address: _____
Phone: _____
Email Address: _____

Request Information:

This request is for (select one):
☐ Initial Request (Referral accepted upon admission)
☐ Annual Redetermination (Referral accepted 60 days prior to end of current eligibility/authorization)
☐ Change in Condition Request (Requires a significant change in acuity lasting 30+ days)

Original Admission Date for the current placement setting (if applicable): _____

Managed Care Enrollment Status:
☐ Coordinated Care Organization (CCO): _____
☐ Fee-for-service (FFS)

Requesting/Submitting Provider or Individual:

Name: _____
MCD Number (if applicable): _____ Phone Number: _____

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List the individual's primary ICD-10 diagnosis code.

Check the appropriate box to indicate if the individual was admitted Voluntary, Voluntary by Guardian, Civil Commitment, PSRB, or 370 Aid and Assist.

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☐ Conditional Release/Community Evaluation for individuals involved with Psychiatric Security Review Board (PSRB)

☐ APD/DD license (for all APD/DD placements)

☐ Incident Reports (if applicable)

☐ Nursing Delegation Form(s) CH-011 and supporting documentation (if applicable)

☐ Signed Consent for Release of Information and Participation in the Oregon Behavioral Health Support Program (signed by legal guardian/authorized representative if applicable)

Individual/Member Information

Last Name: _____ First Name: _____
Date of Birth: _____ Primary ICD-10 Diagnosis Code: _____
Medicaid ID (prime number): _____

Current Legal Status (select one):

☐Voluntary ☐Voluntary by Guardian ☐Civil Commitment ☐PSRB ☐370 Aid and Assist

Legal Guardian/Authorized Representative Information (if applicable):

Name: _____
Relationship to Individual: _____
Address: _____
Phone: _____
Email Address: _____

Request Information:

This request is for (select one):
☐ Initial Request (Referral accepted upon admission)
☐ Annual Redetermination (Referral accepted 60 days prior to end of current eligibility/authorization)
☐ Change in Condition Request (Requires a significant change in acuity lasting 30+ days)

Original Admission Date for the current placement setting (if applicable): _____

Managed Care Enrollment Status:
☐ Coordinated Care Organization (CCO): _____
☐ Fee-for-service (FFS)

Requesting/Submitting Provider or Individual:

Name: _____
MCD Number (if applicable): _____ Phone Number: _____

Form CH-006: PA-BH-Res-PCS
Revised April 2026

Check the appropriate box to identify if the referral is for an initial request, annual redetermination, or a change in condition.

Please refer to the Medicaid Management Information System (MMIS) and/or the individual's insurance card for CCO details.

Please note the timeline for when documents can be submitted.

Date of initial admission.

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☐ Conditional Release/Community Evaluation for individuals involved with Psychiatric Security Review Board (PSRB)

☐ APD/DD license (for all APD/DD placements)

☐ Incident Reports (if applicable)

☐ Nursing Delegation Form(s) CH-011 and supporting documentation (if applicable)

☐ Signed Consent for Release of Information and Participation in the Oregon Behavioral Health Support Program (signed by legal guardian/authorized representative if applicable)

Individual/Member Information

Last Name: _____ First Name: _____
Date of Birth: _____ Primary ICD-10 Diagnosis Code: _____
Medicaid ID (prime number): _____

Current Legal Status (select one):

☐ Voluntary ☐ Voluntary by Guardian ☐ Civil Commitment ☐ PSRB ☐ 370 Aid and Assist

Legal Guardian/Authorized Representative Information (if applicable):

Name: _____
Relationship to Individual: _____
Address: _____
Phone: _____
Email Address: _____

Request Information:

This request is for (select one):

☐ Initial Request (Referral accepted upon admission)
☐ Annual Redetermination (Referral accepted 60 days prior to end of current eligibility/authorization)
☐ Change in Condition Request (Requires a significant change in acuity lasting 30+ days)

Original Admission Date for the current placement setting (if applicable): _____

Managed Care Enrollment Status:

☐ Coordinated Care Organization (CCO): _____
☐ Fee-for-service (FFS)

Requesting/Submitting Provider or Individual:

Name: _____
MCD Number (if applicable): _____ Phone Number: _____

List the name of the requesting provider (entity requesting services-community mental health provider, county etc.) and MCD number (Provider ID number issued by Oregon Health Authority).

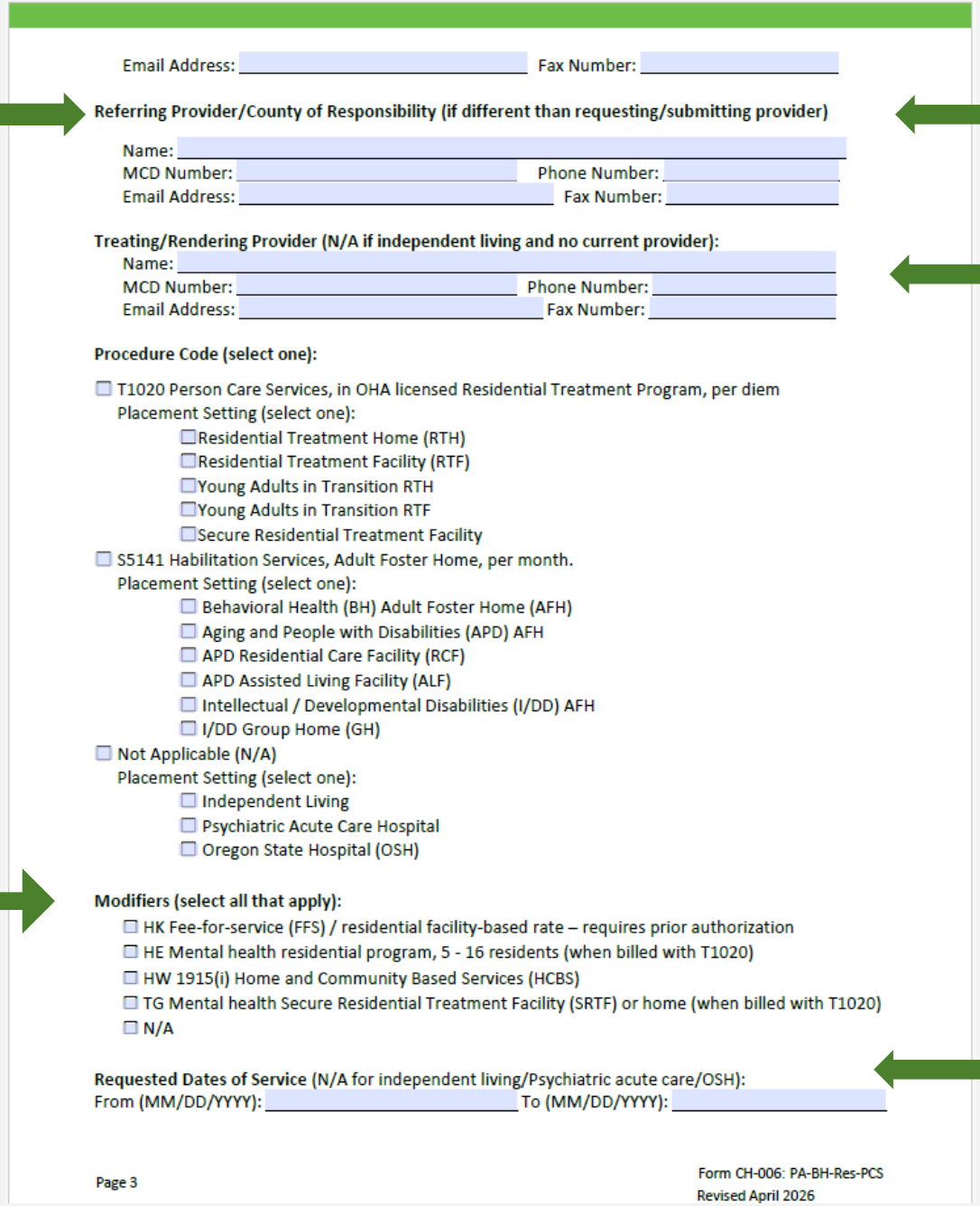
List provider contact information including phone number, email address, and fax number (if applicable).

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List the name of the referring provider (Entity requesting services- Community Mental Health Provider, County etc.) and MCD number (Provider ID number issued by the Oregon Health Authority).

Check the box indicating the correct procedure code and subsequent placement setting. If the individual is in independent living, psychiatric acute care, or Oregon State Hospital check N/A.

Check box(s) for all applicable modifiers. Modifiers are not applicable for independent living, psychiatric acute care, or Oregon State Hospital.



Email Address: _____ Fax Number: _____

Referring Provider/County of Responsibility (if different than requesting/submitting provider)

Name: _____
MCD Number: _____ Phone Number: _____
Email Address: _____ Fax Number: _____

Treating/Rendering Provider (N/A if independent living and no current provider):

Name: _____
MCD Number: _____ Phone Number: _____
Email Address: _____ Fax Number: _____

Procedure Code (select one):

☐ T1020 Person Care Services, in OHA licensed Residential Treatment Program, per diem
Placement Setting (select one):
- ☐ Residential Treatment Home (RTH)
- ☐ Residential Treatment Facility (RTF)
- ☐ Young Adults in Transition RTH
- ☐ Young Adults in Transition RTF
- ☐ Secure Residential Treatment Facility

☐ S5141 Habilitation Services, Adult Foster Home, per month.
Placement Setting (select one):
- ☐ Behavioral Health (BH) Adult Foster Home (AFH)
- ☐ Aging and People with Disabilities (APD) AFH
- ☐ APD Residential Care Facility (RCF)
- ☐ APD Assisted Living Facility (ALF)
- ☐ Intellectual / Developmental Disabilities (I/DD) AFH
- ☐ I/DD Group Home (GH)

☐ Not Applicable (N/A)
Placement Setting (select one):
- ☐ Independent Living
- ☐ Psychiatric Acute Care Hospital
- ☐ Oregon State Hospital (OSH)

Modifiers (select all that apply):

- ☐ HK Fee-for-service (FFS) / residential facility-based rate – requires prior authorization
- ☐ HE Mental health residential program, 5 - 16 residents (when billed with T1020)
- ☐ HW 1915(i) Home and Community Based Services (HCBS)
- ☐ TG Mental health Secure Residential Treatment Facility (SRTF) or home (when billed with T1020)
- ☐ N/A

Requested Dates of Service (N/A for independent living/Psychiatric acute care/OSH):
From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

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County of Responsibility: County responsible for coordinating care.

List the name of the rendering provider (provider delivering service), and the MCD number.

List the requested dates of service. POC date range is concurrent with the last POC approval. Any request submitted more than 90 days after the last POC end date (and meant to be concurrent with previous POC approval period) is considered a Retro Authorization.

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Any additional team members who assist in coordinating care for the individual.



Care Coordinator/s, if assigned (Ex. ENCC, CCO/FFS Care Coordinator, Residential Specialist)

Name: _____

Role: _____ Phone Number: _____

Email Address: _____

Name: _____

Role: _____ Phone Number: _____

Email Address: _____

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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