Comagine Health

Oregon Behavioral Health Support Program

Request for OSH Initial Determination for 1915(i) Services for Forensic Status Individuals

Form CH-012

*Please submit this form to request an initial determination for 1915i services at least **14 days** prior to scheduling a 1915(i) assessment.*

Please send completed requests to Comagine Health via one of the following methods:

Fax: 877-575-8309

Secure email:
OSHTeam@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):

- ☐ Psychosocial Assessment signed by Qualified Metal Health Professional (QMHP) within one year of service start date for current authorization *
- ☐ Treatment Plan which must address all the BH consumer's service needs dated within one year of the authorization start date *
- ☐ RN ADL/Functional Needs Assessment *
- ☐ Clinical Hospital Level of Care Assessment *
- ☐ Legal Guardianship Paperwork (if applicable) *
- ☐ Progress Notes (most recent 60 days, psychiatry, nursing, group, etc.) *
- ☐ Risk Management Plan (for identified risks i.e., suicide, choking, fall, elopement, etc.)
- ☐ Community Living Assessment Referral (if applicable)
- ☐ Seclusion Reports (if applicable)

Individual/Member Information

Last Name: _____ First Name: _____

Date of Birth: _____ Primary ICD-10 Diagnosis Code: _____

Medicaid ID (prime number if known): _____

Legal Status: ☐ 370 Aid and Assist ☐ PSRB

Guardian Information

Legal Guardian Name: _____

Relationship to Individual: _____

Legal Guardian Address: _____

Legal Guardian Phone: _____

Legal Guardian Email Address: _____

Request Information

1915(i) assessment Pre-1915(i) assessment APD/DD rate screening (*excludes DD AFH)*

Level of Care (select one, if known): AFH RTH RTF SRTF DD AFH DD Group Home

APD AFH APD RCF APD Assisted Living Facility (ALF) Independent Living

The IQA is required to check-in with the consumer and the provider within 30 days of discharge from OSH. Upon review, if the consumer's service needs or status has changed since discharge, the IQA will conduct a re-assessment, which may result in a rate adjustment.

Expected Admission Date to Residential Program (MM/DD/YYYY) if known: _____

ENCC Name: _____ Phone Number:_____

ENCC Email:_____

Aid & Assist or PSRB Liaison/Coordinator Name:_____Phone Number: _____

Aid & Assist Liaison/Coordinator Email:_____

OSH Social Worker Name:_____ Phone Number:_____

OSH Social Worker Email: _____

Resource Coordinator Name:_____Phone Number:_____

Resource Coordinator Email:_____

Other Treatment Team Members:

Name:_____ Title:_____

Email:_____Phone Number:_____

Name:_____ Title:_____

Email:_____Phone Number:_____

Is the individual/guardian aware this referral is being submitted on their behalf? Yes No

If No, please explain: _____

SIGNATURES

By signing below, the staff completing the form have reviewed the above services and recommend them for this member.

_____	_____	_____
Signature	Name and Title	Date
Provider/Staff Submitting Form		

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