Portland, OR
www.comagine.org/obhsp
Phone: 888-416-3184
Fax: 877-575-8309

Oregon Behavioral Health Support Program

Form CH-009: Secure Residential Treatment Facility (SRTF) Medical Necessity/ Medical Appropriateness Review Referral

OAR 410-172-0720(7)

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 a medical necessity/medical appropriateness review for pre-admission/ concurrent stay in a secure residential treatment facility. The Independent and Qualified Agent (IQA) will make a medical necessity/medical appropriateness determination based on referral information and supporting documentation.

Unless otherwise indicated, all information on this form is required.

Suggested Documentation (as applicable)*

- Mental/Behavioral Health Assessment signed by a Qualified Mental Health Professional (QMHP) that identifies current symptoms and behaviors
- Psychiatric Assessment
- Nursing Assessment
- Treatment plan that addresses the individual's current behavioral health support needs
- Conditional Release/Community Evaluation for individual's involved with Psychiatric Security Review Board
- Progress notes (daily clinical, nursing, psychiatric, etc.) from most recent 90 days
- Risk Management Plan (for identified risks; i.e., suicide, elopement, violence)
- Incident reports
- Medication Administration Records (MAR)
- Involuntary Medication Order (required for class I SRTF)

Date:

Individual Information

***Name:** ***Date of birth:**

***Address:**

***Medicaid ID #:**

***Legal Status:** ☐ Civil Commitment ☐ Voluntary by Guardian ☐ Voluntary
☐ PSRB ☐ Aid & Assist

***Guardian name (if applicable):**

Guardian email: Guardian phone number:

Guardian address:

***Individual's current placement/residence:**

Facility/program name (if applicable):

Facility/provider email address:

Facility/provider mailing address:

Facility/provider phone number:

***Referring Provider Information:**

Name/Title:

Email: Phone number:

Facility/County Name:

Facility/County MCD #:

***Exceptional Needs Care Coordinator (if known):**

Name:

County:

Email: Phone number:

***County of Responsibility:**

SRTF Admission information (if applicable):

Program Name: Date of anticipated admission:

***Requested Dates of Service (for concurrent stay review):** to

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***Please provide documentation to support all information provided below.**

1. The individual does not require 24-hour hospital care and treatment.
   - A. ☐ Yes – go to question #2.
   - B. ☐ **No – Stop, please review OAR 410-172-0720(7)(a).**

2. The individual requires highly structured and secured 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. ☐ Yes – Attach supporting documentation; proceed to question #3.
   - B. ☐ **No – Stop, please review OAR 410-172-0720(7)(b).**

3. Due to a mental illness, and as evidenced by clinically documented instances of behaviors displayed within the last 90 days, the individual presents with one or more of the following:
   - A. ☐ Clear intention or specific acts of bodily harm to others.
   - B. ☐ Ideation of suicide with intent and ability if not in a secured environment or of self-harm posing significant risk of serious injury.
   - C. ☐ Inability to care for basic needs that results in worsening or development of a significant health condition, or the individual's mental health symptoms impact judgment and awareness to the degree that the individual may place themselves at risk of imminent harm.
   - D. ☐ 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.
     1. ☐ Yes – One or more of the above are applicable.
     2. ☐ No – Stop, please review OAR 410-172-0720(7)(A-D).

The following circumstances require a Class I SRTF per OAR 309-033-0520(2)

Supporting documentation required.

1. The individual is under an involuntary medication order.
   - A. ☐ Yes
   - B. ☐ No

2. The individual has orders for seclusion and/or restraints, if needed.
   - A. ☐ Yes
   - B. ☐ No

***Please provide a brief description of how a Secure Residential Treatment Facility placement will support the current behavioral health needs of the individual.**

Signature and Date

Signature	Full name	Date

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