

State Managed Services Program



Request Form

VERY IMPORTANT INFORMATION:

- Please read the instructions completely before submitting this request. Instructions can be found on the program website at www.healthoregon.org/hiv . This request must be complete before processing will occur.

Is this a Provider UPDATE to a previously authorized request? Yes No

If "Yes", only complete questions 1, 2, 7 and 8.

1. Client Name: _____

2. Date of Request: _____

3. a. Funding Requested For (a separate request must be submitted for each service requested):

Service Requested	Maximum Benefit	Initial Assessment
<input type="checkbox"/> Dental Services	Based on Local Assessment	A copy of the Services/ Treatment Plan (from the provider listed below) indicating the total charges must be attached. The client will only be authorized for the amount shown on the services plan up to the maximum benefit (with the exception of Dental Services). See the SMS program instructions for more information.
<input type="checkbox"/> Substance Abuse Treatment- Outpatient	\$5000	
<input type="checkbox"/> Substance Abuse Treatment- Residential		
<input type="checkbox"/> Mental Health Services	\$6500	
<input type="checkbox"/> Home Health Care- Professional/Specialized	\$2000	
<input type="checkbox"/> Home Health Care- Paraprofessional		

3. b. I would like to request payment for the initial assessment (Maximum Benefit = \$300) in order to obtain the required treatment/service plan needed to complete this Request Form.

Yes No

I understand that if I mark "Yes" I will receive two service authorization forms, one for the initial assessment and one after the treatment/service plan has been sent in to the SMS program. Services MUST be pre-authorized by the SMS program.

4. If the service requested is for Dental Services please indicate the "Dental Acuity" of the client.

- Level 1 Level 2 Level 3 Level 4

5. Does the client have any form of health insurance? Yes No

If the answer is "Yes" list the insurance provider(s) and indicate whether they will pay a portion of this requested service. *Due to the Mental Health Parity Act mental health and substance use treatment services are covered by most insurance plans. Ryan White funds are the funds of last resort and must be utilized after insurance coverage. Remember- Oregon Health Plan (Medicaid) and Medicare are insurance providers. The Oregon Health Plan will cover Mental Health, Substance Abuse Outpatient and Emergency Dental Services.*

Health Insurance Provider	Do they cover any portion of this service?
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Is there a Federally Qualified Community Health Clinic, Community Health Clinic, Dental Clinic or other community resource in your service area where the client could receive this service?

- Yes No

If the answer is "Yes", AND the service requested is not being performed by this provider, please explain why. _____

7. Complete the contact information for the service provider identified. **Please PRINT LEGIBLY.**

Agency/Health Systems/Clinic Name: _____

Provider/Doctor Name: _____

Provider Address: _____

Phone: _____ Fax: _____

- Yes, this provider **Will** accept VISA® as a form of payment.
 No, this provider **will NOT** accept VISA® as a form of payment.

*If "No", provide the Tax ID number of the provider: _____

8. I have referred to the *HIV Case Management Standards of Service* and the *HIV Case Management and Support Services Program- Program Policies, Services Definitions & Guidance* and have determined that this individual is eligible for the service requested above in item 2. In addition, I have updated my client's *Release of Information* to include the Department of Human Services, HIV Care and Treatment Program and the service provider listed above in item 4 of this request. I understand that SMS services are intended to address emergent needs and further understand that the first invoice must be received within 90 days of the date of the SMS service authorization or the authorization will be cancelled.

HIV Case Manager Name: _____ County _____

Address: _____

Phone: _____

Fax: _____ Email: _____

Signature: _____ Date: _____

DENTAL SERVICE REQUEST ONLY

9. Tier 1 providers must receive approval from the HIV Alliance Clock Tower Dental Clinic Coordinator prior to submitting this application. Tier 1 includes those providers served through the HIV Alliance Clock Tower Dental Clinic. The Clock Tower Dental Clinic provides free comprehensive dental care to persons living with HIV/AIDS in a 15 county area. <http://www.hivalliance.org/dentalclinic.html>
Tier 1: Benton, Coos, Crook, Curry, Deschutes, Douglas, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Linn and Malheur

I have consulted with the above, signed HIV case manager and have reviewed this application. SMS funds are being requested due to the following: the Clock Tower Dental Clinic can not provide all of the needed dental services free of charge and/or the client cannot access the clinic due to extenuating circumstances.

Dental Coordinator Signature: _____ Date: _____

**FAX THIS REQUEST TO DHS
971-673-0177, ATTENTION: SMS**

*Additional forms can be found on the program website at www.healthoregon.org/hiv .