REQUEST FOR LONG TERM PSYCHIATRIC CARE FOR PERSONS AGE 17 AND UNDER

REQUEST	
Child's Name:	Date Received:
Parent/Guardian:	
Address:	Phone:
City: Zip code:	County:
Child's Medicaid Prime No:	Other Insurance:
Mental Health Organization:	DOB:
Current Program:	Admission Date:

REFERRING AGENGY
County/MHO:
Contact Person:
Phone #: Fax #:
Date of Decision: By
Approved: ☐ Denied: ☐

For OHA / AMH completion only
Reviewed by: ☐ John Boyd ☐ Rita McMillan ☐ Nancy Allen
Date of Decision:
Approved: ☐ Denied: ☐
Denial Reason:
☐ SCIP Referral
Determination form faxed to Julia Grzywinski FX: 503-205-0190, PH: 503-205-4371
☐ SAIP Referral
Determination form faxed to Lauralyn Roullier FX: 541-758-7737, PH: 541-750-1124
Should you have any questions please contact either John Boyd at 503-947-5527, email john.w.boyd@state.or.us or Rita McMillan at 503-947-5523, email rita.l.mcmillan@state.or.us.
A Trillium representative will contact your agency regarding admission upon approval.