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| HEALTH SYSTEMS DIVISIONChild and Family Behavioral Health |  |
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Request for Long-Term Psychiatric Care for Persons Age 17 And Under

# Request information

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| Child’s name:      | Date received:      |
| Parent/guardian:      |
| Address:      | Phone:      |
| City      | ZIP code:      | County:      |
| Child’s Oregon Medicaid or Prime ID      | Date of birth      |
| Coordinated care organization (CCO):      | Other insurance:      |
| Current program:      | Admission date:      |

# Referring agency information

|  |  |
| --- | --- |
| County or CCO:      | Contact person:      |
| Phone number:      | Fax number:      |
| Date of review:      | Reviewed by:      |
| Result of review: |
| [ ]  Support referral | [ ]  Recommend alternative:       |
| [ ]  Guardian is aware of the expectation for family participation in the program. |

# For Utilization Management Organization completion only:

|  |  |
| --- | --- |
| Reviewed by:      | Date of decision:      |
| Result of review*:* |
| [ ]  Approved | [ ]  Denied. Reason for denial:  |       |

# For Oregon Health Authority completion only. *If you have questions about this decision, contact Summer Hunker at* *summer.hunker@dhsoha.state.or.us* *or 503-756-8540. If your request is approved, a Trillium representative will contact your agency regarding admission timelines and procedures.*

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| Reviewed by:[ ]  Summer Hunker | [ ]        | Date of decision:      |
| Result of review*:* |
| [ ]  Approved | [ ]  Denied. Reason for denial:  |       |
| [ ]  SCIP Referral | [ ]  SAIP Referral |  |
| [ ]  Determination form faxed to Trillium Family Services |