ADULT FOSTER HOME
INCENTIVE PAYMENT FORM

DHS | Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

Per a Letter of Agreement signed January 20, 2022, between SEIU and the Oregon Department of Administrative Service on behalf of the Oregon Department of Human Services and the Oregon Health Authority, an incentive payment will be made to any adult foster home provider that admits a new individual to their adult foster home directly from a hospital. The incentive payment is independent of the provider's regular rate, whether Medicaid or private payment. The AFH provider must screen the individual to determine if they can meet the individual's care needs. Once accepted, the AFH provider many not involuntarily discharge the individual for at least 90 days from the date of admission to the AFH.

Individual Needing Placement Information	
Name:	Date of Birth:
☐ Individual has Medicaid Medicaid Number ☐ Private Pay ☐ Individual has other Insurance? Type: ☐ Other:	
Date of Admission to Hospital:	Date of Discharge to AFH:
Hospital:	
Individual's Previous Living Situation : Home ☐ LTC Facility ☐ Houseless ☐ Other ☐ If Other, explain:	
Did the individual agree to foster home placement? Yes ☐ No ☐ If the individual is unable to agree to foster home placement, was a legal representative involved? Yes ☐ No ☐ If no to both questions, who made the decision?	

Male ☐ **Female** ☐	
☐ **American Indian and Alaska Native**	☐ **Native Hawaiian and Pacific Islander**
☐ **Asian**	☐ **Middle Eastern or Northern African**
☐ **Black/African American**	☐**White**
☐ **Latinx/Hispanic**	☐ **Other** ______________

What language or languages spoken?:
Is there difficulty communicating or being understood by others? ☐ **Yes** ☐ **No**
If Yes, please list:
Does the patient have other Disabilities? ☐ **Yes** ☐**No**
If Yes, please list:

Adult Foster Home Information		
Tax ID:	Medicaid Number:	License Number
Provider Name:	Name of Home:	
Phone:	Email:	
Address:		

By signing this form, you attest that the following is true:

- A screening of the individual is complete and I am willing and able to provide the needed level of care.
- This individual is being discharged from a hospital after an admission to that hospital.
- This individual was not a resident of your home prior to admitting to the hospital.
- You will continue to serve this individual for at least 90 days from the date of admit to your home.
- You will follow all licensing and compliance requirements including the discharge process as defined in administrative rules.

Email the completed form to: HCBS.Oregon@dhsoha.state.or.us

Signature of Provider	Date
Printed Name	

Adult foster home licensee or provider will be required to refund the payment amount if admission is found to not qualify for the incentive. Adult foster home incentive payments are subject to audit at the discretion of the Department.

DHS/APD Use Only	For OFS
Date Received: **Date Initial Payment:** **Date Final Payment:** **Reviewed and Approved By:**	**Amount Authorized:** **PCA: 39093** **Index: 33930** **AOBJ: 7927** **MMIS Reason Code: 3008**