Medicaid Services and Supports Intake Process Guide

Updated: Aug. 11, 2026

Contents

Purpose

To ensure all intake referrals are processed consistently, timely, and in accordance with program eligibility and assessment requirements.

Step one: Initial contact attempt

Upon receipt of a referral or request for Long-Term Services and Supports (LTSS):

1. Attempt initial contact within **three business days**.
2. Make a total of **three contact attempts** on separate dates within the first week.
3. Document all contact attempts in the Intake Module.

If the individual does not respond

Determine whether a designated representative (Rep.) is identified.

If no Rep. exists

1. Send form 4234 and Request for Information or Verification.
2. Include a response due date of **10 business days**.
3. Send a No Contact Letter if the individual has not responded to contact attempts.
4. Wait for response through the **45th day** from application/referral.

If a Rep. exists

1. Contact the Rep. using the same outreach process.

Document all attempts and outcomes in the Intake Module.

Step two: Response received

If the individual or Rep. responds

Proceed with the Intake process.

If no response is received by day 45

1. Send Form 540, for 'failure to participate in assessment' decision notice.
2. Narrate all outreach efforts.
3. Close the intake.

Note: If the individual or Rep. never agreed to pursue LTSS, the Intake should be closed and no 540 is required.

Step three: Verify interest in LTSS

Determine whether the individual wishes to pursue LTSS.

If the individual declines services

1. Document the declination.
2. Close the intake.

If the individual previously requested services but later withdraws

1. Send form 540 (see APD-PT-23-006).
2. Document the withdrawal request.
3. Close the Intake and mark it as withdrawn.

If the individual wishes to proceed

Continue with assessment activities.

Step four: Complete assessment requirements

Required Actions

1. Conduct the Functional Needs Assessment in CA/PS.

Reminder: If individual does want to apply for services, CM must complete the Service Options Counseling Tool at the assessment.

2. Determine the Service Priority Level (SPL).

Important: SPL determination must be completed before the 45th day whenever possible.

If additional time is needed:

1. Request an extension from a supervisor.
2. Ensure appropriate documentation is entered to prevent incorrect system-generated notices.

Step five: SPL 14-18 and/or 99 (SPPC/EWE/OPI-M)

SPL 14–18

Proceed with LTSS eligibility review.

SPL 99

1. Complete the assessment.
2. Send SPAN requesting denial language.
3. Issue appropriate denial notice.
4. Document and close intake

Step six: Determine LTSS eligibility

Is the individual eligible for LTSS?

Yes

Proceed to financial eligibility review.

No

Evaluate for alternative programs.

Alternative program review

SPPC eligibility

- Must be an OHP recipient at the time of application.

If not eligible:

1. Send denial notice using SPAN language indicating the individual is not eligible for SPPC.
2. Offer OPI-M, if appropriate.

OPI-M Consideration

Review eligibility based on age and program criteria.

Step seven: Financial eligibility determination

Financially eligible

Proceed with service authorization and planning.

Not financially eligible

1. Send Form 540 stating:
   "Meets SPL criteria but is not financially eligible."
2. Narrate eligibility findings.
3. Close the Intake and Oregon ACCESS (OA) case.

Financial eligibility not yet determined

Place services in pending status until determination is completed.

Step eight: Special program considerations

Under age 65 / OPI-M Applicant

Review for OPI-M eligibility and proceed according to program requirements.

Medicaid Mental or Emotional Disorders Review (MED) required

Complete review and document MED determination.

Step nine: Evaluate service need

Determine whether service needs are primarily:

Physical-need driven

1. Develop service plan.
2. Authorize services as appropriate.
3. Complete all required documentation.

Mental health, emotional, or substance use disorder driven

1. Document findings.
2. Send Form 540 indicating:
   "Service needs are related to mental, emotional, or substance use disorder."
3. Close the case, if LTSS criteria are not met.

Step ten: Service authorization

When all eligibility criteria are met:

1. Develop service plan.
2. Authorize services.
3. Complete required notices and documentation.
4. Enter case narration.
5. Establish ongoing case management activities.

Intake closure checklist

Before closing an intake, verify:

- [ ] Required contact attempts completed
- [ ] Rep. contacted (if applicable)
- [ ] Notices sent and documented
- [ ] CA/PS completed (if applicable)
- [ ] SPL determined
- [ ] Financial eligibility reviewed
- [ ] Alternative programs offered when required
- [ ] Narration completed
- [ ] Appropriate closure notice issued

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Aging and People with Disabilities at apd.ltss@odhs.oregon.gov or 503-945-5600. We accept all relay calls.

OREGON DEPARTMENT OF
Human Services

Aging and People with Disabilities
Medicaid Services and Supports
500 Summer St. NE, E-10
Salem, OR 97301-1076
503-945-5600
odhs.info@odhs.oregon.gov
www.oregon.gov/odhs