Information Memorandum Transmittal
Aging and People with Disabilities

Erika Miller
Authorized signature

Number: APD-IM-22-109
Issue date: 10/31/2022
UPDATED: 12/21/2022
Due date:

Topic: Long Term Care

Subject: Discharge Incentive Payment Program

Applies to (*check all that apply*):

- ☐ All DHS employees
- ☒ Area Agencies on Aging: Type B
- ☒ Aging and People with Disabilities
- ☐ Self Sufficiency Programs
- ☒ County DD program managers
- ☒ Support Service Brokerage Directors
- ☐ ODDS Children's Residential Services
- ☐ Child Welfare Programs
- ☒ County Mental Health Directors
- ☐ Health Services
- ☒ Office of Developmental Disabilities Services (ODDS)
- ☐ ODDS Children's Intensive In Home Services
- ☐ Stabilization and Crisis Unit (SACU)
- ☒ Other (*please specify*): OHA HSD

This IM is being updated to reflect an adjustment to the IHCA hour requirement from 35 hours a week to 25 hours a week, starting 12/19/2022.

Message:
Due to the ongoing hospital and (skilled) nursing facility (SNF/NF) capacity concerns, the Oregon Legislature approved the Oregon Department of Human Services (ODHS) and Oregon Health Authority (OHA) providing a discharge incentive of $5,000 to any Adult Foster Home (AFH) provider or Residential Care Facility (RCF) that admits a new individual directly from hospitals or SNF/NF between Nov. 1, 2022, and Apr. 30, 2023. Incentive payments are also available to qualifying* In-Home Care Agencies (IHCA) that begin providing in-home services to a new individual directly from a hospital or SNF/NF between the same dates, Nov. 1, 2022, and Apr. 30, 2023, as long as the individual receives Medicaid services through APD.
See* ***IHCA-Specific Requirements* *section, below*

Eligible Providers

- AFHs licensed through APD, Office of Developmental Disabilities Services (ODDS), the Oregon Health Authority (OHA) and Multnomah County; and Adult Group Homes licensed through ODDS
- Residential Care Facilities (RCF) licensed through APD
- Qualifying In-Home Care Agencies (IHCA) licensed through OHA

AFH-Specific and RCF-Specific Requirements

- Incentive payments are independent of the provider's regular rate, whether Medicaid or private pay.
- The incentive applies for any individual admitted directly from a hospital or SNF/NF to an AFH or RCF for residency between 11/01/22 - 04/30/23. For each new direct-from-hospital-admission and direct-from-NF-admission (excluding individuals boarded or seen in the emergency department), the AFH/RCF may request $2,000 after initial admission, and $3,000 after the individual has been in the AFH/RCF for 90 days. The date the individual must move into the AFH/RCF must be between 11/01/22 - 04/30/23.
- If a move-out notice is issued, the AFH/RCF must provide a copy of the notice to their local licensing authority, including the reason for the involuntary discharge, and email APD at: hcbs.oregon@odhsoha.oregon.gov. In this case, the AFH/RCF will not be eligible to receive the second payment;
- If the individual voluntarily moves to another setting or passes away prior to 90 days from the date of admission, the AFH/RCF must notify APD by emailing: hcbs.oregon@odhsoha.oregon.gov and include the reason the individual is no longer living there. The AFH/RCF may still receive the second payment.

IHCA-Specific Requirements

- "Qualifying IHCA" means a IHCA that has a valid Medicaid provider enrollment agreement.
- Incentive payments are independent of the direct care services being authorized to IHCAs for regular reimbursement.
- The individual must be receiving Medicaid services through APD.
- The individual must need a minimum of ~~35~~ **25** hours per week of services from the IHCA.
- For each new direct-from-hospital or SNF/NF individual for whom the IHCA begins providing services, the IHCA may request $2,000 after the individual begins receiving services, and $3,000 after the individual has received services for 90 days. The individual must have begun receiving services from the IHCA between 11/01/22 - 04/30/23.
- Within 72 hours of referral, and prior to discharge from the hospital or SNF/NF, the IHCA must:
    - Complete an assessment

    - Establish a discharge date within five business days of the assessment
    - Develop a plan to begin on the date of discharge
- At discharge from the hospital or SNF/NF, the IHCA must ensure:
    - Providers are in place
    - Prescriptions are obtained
    - Durable medical equipment is in place or ordered
    - A signed, dated service plan is in place showing that the hours assigned will meet identified ADL and IADL care needs

Incentive Criteria
- Providers must:
    - Screen the individual in the hospital or SNF/NF to ensure they can meet the individual's care needs;
    - Follow all other licensing, compliance, and program requirements, as defined in Oregon Administrative Rules;
    - Not have restrictions on their license for admissions are not eligible for the incentive payment.
- Individuals must be discharging directly from a hospital or SNF/NF from an admitted status. (i.e., individuals boarded or seen in the emergency department are not eligible)
- By signing the Incentive Payment Request form, Providers attest that they will:
    - Refer to their Provider Alert for program requirements.
    - Refund the incentive payment(s) if it is later found that the provider does not qualify for the incentive payment(s). All discharge payments are subject to audit at the discretion of ODHS.
- Assisted Living Facilities (ALF), as well as OHA-licensed Residential Treatment Homes (RTH) and Residential Treatment Facilities (RTF), do not qualify for this program.

Payments Generally
- Payments are issued from APD Central Office. ODHS and OHA will communicate directly with providers about the incentive payments and the process for requesting payments. Local offices will <u>not</u> be responsible for approving or processing these payments. Each provider has the opportunity to receive up to two incentive payments for each individual who discharges directly from a hospital or SNF/NF.
- Payment requests must be made using the approved form(s) and emailed to APD at: hcbs.oregon@odhsoha.oregon.gov.

Incentive Payments Allowed
- For AFHs licensed by APD, ODDS and OHA's Health Systems Division, and Adult residential group homes licensed by ODDS. Incentive payments are applicable for

all individuals, regardless of payer source (e.g., Medicaid, privately paid, etc.);

- For RCFs licensed by ODHS and are applicable for all individuals, regardless of payer source;
- For IHCA licensed by OHA with a valid Medicaid provider enrollment agreement, and are eligible for individuals receiving Medicaid;
- Independent of the rate and independent of payer source, including, Medicaid, PACE, private pay and other providers;
- When an individual voluntarily does one of the following within 90 days from discharging from the hospital or SNF/NF, the provider must notify APD by emailing: hcbs.oregon@odhsoha.oregon.gov with the reason for the change:
    - Moves to a different residential setting (one not owned by the same corporate entity/Licensee's facility as the current provider), or
    - Changes IHCA (one not owned by the same corporate entity), or
    - Passes away.

  In these scenarios, the initial provider may still receive the second incentive payment.

Initial (or first) Payment - $2,000

- The provider has 30 days from the date the individual discharged from the hospital or SNF/NF to request the first payment. [Example: We can refer to the attached resource, "Discharge Incentive Payment Program Date Calculator" to see the date by which the provider must submit the request for payment. If the individual discharged on 11/01/22 (Column A), and the provider has 30 days after that, this provider must request their first payment by 12/01/22 (Column B).]
- Upon receipt of that request, APD will confirm the consumer and provider meet the above criteria. Within 10 days of receiving an appropriate request, APD will ask the Office of Financial Services (OFS) to issue a payment.

Subsequent (or second) Payment - $3,000

- The provider has 30 days from the 90th day after discharging from the hospital or SNF/NF to request the second payment. [Using the above example and the same attachment, where the individual discharged from the hospital on 11/01/22 (Column A), we locate 90 days from discharge, which is 01/30/23 (Column C). The provider has 30 days after that 90th day to request the second payment, or by 03/01/23 (Column D).]
- For AFH/RCF:
    - When the individual has been with the provider for 90 days, the provider may request the second payment.
    - Upon receipt of that request, APD will confirm the consumer and provider meet the above criteria. Within 10 days of receiving an appropriate request, APD will ask the Office of Financial Services (OFS) to issue a payment;
- For IHCA-only:
    - When the individual has been receiving services from the IHCA for 90 days,

the IHCA may request the second payment along with Electronic Visit Verification (EVV) records for each of the individual's In-Home Care Workers for the first 90 days of care.
    - Upon receipt of both that request and the EVV records, APD will review the EVV records and confirm the consumer and provider meet the above criteria. Within 10 days of receiving an appropriate request, APD will ask the Office of Financial Services (OFS) to issue a payment.

Note: The number of providers participating in this incentive program may be large, so providers will need to allow time for payments to process. If payment has not been received within 30 days of when it was requested, the provider may email APD at: hcbs.oregon@odhsoha.oregon.gov

Incentive Payments Not Allowed

- Incentive payments are not allowed for readmissions.
    - The individual cannot have lived at the AFH or Licensee's facility (RCF), or have been receiving services from the IHCA, prior to their admission to the hospital or SNF/NF from which they are now discharging;
    - If an individual readmits to a hospital or SNF/NF within the first 90 days, and:
        - Discharges back to the same AFH/RCF, or begins receiving services from the same IHCA, as the one who received the initial incentive payment. This is a resident readmission and is excluded;
        - Chooses a new AFH, RCF or IHCA upon discharge. The new provider cannot request or receive another initial incentive payment for the individual if the new provider is owned by the same corporate entity/Licensee's facility as the initial provider. This is a resident readmission and is excluded.
- If the provider begins the involuntary move-out process (AFH/RCF), or termination of services without the individual's consent (IHCA), within the first 90 days, the provider must notify APD at: hcbs.oregon@odhsoha.oregon.gov, and include the reason for this action. In this case, the provider will not be eligible to receive the second incentive payment. AFHs will still need to email a copy of the notice to the local licensing authority, as is current practice. RCFs will also need to email a copy of the notice to their SOQ Policy Analyst at: soq.transfers@odhsoha.oregon.gov.
- If the individual moves out (AFH/RCF), or stops receiving services from the provider (IHCA), prior to 90 days because their needs were not being met, or if it is later determined that the provider's staff did not meet the individual's needs, the provider must refund/return the incentive payment(s);
- If Adult Protective Services (APS) becomes involved due to a failure on the part of the provider toward the individual, and APS confirms or substantiates that failure, the provider must refund/return any incentive payment(s) already received. The provider will not be eligible to receive any incentive payment(s).

Application Instructions for Providers (i.e., how to request payment)

- Providers must fill out the Discharge Incentive Payment Form that accompanies this Provider Alert; then submit it to APD by emailing: hcbs.oregon@odhsoha.oregon.gov
- Instructions for the forms are in the process of being translated into other languages; if needed, request one at: hcbs.oregon@odhsoha.oregon.gov

Individuals Receiving Medicaid Services through APD

For individuals receiving Medicaid Long Term Services and Supports, APD Central Office staff will narrate in Oregon ACCESS when their provider requests an incentive payment. When a Case Manager or other involved person becomes aware that an individual received an involuntary move-out notice (AFH/RCF), or notice of termination of services (IHCA), email that information to APD Central Office at hcbs.oregon@odhsoha.oregon.gov; include a copy of the notice, if available, and the reason for move-out/termination.

Provider Alerts with Budget Note

AFH, RCF and IHCA providers received a Provider Alert with the details of this program. The Alert includes the Legislative E-board Budget Note directing this work.

Please see the associated Provider Alert (AFH Provider Alert included) and Letter of Agreement (AFH-only) for more information. Also included are forms, instructions for the forms, and a Discharge Date Calculator which may be used by providers to locate key dates (e.g., 30 days from date of discharge). Forms, instructions and the Date Calculator will be posted online for providers (*Links to documents will be posted on RCF and APD-AFH Provider/SOQ webpages; IHCA posting location to be determined*).

If you have any questions about this information, contact:

Contact(s): HCBS Oregon	
Phone:	Fax:
Email: hcbs.oregon@odhsoha.oregon.gov	

Adult Foster Home Provider Alert

Policy updates, rule clarifications and announcements

Date: October 31, 2022

To: Adult Foster Home Providers (APD, ODDS, HSD)

From: ODHS Aging and People with Disabilities (APD) Safety, Oversight and Quality Unit; ODHS Office of Developmental Disabilities Services (ODDS) and OHA Health Systems Division (HSD)

Topic: **Letter of Agreement: Hospital and Nursing Facility Discharge Incentive**

To: All Adult Foster Homes (AFH)
Subject: Discharge Incentive Payment Program to Assist with Hospital and (Skilled) Nursing Facility (SNF/NF) Bed Shortage

Due to the ongoing hospital and SNF/NF capacity concerns, the Oregon Legislature approved the Oregon Department of Human Services (ODHS) and Oregon Health Authority (OHA) providing a discharge incentive of $5,000 to any AFH provider that admits a new individual to their home directly from a hospital or SNF/NF between Nov. 1, 2022, and Apr. 30, 2023. ODHS partnered with SEIU Local 503 to offer the incentive. Incentive payments are also being offered to Residential Care Facilities (RCF), ODDS Intellectual/Developmental Disabilities (I/DD) residential group homes, HSD Adult Foster Homes, and qualifying In-Home Care Agencies (IHCA). Incentive payments are independent of the provider's regular rate, whether Medicaid or private pay.

ODHS APD is administering this program and will be requesting the Office of Financial Services (OFS) process the incentive payments, even if the individual is enrolled with ODDS or HSD services or if the AFH is licensed by ODDS or HSD. HSD Residential Treatment Homes/Facilities are excluded from this program.

Please see below for criteria to qualify for this incentive.

Incentive Criteria

- The incentive is applicable for any individual admitted directly from a hospital or SNF/NF to an AFH for residency between 11/01/22 - 04/30/23.
- The individual must be discharging directly from a hospital or SNF/NF from an admitted status (individuals boarded or seen in the emergency department are not eligible).
- The AFH must screen the individual in the hospital or SNF/NF to ensure they can meet the individual's care needs.
- Discharge incentive payments are for AFHs/AGHs licensed APD, ODDS, and HSD, and are applicable for all individuals, regardless of payer source (e.g., Medicaid, privately paid, etc.).
- The AFH must not have a restriction on the license for admissions to qualify for the incentive payment.
- The AFH must follow all other licensing, compliance and program requirements as defined in administrative rules.
- The individual cannot have lived at the AFH prior to his/her admission to the hospital or SNF/NF from which he/she is now discharging.
- If a move-out notice is issued, the AFH must provide a copy of the notice to their local licensing authority, including the reason for the involuntary discharge, and email ODHS at: hcbs.oregon@odhsoha.oregon.gov. In this case, the AFH will not be eligible to receive the second payment.
- If the individual voluntarily moves to another setting or passes away prior to 90 days from the date of admission, the AFH must notify ODHS by emailing: hcbs.oregon@odhsoha.oregon.gov and include the reason the individual is no longer living there. The AFH may still receive the second payment.
- An individual who readmits to the hospital or SNF/NF during the first 90 days from initial discharge has the right to return to the AFH upon discharge. However, if the individual chooses a new AFH, owned by the same corporate entity as the initial AFH, the AFH cannot request or receive another first incentive payment for the individual. Resident readmissions are excluded.
- If the individual moves out of the AFH prior to 90 days because his/ her needs were not being met, or if it is later determined that the AFH staff did not meet the individual's needs, the AFH must refund/return the second incentive payment.

- If Adult Protective Services (APS) becomes involved due to a failure on the part of the AFH toward this individual, and APS confirms or substantiates that failure, the AFH must refund/return the second incentive payment.

Payments

Payment requests must be made using the approved form(s) and emailed to ODHS at: hcbs.oregon@odhsoha.oregon.gov

Initial (or first) Payment - $2,000

- The AFH has 30 days from the date the individual discharged from the hospital or SNF/NF to request the first payment. [Example: We can refer to the attached resource, "Discharge Incentive Payment Program Date Calculator" to see the date by which the provider must submit the request for payment. If the individual discharged on 11/01/22 (Column A), and the provider has 30 days after that, this provider must request their first payment by 12/01/22 (Column B).]
- Upon receipt of that request, ODHS will confirm the consumer and provider meet the above criteria. Within 10 days of receiving an appropriate request, ODHS will ask OFS to issue a payment.

Subsequent (or second) Payment - $3,000

- The AFH has 30 days from the 90th day after discharging from the hospital or SNF/NF to request the second payment. [Using the above example and the same attachment, where the individual discharged from the hospital on 11/01/22 (Column A), we locate 90 days from discharge, which is 01/30/23 (Column C). The provider has 30 days after that 90th day to request the second payment, or by 03/01/23 (Column D).]
- When the individual has been with the AFH for 90 days, the AFH may request the second payment.
- Upon receipt of that request, ODHS will confirm the consumer and provider meet the above criteria. Within 10 days of receiving an appropriate request, ODHS will ask OFS to issue a payment.

The number of providers participating with this incentive program is large, so allow time for payments to process. If you have not received payment within 30 days, notify ODHS by emailing: hcbs.oregon@odhsoha.oregon.gov

Application Instructions

Fill out the Discharge Incentive Payment Form that accompanies this Provider Alert and submit it by emailing it to ODHS at: hcbs.oregon@odhsoha.oregon.gov

If you have questions, please contact hcbs.oregon@odhsoha.oregon.gov

September 2022 Legislative Budget Note directing this work:

#27
Oregon Department of Human Services
Streepey

The second strategy proposed by ODHS is a discharge incentive payment to providers to take clients from hospitals. This strategy was implemented from January 2022 to March 2022, ODHS provided a $10,000 incentive to Adult Foster Homes (AFH) that could accept discharged patients from hospitals. During the two-month operational period of this incentive, 264 placements were made. Many of the individuals were discharged on hospice and/or had very complex medical conditions. As a result, 41% of placements did not remain in the AFH beyond 90 days. ODHS is proposing to expand the placement options beyond AFH's to including foster homes under the ODHS Office of Developmental Disabilities Services and OHA's Health Services Division, as well as residential care facilities and in-home care agencies. With this proposal, the incentive payment is reduced from $10,000 to $5,000. The program is estimated to last six months with a cost of $4.2 million General Fund, $6 million total funds. According to ODHS, the prior AFH incentive payment allowed providers to serve individuals with higher acuity. Providers were able to use the incentive payments to hire staff to serve the higher acuity individuals for the period of time the individual had higher needs.

Letter of Agreement
Adult Foster Home - Hospital and Nursing Facility Decompression Discharge Incentives

This Agreement is made by and between the State of Oregon, hereinafter referred to as "the State", through the Department of Administrative Services (DAS), the Oregon Department of Human Services, (ODHS) and the Oregon Health Authority (OHA) hereinafter known as "the State" and the Service Employees International Union (SEIU) Local 503, OPEU hereinafter referred to as "the Union" and jointly hereafter referred to as "the Parties".

The Parties acknowledge the capacity crisis which currently exists with Oregon hospitals and nursing facilities and the increasing number of individuals facing discharge delays. OHA-ODHS has determined to partner with Adult Foster Home Providers and to establish an incentive to Providers who admit new individuals to their Adult Foster Home directly from a hospital or (skilled) nursing facility (SNF/NF).

Accordingly, the Parties agree as follows:

1. For any individual admitted directly from a hospital or SNF/NF to an Adult Foster Home for residency between November 1, 2022, and April 30, 2023, the Adult Foster Home may request an initial payment of $2,000, within thirty (30) days of admission to the Adult Foster Home. Ninety (90) days after the date of admission, the Adult Foster Home may request a subsequent payment of $3,000, within thirty (30) days of the '90-days after the date of admission' to the Adult Foster Home. Each payment request must be submitted using the ODHS approved form.

2. The Provider must screen the individual in the hospital or SNF/NF to ensure the individual's care needs can be met. The Provider will be accountable to all applicable OARs.

3. The Provider may not request payment for an individual who lived at an Adult Foster Home prior to being in the hospital or SNF/NF from which they are now discharging. Re-admissions to the Adult Foster Home are excluded.

4. Individual must be discharging from a hospital from an admitted status (not boarded in or seen in Emergency Departments). The incentive payment applies to all licensing types (ODHS Aging and People with Disabilities (APD), ODHS Office of Developmental Disabilities Services (ODDS) and OHA Behavioral Health Services (BH) and is eligible for all individuals, regardless of payer status (Medicaid/Medicare/Private/LTC insurance).

5. The State will submit payment requests to the ODHS Office of Financial Services (OFS) within ten (10) business days from the date the Adult Foster Home submitted the payment request. The payment will be made in one of two ways: (1) EFT, if the Adult Foster Home is already set up for EFT; otherwise, (2) The payment will be sent via US Mail in the form of a paper check. Payments are typically processed within 10-20 days, depending on OFS's workload.

6. This payment is independent of the Provider's regular rate as provided for in the Parties' Collective Bargaining Agreement or the rate that the Adult Foster Home charges private pay individuals.

7. The Adult Foster Home will not receive the second payment if an involuntary move-out notice is given to the individual during the 90 days from date of admission.

8. An individual who readmits to the hospital or SNF/NF during the first 90 days from initial discharge has the right to return to the Adult Foster Home upon discharge. However, if the individual chooses a new Adult Foster Home owned by the same corporate entity as the initial Adult Foster Home, the new Adult Foster Home cannot request or receive another initial payment for the individual. Re-admissions are excluded.

9. If the individual moves out of the Adult Foster Home prior to 90 days because the individual's needs were not being met, or if it is later determined that the Adult Foster Home staff did not meet the individual's needs, the Adult Foster Home must refund the subsequent incentive payment.

10. If Adult Protective Services (APS) becomes involved due to a failure on the part of the Adult Foster Home toward the individual, and APS confirms or substantiates that failure, the Adult Foster Home must refund the incentive payment(s).

11. ODHS will work collaboratively with SEIU to ensure the admitting Adult Foster Home Providers, as defined above, receive the incentive payment(s) accurately and timely.

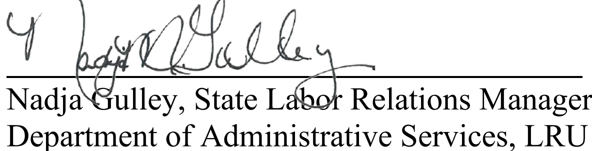
12. The Adult Foster Provider will follow all licensing and compliance requirements including the discharge processes as defined in administrative rules.

13. For Adult Foster Homes licensed by the Office of Developmental Disabilities Services, individuals admitted must meet program criteria and must continue to meet program criteria.

14. Adult Foster Homes must be eligible to admit residents.

This Letter of Agreement is effective upon final signature below and shall expire on April 30, 2023.

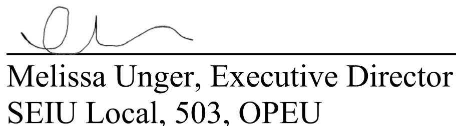
For the State:



10/28/2022

Nadja Gulley, State Labor Relations Manager — Date
Department of Administrative Services, LRU

For the Union:



10/27/2022

Melissa Unger, Executive Director — Date
SEIU Local, 503, OPEU

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

DISCHARGE INCENTIVE PAYMENT FORM
PART ONE

With approval from the Oregon Legislature, the Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA) will be providing discharge incentive payments to any Adult Foster Home (AFH) provider or Residential Care Facility (RCF) that admits a new individual to their facility directly from a hospital or (skilled) nursing facility (SNF/NF). Incentive payments are also available to qualifying In-Home Care Agencies (IHCA) that begin providing in-home services to new individuals directly from a hospital or SNF/NF, as long as the individuals receive long-term services and supports through the ODHS Aging and People with Disabilities (APD) program and Medicaid. Incentive payments are independent of the provider's regular rate, whether Medicaid or private pay. *This is the approved Discharge Incentive Payment Request Form.*

Information about the Individual needing AFH/RCF Placement or IHCA Services

1. Individual's name:	2. Date of Birth:
3. Insurance: ☐ Medicaid - 3.a. Individual's Medicaid ("Prime") #: ☐ Private Pay ☐ Other: Type	4. Did you do an assessment of the individual's needs in the hospital or SNF/NF? ☐ Yes ☐ No 5. Have you done a full assessment of your ability to meet the individual's needs? ☐ Yes ☐ No
6. Name of hospital/SNF/NF: 7. Date of admission to hospital/SNF/NF: 8. Length of stay (# of days) at hospital/SNF/NF: 9. Reason for delayed discharge from hospital/SNF/NF, if known:	10. Date of admission to this AFH/RCF, or date started services with this IHCA: 11. Is the individual now going to receive hospice care? ☐ Yes ☐ No

12. Individual's living situation prior to the hospital/SNF/NF:
☐ AFH/AGH ☐ Assisted Living/RCF ☐ Home ☐ Houseless ☐ SNF/NF ☐ Other
12a. If Other, explain:

13. Did the individual agree to placement with this AFH/RCF, or to receive services from this IHCA?
☐ Yes ☐ No
14. If the individual is unable to agree to placement with this AFH/RCF, or to receive services from this IHCA, was a legal representative involved? ☐ Yes ☐ No
14a. If Yes, provide the legal representative's name:
15. If No to both 13 and 14, provide the name of the person who made the decision:

Individual's Demographic Information

16. Gender this individual identifies as: ☐ Female ☐ Male ☐ Other
17. Race/Ethnicity:

a. ☐ American Indian and/or Alaska Native
b. ☐ Asian
c. ☐ Black/African American
d. ☐ Latinx/Hispanic
e. ☐ Middle Eastern or Northern African
f. ☐ Native Hawaiian and/or Pacific Islander
g. ☐ White/Caucasian
h. ☐ Other

Individual's Demographic Information (continued)

18. Does this individual have difficulty communicating or being understood by others? ☐ Yes ☐ No
    18a. If Yes, explain the reason for the difficulty:
19. What language(s) does this individual speak?
20. In what language(s) does this individual write?
21. What are this individual's primary disabilities, if any?

Information about the Provider	**22. Provider Type:** ☐ **AFH** ☐ **RCF** ☐ **IHCA**
23. Tax ID:	24. Medicaid Number:
25. Provider Name:	26. Name of AFH, RCF or IHCA, if different:
27. Phone:	28. Email:
29. Address:	

By signing this form, you, as the individual's new provider, attest that the following is true:

- I do not have any restrictions on my license for admissions.
- I understand I have 30 days from the date the individual discharges from the hospital or SNF/NF to request the initial payment.
- To receive the second payment, I will continue to serve this individual for at least 90 days from the date of admission to this AFH or RCF, or from the date this individual started receiving services from this IHCA.
- I will follow all licensing and compliance requirements including the discharge process as defined in administrative rules.
- I will refer to the Provider Alert for my provider type for all program requirements.
- **The provider will be required to refund the incentive payment(s) if it is later found that the provider does not qualify for the incentive payment(s). All discharge incentive payments are subject to audit at the discretion of the Oregon Department of Human Services.**

Email the completed form to: HCBS.Oregon@odhsoha.oregon.gov

Signature of Provider *(sign above the line)* Date

Printed Name *(print above the line)*

ODHS APD Use Only	For OFS
Date Received:	**Amount Authorized:**
Date of Initial Payment:	**PCA: 39093**
Date of Second Payment:	**Index: 33930**
Reviewed and Approved By:	**AOBJ: 7927**
MMIS #:	**MMIS Reason Code: 3008**

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

DISCHARGE INCENTIVE PAYMENT FORM
PART TWO

With approval from the Oregon Legislature, the Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA) will be providing discharge incentive payments to any Adult Foster Home (AFH) provider or Residential Care Facility (RCF) that admits a new individual to their facility directly from a hospital or (skilled) nursing facility (SNF/NF). Incentive payments are also available to qualifying In-Home Care Agencies (IHCA) that begin providing in-home services to new individuals directly from a hospital or SNF/NF, as long as the individuals receive Medicaid services through the ODHS Aging and People with Disabilities (APD) program. Incentive payments are independent of the provider's regular rate, whether Medicaid or private pay. *This is the approved Discharge Incentive Payment Request Form.*

Information about the Individual needing AFH/RCF Placement or IHCA Services

1. Individual's name:	2. Date of Birth:

3. Date of admission to this AFH/RCF, or date individual started receiving services from this IHCA:

4. Is the individual receiving hospice care now? ☐ Yes ☐ No
5. Was the individual referred to hospice care after admitting to this AFH/RCF, or since starting services with this IHCA? ☐ Yes ☐ No
6. During the 90 days since the individual admitted to this AFH/RCF, or started receiving IHCA services:
   a. Did the individual discharge from this AFH/RCF, or stop receiving services from this IHCA? ☐ Yes ☐ No ☐ N/A
   b. If 6a is Yes, explain the reason why:
7. For this individual, was this change: ☐ Voluntary ☐ Involuntary ☐ Other
8. Has the individual passed away? ☐ Yes ☐ No 8a. If Yes, date of death:
9. What is the individual's new living situation (if applicable)?
   a. ☐ AFH/AGH
   b. ☐ Assisted Living/Residential Care
   c. ☐ Home
   d. ☐ Hospital
   e. ☐ Houseless
   f. ☐ SNF/NF
   g. ☐ Other
   h. If Other, explain:

Information about the Provider **10. Provider Type:** ☐ **AFH** ☐ **RCF** ☐ **IHCA**

11. **IHCA-only**: Have you provided EVV records? ☐ Yes ☐ No

12. Tax ID:	13. Medicaid Number:
14. Provider Name:	15. Name of AFH, RCF or IHCA, if different:
16. Phone:	17. Email:
18. Address:	

By signing this form, you, as the individual's new provider, attest that the following is true:

- The individual did not move out of this Adult Foster Home (AFH) or Residential Care Facility (RCF) involuntarily; or did not stop receiving services from this IHCA involuntarily during the first 90 days from initial discharge from a hospital or SNF/NF.
- I understand I must request the 2nd incentive payment within 30 days from the '90th day from discharge from the hospital or SNF/NF'.
- I understand that an individual who readmits to the hospital or SNF/NF during the first 90 days from initial discharge has the right to return to this AFH or RCF, or to continue receiving services from this IHCA, upon discharge. However, if the individual chooses to go to a new AFH/RCF, or start with a new IHCA, owned by the same corporate entity/licensee as this AFH, RCF or IHCA, I cannot request or receive another initial payment for the individual. Resident readmissions are excluded from this Incentive Program.
- I understand that if this individual left prior to 90 days because his/her needs were not being met, or if it is later determined that this provider did not meet the individual's needs, I need to refund/return the second incentive payment.
- I understand that if Adult Protective Services (APS) becomes involved due to a failure on the part of this provider toward this individual, and APS confirms or substantiates that failure, this provider must refund/return the second incentive payment.
- I have followed all licensing and compliance requirements, including the discharge process as defined in administrative rules.
- I will refer to the Provider Alert for my provider type for all program requirements.
- **The provider will be required to refund the incentive payment(s) if it is later found that the provider does not qualify for the incentive payment(s). All discharge incentive payments are subject to audit at the discretion of the Oregon Department of Human Services.**

Email the completed form to: HCBS.Oregon@odhsoha.oregon.gov

Signature of Provider *(sign above the line)*	Date
Printed Name *(print above the line)*	

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

Instructions for How to Complete the Discharge Incentive Payment Forms - Part 1 and Part 2

To ensure timely processing of Payment Request sent to the Oregon Department of Human Services (ODHS) Aging and People with Disabilities (APD) Central Office, email the completed Discharge Incentive Payment Form (or Payment Form) to: hcbs.oregon@odhsoha.oregon.gov

Requesting 1st Payment? Use Form Part One

Use the 'Discharge Incentive Payment Form – Part One' to request the initial (first) payment. You (the provider) have 30 days from the date the individual discharged from the hospital or (skilled) nursing facility (SNF/NF) to request the first payment.

Box #	Information you need to enter for Form Part 1
About the Individual	
1	Name
2	Date of Birth
3	Insurance (If "Other" is selected, include the Type of insurance)
3a	If individual has Medicaid, put the Medicaid # (or 'Prime #')
4	Did you do an assessment of the individual's needs in the hospital or SNF/NF?
5	Have you done a full assessment of your ability to meet the individual's needs?
6	Name of hospital or SNF/NF
7	Date individual was admitted to that hospital or SNF/NF
8	# of days the individual stayed at the hospital or SNF/NF
9	If individual's discharge was delayed, reason for delay (if known)
10	Date individual is moving in (AFH/RCF) or is starting to receive services (IHCA)
11	Is the individual now going to get hospice care
12	Living situation prior to going to the hospital or SNF/NF
12a	If "Other" is selected, explain

13	Did the individual agree to moving in (AFH/RCF), or starting to receive services (IHCA), himself/herself
14	If he/she is unable to agree to moving in (AFH/ RCF), or starting to receive services (IHCA), was a legal representative involved
14a	Name of the legal representative, if one was involved
15	Name of person who made the decision for the individual to move in (AFH/ RCF), or to start receiving services (IHCA), if the individual couldn't and no legal representative was involved
16	Gender the individual identifies as
17	Race/Ethnicity
17a	American Indian and/or Alaska Native
17b	Asian
17c	Black/African American
17d	Latinx/Hispanic
17e	Middle Eastern or Northern African
17f	Native Hawaiian and/or Pacific Islander
17g	White/Caucasian
17h	Other
18	Does the individual have difficulty communicating or being understood by others
18a	If "Yes", explain reason for difficulty
19	Language(s) he/she speaks
20	Language(s) he/she writes
21	Primary disabilities, if any
About You (the Provider)	
22	Provider type (AFH, RCF or IHCA)
23	Tax ID #
24	Medicaid # (also called Provider #)
25	Provider's full name (e.g., Jane Smith)
26	Name of AFH, RCF or IHCA, if different than #24
27	Phone #
28	Email address
29	Physical address
Bottom of the Form	
	Provider's signature / Date of signature
	Provider's printed name

Requesting 2nd Payment? Use Form Part Two

Use the 'Discharge Incentive Payment Form – Part Two' to request the subsequent (second) payment. When the individual has been living in your home/facility (AFH/RCF) or receiving services from you (IHCA) for at least 90 days after discharging from the hospital or SNF/NF, you may request the second payment.

Box #	Information you need to enter for Form Part Two
	About the Individual
1	Name
2	Date of Birth
3	Date individual is moving in (AFH/RCF) or is starting to receive services (IHCA)
4	Is the individual receiving hospice care now
5	Was the individual referred to hospice care after moving in (AFH/RCF), or starting to receive services (IHCA)?
6	During the 90 days since the individual moved in (AFH/RCF), or started receiving services (IHCA):
6a	Did he/she move out (AFH/RCF), or stop receiving services (IHCA)?
6b	If 6a is "Yes", explain why he/she moved out or stopped receiving services
7	Was moving out (AFH/RCF), or stopping services (IHCA) voluntary, involuntary or a something else (Other)
8	Has he/she passed away
8a	If "Yes", provide date of death
9	Individual's new living situation (if he/she moved out (AFH/RCF), or stopped services (IHCA), if applicable
9a	Adult Foster Home or Adult Group Home
9b	Assisted Living Facility or Residential Care Facility (this includes facilities that are endorsed for Memory Care)
9c	Home (this would include a house, apartment, family's home/apartment, mobile home)
9d	Hospital
9e	Houseless
9f	Skilled Nursing Facility or Nursing Facility
9g	Other
9h	If "Other" for 9g, explain

About You (the Provider)	
10	Provider type (AFH, RCF or IHCA)
11	**For IHCA-only:** Have you attached EVV records for every person who provides services to this individual through your IHCA for the entire time since he/she discharged from the hospital or SNF/NF
12	Tax ID #
13	Medicaid # (also called Provider #)
14	Provider's full name (e.g., Jane Smith)
15	Name of AFH, RCF or IHCA, if different than #24
16	Phone #
17	Email address
18	Physical address
Bottom of the Form	
	Provider's signature / Date of signature
	Provider's printed name

Once APD gets the Payment Request, they will confirm the individual and provider meet the program requirements. Within 10 days of receiving an appropriate request, APD will ask the Office of Financial Services (OFS) to issue a payment.

NOTE: The number of providers participating with this incentive program is large, so allow time for payments to process. If you have not received payment within 30 days, notify APD by emailing: hcbs.oregon@odhsoha.oregon.gov

If you have questions, please contact: hcbs.oregon@odhsoha.oregon.gov

Discharge Incentive Payment Program Date Calculator

Day of Discharge Column A	Day of Week	30 Days from Discharge Column B	90 Days from Discharge Column C	30 Days from 90th Day Column D
11/1/2022	Tue	12/1/2022	1/30/2023	3/1/2023
11/2/2022	Wed	12/2/2022	1/31/2023	3/2/2023
11/3/2022	Thu	12/3/2022	2/1/2023	3/3/2023
11/4/2022	Fri	12/4/2022	2/2/2023	3/4/2023
11/5/2022	Sat	12/5/2022	2/3/2023	3/5/2023
11/6/2022	Sun	12/6/2022	2/4/2023	3/6/2023
11/7/2022	Mon	12/7/2022	2/5/2023	3/7/2023
11/8/2022	Tue	12/8/2022	2/6/2023	3/8/2023
11/9/2022	Wed	12/9/2022	2/7/2023	3/9/2023
11/10/2022	Thu	12/10/2022	2/8/2023	3/10/2023
11/11/2022	Fri	12/11/2022	2/9/2023	3/11/2023
11/12/2022	Sat	12/12/2022	2/10/2023	3/12/2023
11/13/2022	Sun	12/13/2022	2/11/2023	3/13/2023
11/14/2022	Mon	12/14/2022	2/12/2023	3/14/2023
11/15/2022	Tue	12/15/2022	2/13/2023	3/15/2023
11/16/2022	Wed	12/16/2022	2/14/2023	3/16/2023
11/17/2022	Thu	12/17/2022	2/15/2023	3/17/2023
11/18/2022	Fri	12/18/2022	2/16/2023	3/18/2023
11/19/2022	Sat	12/19/2022	2/17/2023	3/19/2023
11/20/2022	Sun	12/20/2022	2/18/2023	3/20/2023
11/21/2022	Mon	12/21/2022	2/19/2023	3/21/2023
11/22/2022	Tue	12/22/2022	2/20/2023	3/22/2023
11/23/2022	Wed	12/23/2022	2/21/2023	3/23/2023
11/24/2022	Thu	12/24/2022	2/22/2023	3/24/2023
11/25/2022	Fri	12/25/2022	2/23/2023	3/25/2023
11/26/2022	Sat	12/26/2022	2/24/2023	3/26/2023
11/27/2022	Sun	12/27/2022	2/25/2023	3/27/2023
11/28/2022	Mon	12/28/2022	2/26/2023	3/28/2023
11/29/2022	Tue	12/29/2022	2/27/2023	3/29/2023
11/30/2022	Wed	12/30/2022	2/28/2023	3/30/2023
12/1/2022	Thu	12/31/2022	3/1/2023	3/31/2023
12/2/2022	Fri	1/1/2023	3/2/2023	4/1/2023
12/3/2022	Sat	1/2/2023	3/3/2023	4/2/2023
12/4/2022	Sun	1/3/2023	3/4/2023	4/3/2023
12/5/2022	Mon	1/4/2023	3/5/2023	4/4/2023
12/6/2022	Tue	1/5/2023	3/6/2023	4/5/2023
12/7/2022	Wed	1/6/2023	3/7/2023	4/6/2023
12/8/2022	Thu	1/7/2023	3/8/2023	4/7/2023
12/9/2022	Fri	1/8/2023	3/9/2023	4/8/2023
12/10/2022	Sat	1/9/2023	3/10/2023	4/9/2023
12/11/2022	Sun	1/10/2023	3/11/2023	4/10/2023
12/12/2022	Mon	1/11/2023	3/12/2023	4/11/2023

As of 10/20/2022

Discharge Incentive Payment Program Date Calculator

Day of Discharge Column A	Day of Week	30 Days from Discharge Column B	90 Days from Discharge Column C	30 Days from 90th Day Column D
12/13/2022	Tue	1/12/2023	3/13/2023	4/12/2023
12/14/2022	Wed	1/13/2023	3/14/2023	4/13/2023
12/15/2022	Thu	1/14/2023	3/15/2023	4/14/2023
12/16/2022	Fri	1/15/2023	3/16/2023	4/15/2023
12/17/2022	Sat	1/16/2023	3/17/2023	4/16/2023
12/18/2022	Sun	1/17/2023	3/18/2023	4/17/2023
12/19/2022	Mon	1/18/2023	3/19/2023	4/18/2023
12/20/2022	Tue	1/19/2023	3/20/2023	4/19/2023
12/21/2022	Wed	1/20/2023	3/21/2023	4/20/2023
12/22/2022	Thu	1/21/2023	3/22/2023	4/21/2023
12/23/2022	Fri	1/22/2023	3/23/2023	4/22/2023
12/24/2022	Sat	1/23/2023	3/24/2023	4/23/2023
12/25/2022	Sun	1/24/2023	3/25/2023	4/24/2023
12/26/2022	Mon	1/25/2023	3/26/2023	4/25/2023
12/27/2022	Tue	1/26/2023	3/27/2023	4/26/2023
12/28/2022	Wed	1/27/2023	3/28/2023	4/27/2023
12/29/2022	Thu	1/28/2023	3/29/2023	4/28/2023
12/30/2022	Fri	1/29/2023	3/30/2023	4/29/2023
12/31/2022	Sat	1/30/2023	3/31/2023	4/30/2023
1/1/2023	Sun	1/31/2023	4/1/2023	5/1/2023
1/2/2023	Mon	2/1/2023	4/2/2023	5/2/2023
1/3/2023	Tue	2/2/2023	4/3/2023	5/3/2023
1/4/2023	Wed	2/3/2023	4/4/2023	5/4/2023
1/5/2023	Thu	2/4/2023	4/5/2023	5/5/2023
1/6/2023	Fri	2/5/2023	4/6/2023	5/6/2023
1/7/2023	Sat	2/6/2023	4/7/2023	5/7/2023
1/8/2023	Sun	2/7/2023	4/8/2023	5/8/2023
1/9/2023	Mon	2/8/2023	4/9/2023	5/9/2023
1/10/2023	Tue	2/9/2023	4/10/2023	5/10/2023
1/11/2023	Wed	2/10/2023	4/11/2023	5/11/2023
1/12/2023	Thu	2/11/2023	4/12/2023	5/12/2023
1/13/2023	Fri	2/12/2023	4/13/2023	5/13/2023
1/14/2023	Sat	2/13/2023	4/14/2023	5/14/2023
1/15/2023	Sun	2/14/2023	4/15/2023	5/15/2023
1/16/2023	Mon	2/15/2023	4/16/2023	5/16/2023
1/17/2023	Tue	2/16/2023	4/17/2023	5/17/2023
1/18/2023	Wed	2/17/2023	4/18/2023	5/18/2023
1/19/2023	Thu	2/18/2023	4/19/2023	5/19/2023
1/20/2023	Fri	2/19/2023	4/20/2023	5/20/2023
1/21/2023	Sat	2/20/2023	4/21/2023	5/21/2023
1/22/2023	Sun	2/21/2023	4/22/2023	5/22/2023
1/23/2023	Mon	2/22/2023	4/23/2023	5/23/2023

Discharge Incentive Payment Program Date Calculator

Day of Discharge Column A	Day of **Week**	**30 Days from Discharge** Column B	**90 Days from Discharge** Column C	**30 Days from 90th Day** Column D
1/24/2023	Tue	2/23/2023	4/24/2023	5/24/2023
1/25/2023	Wed	2/24/2023	4/25/2023	5/25/2023
1/26/2023	Thu	2/25/2023	4/26/2023	5/26/2023
1/27/2023	Fri	2/26/2023	4/27/2023	5/27/2023
1/28/2023	Sat	2/27/2023	4/28/2023	5/28/2023
1/29/2023	Sun	2/28/2023	4/29/2023	5/29/2023
1/30/2023	Mon	3/1/2023	4/30/2023	5/30/2023
1/31/2023	Tue	3/2/2023	5/1/2023	5/31/2023
2/1/2023	Wed	3/3/2023	5/2/2023	6/1/2023
2/2/2023	Thu	3/4/2023	5/3/2023	6/2/2023
2/3/2023	Fri	3/5/2023	5/4/2023	6/3/2023
2/4/2023	Sat	3/6/2023	5/5/2023	6/4/2023
2/5/2023	Sun	3/7/2023	5/6/2023	6/5/2023
2/6/2023	Mon	3/8/2023	5/7/2023	6/6/2023
2/7/2023	Tue	3/9/2023	5/8/2023	6/7/2023
2/8/2023	Wed	3/10/2023	5/9/2023	6/8/2023
2/9/2023	Thu	3/11/2023	5/10/2023	6/9/2023
2/10/2023	Fri	3/12/2023	5/11/2023	6/10/2023
2/11/2023	Sat	3/13/2023	5/12/2023	6/11/2023
2/12/2023	Sun	3/14/2023	5/13/2023	6/12/2023
2/13/2023	Mon	3/15/2023	5/14/2023	6/13/2023
2/14/2023	Tue	3/16/2023	5/15/2023	6/14/2023
2/15/2023	Wed	3/17/2023	5/16/2023	6/15/2023
2/16/2023	Thu	3/18/2023	5/17/2023	6/16/2023
2/17/2023	Fri	3/19/2023	5/18/2023	6/17/2023
2/18/2023	Sat	3/20/2023	5/19/2023	6/18/2023
2/19/2023	Sun	3/21/2023	5/20/2023	6/19/2023
2/20/2023	Mon	3/22/2023	5/21/2023	6/20/2023
2/21/2023	Tue	3/23/2023	5/22/2023	6/21/2023
2/22/2023	Wed	3/24/2023	5/23/2023	6/22/2023
2/23/2023	Thu	3/25/2023	5/24/2023	6/23/2023
2/24/2023	Fri	3/26/2023	5/25/2023	6/24/2023
2/25/2023	Sat	3/27/2023	5/26/2023	6/25/2023
2/26/2023	Sun	3/28/2023	5/27/2023	6/26/2023
2/27/2023	Mon	3/29/2023	5/28/2023	6/27/2023
2/28/2023	Tue	3/30/2023	5/29/2023	6/28/2023
3/1/2023	Wed	3/31/2023	5/30/2023	6/29/2023
3/2/2023	Thu	4/1/2023	5/31/2023	6/30/2023
3/3/2023	Fri	4/2/2023	6/1/2023	7/1/2023
3/4/2023	Sat	4/3/2023	6/2/2023	7/2/2023
3/5/2023	Sun	4/4/2023	6/3/2023	7/3/2023
3/6/2023	Mon	4/5/2023	6/4/2023	7/4/2023

Discharge Incentive Payment Program Date Calculator

Day of Discharge Column A	Day of Week	30 Days from Discharge Column B	90 Days from Discharge Column C	30 Days from 90th Day Column D
3/7/2023	Tue	4/6/2023	6/5/2023	7/5/2023
3/8/2023	Wed	4/7/2023	6/6/2023	7/6/2023
3/9/2023	Thu	4/8/2023	6/7/2023	7/7/2023
3/10/2023	Fri	4/9/2023	6/8/2023	7/8/2023
3/11/2023	Sat	4/10/2023	6/9/2023	7/9/2023
3/12/2023	Sun	4/11/2023	6/10/2023	7/10/2023
3/13/2023	Mon	4/12/2023	6/11/2023	7/11/2023
3/14/2023	Tue	4/13/2023	6/12/2023	7/12/2023
3/15/2023	Wed	4/14/2023	6/13/2023	7/13/2023
3/16/2023	Thu	4/15/2023	6/14/2023	7/14/2023
3/17/2023	Fri	4/16/2023	6/15/2023	7/15/2023
3/18/2023	Sat	4/17/2023	6/16/2023	7/16/2023
3/19/2023	Sun	4/18/2023	6/17/2023	7/17/2023
3/20/2023	Mon	4/19/2023	6/18/2023	7/18/2023
3/21/2023	Tue	4/20/2023	6/19/2023	7/19/2023
3/22/2023	Wed	4/21/2023	6/20/2023	7/20/2023
3/23/2023	Thu	4/22/2023	6/21/2023	7/21/2023
3/24/2023	Fri	4/23/2023	6/22/2023	7/22/2023
3/25/2023	Sat	4/24/2023	6/23/2023	7/23/2023
3/26/2023	Sun	4/25/2023	6/24/2023	7/24/2023
3/27/2023	Mon	4/26/2023	6/25/2023	7/25/2023
3/28/2023	Tue	4/27/2023	6/26/2023	7/26/2023
3/29/2023	Wed	4/28/2023	6/27/2023	7/27/2023
3/30/2023	Thu	4/29/2023	6/28/2023	7/28/2023
3/31/2023	Fri	4/30/2023	6/29/2023	7/29/2023
4/1/2023	Sat	5/1/2023	6/30/2023	7/30/2023
4/2/2023	Sun	5/2/2023	7/1/2023	7/31/2023
4/3/2023	Mon	5/3/2023	7/2/2023	8/1/2023
4/4/2023	Tue	5/4/2023	7/3/2023	8/2/2023
4/5/2023	Wed	5/5/2023	7/4/2023	8/3/2023
4/6/2023	Thu	5/6/2023	7/5/2023	8/4/2023
4/7/2023	Fri	5/7/2023	7/6/2023	8/5/2023
4/8/2023	Sat	5/8/2023	7/7/2023	8/6/2023
4/9/2023	Sun	5/9/2023	7/8/2023	8/7/2023
4/10/2023	Mon	5/10/2023	7/9/2023	8/8/2023
4/11/2023	Tue	5/11/2023	7/10/2023	8/9/2023
4/12/2023	Wed	5/12/2023	7/11/2023	8/10/2023
4/13/2023	Thu	5/13/2023	7/12/2023	8/11/2023
4/14/2023	Fri	5/14/2023	7/13/2023	8/12/2023
4/15/2023	Sat	5/15/2023	7/14/2023	8/13/2023
4/16/2023	Sun	5/16/2023	7/15/2023	8/14/2023
4/17/2023	Mon	5/17/2023	7/16/2023	8/15/2023

Discharge Incentive Payment Program Date Calculator

Day of Discharge Column A	**Day of Week**	**30 Days from Discharge** Column B	**90 Days from Discharge** Column C	**30 Days from 90th Day** Column D
4/18/2023	Tue	5/18/2023	7/17/2023	8/16/2023
4/19/2023	Wed	5/19/2023	7/18/2023	8/17/2023
4/20/2023	Thu	5/20/2023	7/19/2023	8/18/2023
4/21/2023	Fri	5/21/2023	7/20/2023	8/19/2023
4/22/2023	Sat	5/22/2023	7/21/2023	8/20/2023
4/23/2023	Sun	5/23/2023	7/22/2023	8/21/2023
4/24/2023	Mon	5/24/2023	7/23/2023	8/22/2023
4/25/2023	Tue	5/25/2023	7/24/2023	8/23/2023
4/26/2023	Wed	5/26/2023	7/25/2023	8/24/2023
4/27/2023	Thu	5/27/2023	7/26/2023	8/25/2023
4/28/2023	Fri	5/28/2023	7/27/2023	8/26/2023
4/29/2023	Sat	5/29/2023	7/28/2023	8/27/2023
4/30/2023	Sun	5/30/2023	7/29/2023	8/28/2023