Information Memorandum Transmittal
Aging and People with Disabilities

DHS | Oregon Department of Human Services

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Authorized signature

Number: APD-IM-23-022
Issue date: 3/1/2023
Updated: 3/6/2023
Due date:

Topic: Forms

Subject: Updated SDS 0494 and SDS 0494i

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*):

Message: The SDS 0494, *Specific Need Contact Admission Request*, and SDS 0494i, *Specific Need Contact Admission Request Instructions*, form has been updated and posted to the ODHS forms server and Specific Needs Contracts website: see attached. Effective immediately staff should begin using the new forms, dated 02/2023, immediately and cease using all prior versions.

Note: Other versions of the SDS 0494 will no longer be accepted as valid after close of business on Friday, March 10.

Changes: Forms were updated to expand phone number, title, and name fields. Duplicate information fields were removed, and fields within sections were re-ordered to accommodate the changes. Other changes include simplification of and update to language and the updated submission email box.

If you have any questions about this information, contact:

Contact(s): Karen Kaino	
Phone: 503-569-7034	Fax:
Email: karen.l.kaino@odhs.oregon.gov	

Oregon Department of Human Services
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Specific Needs Contract Admission Request

For information on how to complete this form, use the SDS 0494i instructions.

Please review ORS 411-015-0008 for rule guidance.

Date of request: _____

Requestor: _____

1. Consumer information

Consumer's name: _____

Medicaid prime number: _____ Date of birth: _____

Service priority level: _____

Reason for request:

- ☐ Consumer directed
- ☐ Facility closure
- ☐ Eviction
- ☐ Change in condition or level of care

2. Local staff information

Current CM or TC name: _____

Branch number: _____ Title: _____

Phone: _____ Email: _____

Receiving CM or TC name: _____

Branch number: _____ Title: _____

Phone: _____ Email: _____

3. Provider information

Provider name: _____

Provider number: _____ Contract type: _____

Facility contact: _____ Screening date: _____

Please note: By checking the boxes below, the local office attests all required actions were taken. If a required action was not taken, the request may be returned for completion.

4. Required actions prior to submission

- ☐ Confirmed last CAPS assessment is current and comments reflect the consumer's service needs.
- ☐ Reviewed and verified the consumer meets the target group outlined in the specific contract type statement of work from the SNC website.
- ☐ Confirmed provider has a contract vacancy.
- ☐ Confirmed provider has screened the consumer and will accept the admission.
- ☐ Verified consumer, or their legal representative, has agreed to the placement.
- ☐ Notified receiving branch CM or TC of the pending admission/transfer.
- ☐ Agree to assist provider with coordination of transition care meetings, if needed.
- ☐ Narrated in Oregon ACCESS that all required actions were taken.

5. Central office review

Central Office will respond within two (2) business days of receiving the request. Decisions will be narrated accordingly in Oregon ACCESS.

Date received: _____

Determination:

☐ Approved

☐ Denied Reason: _____

☐ Pending Follow-up action required: _____

Central office reviewer name: _____ Title: _____

Title: _____ Date: _____

Email questions to APD.Admissions@odhsoha.oregon.gov

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Specific Needs Contract Admission Request (SDS 0494) Completion and Submission Instructions

These instructions support the February 2023 version of the SDS 0494. All prior versions are invalid and will be returned if submitted; scanned requests will also be returned.

Please address any process questions with local office management. If further clarification is needed, send an email to APD.Admissions@odhsoha.oregon.gov.

SDS 494 required information

Date of request:	Date requestor is completing the form
Requestor:	Name of APD or AAA staff completing the form
Contract type:	Type of contract being requested

Check the SNC website for specific contract types

1. Consumer information

Consumer name:	First and last name of the person
Medicaid prime number:	Full prime as it appears in Oregon ACCESS
Date of birth:	As stated in Oregon ACCESS
Service priority level:	As stated in Oregon ACCESS
Reason for request:	Oregon ACCESS narration must support the selection

2. Field staff information

Current CM/TC name:	Full name of the case manager (CM) or transition coordinator (TC) who currently has the case. There should only be one name in this field.
Branch number:	Branch where **the case** is located, not the local office staff submitting or receiving the case
Title:	Title of CM or TC submitting request.
Phone:	Phone number of requestor.
Email:	Email address of requestor.

	CM or TC in the receiving local office where the case will be transferred to or the prospective CM if the case remains within the requesting office.
Receiving CM/TC name:	*The requesting CM/TC must make person-to-person contact with the receiving CM/TC prior to making the transfer and narrate the in-person contact in Oregon ACCESS. Contact Central Office if you are unable to reach the receiving branch within two (2) business days. May be waived in an emergency.
Branch number:	Branch where the case is transferring, if applicable.
Title:	Title of CM/TC receiving the case.
Phone:	Phone number of the receiving staff.
Email:	Email address of the receiving staff.

3. Provider information

To accurately complete the data fields in this section, refer to the contact list for specific needs contracts.

Screening date:	Date the prospective provider assessed/screened the consumer. The date and outcome must be narrated in Oregon ACCESS.

4. Required actions prior to submission

All actions listed on the request form must be taken prior to submission. By checking the boxes, the requestor attests all required actions were taken. If a required action was not taken, the request may be returned resulting in a processing delay.

5. Central office review

This section is for Central Office staff only. Central Office staff will narrate the determination in Oregon ACCESS. Determinations are completed within two (2) business days of receiving the request; incomplete or inaccurate submissions may delay processing.

If **approved**, the requestor will receive a completed copy of the request via email. Email from Central Office will include templated instructions to request rate changes.

If **denied**, the reviewer will provide a thorough explanation for the denial. 494 requests will not be denied due to clerical errors. Specific questions regarding the denial can be sent to APD.Admissions@odhsoha.oregon.gov.

If **pended**, the Central Office reviewer will send instructions via email for correction and/or completion. Local office staff should resubmit the corrected 494 request to APD.Admissions@odhsoha.oregon.gov.

Additional guidance

- A thorough review of the specific contract statement of work is necessary to ensure the appropriate contract and provider type are considered and selected.
- Consumers may not be admitted prior to the contract effective date.
- A CAPS assessment completed within 90-days of the date of request is preferred. The most recent Oregon ACCESS assessment comments must reflect current service needs and the reason for contract admission consideration.
- The consumer must have a current and open medical case with accurate case coding.
- Ensure the consumer is aware of their long term and short-term plans. Should a consumer wish to remain in their home or return to their previous living situation, make sure all resources have been considered to honor the consumer's wishes.
- If required by the statement of work for the specific placement, Oregon ACCESS narration must include previous placement attempts. If a consumer already resides in a contract setting and is moving to a different contract setting this documentation is not required.
- If the request is for a move from an enhanced care facility to a contract setting, the requestor must contact the enhanced care facility contract administrator, EnhancedCare.Team@odhsoha.oregon.gov, prior to submitting the request.