

## Long-Term Psychiatric Care Determination Request Form for Ages 17 and Under

### Request Information

|                         |  |
|-------------------------|--|
| <b>Date received</b>    |  |
| <b>Child name</b>       |  |
| <b>Date of birth</b>    |  |
| <b>Medicaid ID</b>      |  |
| <b>Parent/guardian</b>  |  |
| <b>Address</b>          |  |
| <b>Phone number</b>     |  |
| <b>County</b>           |  |
| <b>CCO</b>              |  |
| <b>Other insurance</b>  |  |
| <b>Current provider</b> |  |

### Referring Agency Information

|                         |                                                                                                       |
|-------------------------|-------------------------------------------------------------------------------------------------------|
| <b>County or CCO</b>    |                                                                                                       |
| <b>Contact person</b>   |                                                                                                       |
| <b>Phone number</b>     |                                                                                                       |
| <b>Email address</b>    |                                                                                                       |
| <b>Reviewed by</b>      |                                                                                                       |
| <b>Date of review</b>   |                                                                                                       |
| <b>Result of review</b> | <input type="checkbox"/> Support referral                                                             |
|                         | <input type="checkbox"/> Recommend alternative:                                                       |
|                         | <input type="checkbox"/> Guardian is aware of the expectation for family participation in the program |

For Oregon Health Authority's Utilization Management Organization  
Completion Only

|                         |                                           |                          |  |
|-------------------------|-------------------------------------------|--------------------------|--|
| <b>Reviewed by</b>      |                                           |                          |  |
| <b>Date of decision</b> |                                           |                          |  |
| <b>Result of review</b> | <input type="checkbox"/> Support referral |                          |  |
|                         | <input type="checkbox"/> Denied           | <b>Reason for denial</b> |  |

For Oregon Health Authority Completion Only

*If you have questions about this decision, contact CFBH staff at [childrensltpc.referrals@odhsoha.oregon.gov](mailto:childrensltpc.referrals@odhsoha.oregon.gov) or 503-756-8540. If your request is approved, a Trillium or Nexus representative will contact your agency regarding timelines and procedures*

|                                                                                                                                                                          |                                        |                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------|--|
| <b>Reviewed by</b>                                                                                                                                                       | <input type="checkbox"/> Summer Hunker |                          |  |
|                                                                                                                                                                          | <input type="checkbox"/>               |                          |  |
| <b>Date of decision</b>                                                                                                                                                  |                                        |                          |  |
| <b>Result of review</b>                                                                                                                                                  | <input type="checkbox"/> Approved      |                          |  |
|                                                                                                                                                                          | <input type="checkbox"/> Denied        | <b>Reason for denial</b> |  |
| <input type="checkbox"/> <b>Determination form faxed to Trillium Family Services</b><br><input type="checkbox"/> <b>Determination form faxed to Nexus Family Healing</b> |                                        |                          |  |