

SRTF STAY FORM

Provider/Contractor: Please complete sections 1 through 3 and submit to:
ABH.ResidentialCapacityReporting@odhsoha.oregon.gov

1. Request information (Provider/Contractor to complete)

Date of Request:	Contact Name:
Contact Phone:	Contact Email:
Date SRTF Denial Initiated:	Date to qualify for non-OHP:

2. Provider – Contractor Contact Information (Provider/Contractor to complete)

County:	Program Name:
Contractor Contact Name:	Program Contact Name:
Contractor Contact Email:	Program Contact Email:

3. Individual not meeting medical necessity information (Provider/Contractor to complete)

Name:
Date of Birth:
Populations/Status: <input type="checkbox"/> A&A <input type="checkbox"/> Civil <input type="checkbox"/> PSRB <input type="checkbox"/> Voluntary <input type="checkbox"/> Voluntary by Guardian
Reason for not meeting medical necessity:
Why individual is not able to transition to another setting currently?
What has been attempted to aid individual in transition? Is a transition thought possible in near future?

4. General Fund Cost Analysis (BHD | Provider to complete LSI Score and Daily Rate ONLY)

LSI Score:	Daily Rate:		
BHD Contracts to complete			
Date Range:			
Projected Cost:			
Utilization Review:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Reallocate to Direct
Contract Amendment:			
SE 17-part C by FY and amount:			
Date Received:	Date Reviewed:	Reviewer's Name/Signature:	

5. Recommendation and approval (BHD | Program to complete)

Program Recommendation:		
Date Received:	Date Reviewed:	Program's Name/Signature:

References:

[CH-009](#)

[OAR 410-172-0720](#)

[Comagine Health website](#)

[Prior Authorization Required for SRTF placement starting 3/1/2024](#)

If you have any question about the SRTF Stay Form section 4, please contact Kelly C. Knight at Kelly.C.Knight@oha.oregon.gov

If you have any questions about the SRTF Stay Form section 5, please contact Nicholas Lervick at Nicholas.Lervick@oha.oregon.gov