

Request for Long-Term Psychiatric Care for Persons Age 17 and Under

Request information

Child's name:	Date received:
Parent/guardian:	
Address:	Phone:
City: Zip code:	County:
Child's Oregon Medicaid or Prime ID:	Date of Birth:
Coordinated Care Organization (CCO):	Other insurance:
Current program:	Admission date:

Referring agency information

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

For Utilization Management Organization completion only:

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

For Oregon Health Authority completion only. *If you have questions about this decision, contact CFBH staff at childrenstpc.referrals@odhsoha.oregon.gov or 503-756-8540. If your request is approved, a Trillium representative will contact your agency regarding timelines and procedures*

Reviewed by:

Date of decision:

Summer Hunker

Result of review:

Approved Denied. Reason for denial:

SCIP referral SAIP referral

Determination form faxed to Trillium Family Services