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| HEALTH SYSTEMS DIVISION  Behavioral Health Programs |  |

**RETAINER EXTENSION PAYMENT**

The information on this form is required to be completed for **all** Retainer Extension Payments requests (payments exceeding 30 days)

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| 1. **Request Information:** | | | |
| Date of Request: | | Contact Name: | |
| Contact Phone: | | Contact Email: | |
| Requested Number of Days: | Start Date: | | Return Date: |

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| 1. **Provider Information:** | |
| County: | Provider Medicaid ID: |
| Provider & Program Name: | Licensing Designation:  AFH  RTH  RTF  SRTF |

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| 1. **Client Information:** | |
| Name: | \*Prior Authorization (PA) number: |
| Oregon Medicaid ID *(if client has Medicaid):* | Date of Birth: |
| Reason for Absence: | |
| List dates and thoroughly describe the events leading to absence: | |
| What issues might cause a delay or require an alternate placement? | |

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| 1. **For absences due to acute care or respite admission:** | |
| Date of Admission: | Where Admitted: |
| Medical Reason for Admission:    Attach the following required clinical documentation:   * Last 60 Days of Progress Notes * Hospital Records (current hospitalization) * Treatment Plan \* * Other Clinical Documentation to support request   \* This is required information. | |

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| 1. **For Absences that Exceed 30 Days:** |
| List the following details about the period previously approved by OHA:  Services Client Received:    Total Face-to-Face Contacts with Client (list dates):    Total Consultations with Providers/Support System/CHOICE Model ENCC (list dates): |

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| **F) Transition Planning** |
| Please describe your transition plan for the client and progress towards completing the transition plan.    What is the likelihood the client will return to placement vs needing another placement (i.e.: is the client facing eviction or will they return to placement)?    *If seeking a new placement for client, please complete Section G.* |

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| 1. **Transition Planning for Clients not Returning *(to be completed if client will not be returning to the program*):** |
| Include any significant barriers to progress: |
| What alternatives have you considered: |
| If you are seeking a new placement for the client, describe your progress with referrals and waitlists: |

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| 1. **NON-PSRB** |
| For NON-PSRB clients: Describe the status of the waitlist review with the client’s CCO/ENCC to determine potential admissions in case the client does not return to the program: |

***The Health Services Division (HSD) is committed to ensuring residential providers receive payment for services provided. HSD may also make payments to a provider to continue to temporarily hold for 30 days or more for an individual admitted to acute/respite care. Payment is in accordance to Oregon Administrative Rules 410-172-0705 subsection 21.***

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| **Client Status:** (To be completed after the approved period ends. |
| Returned to Program. Return date: |
| Not returning to program. Date of decision: |

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| **For Oregon Health Authority Use Only:** | | |
| Date Received: | Date Reviewed: | Reviewer Name: |
| **Client Status:** (To be completed after the approved period ends. | | |
| Returned to Program. Return date: | | |
| Not returning to program. Date of decision: | | |
| HSD Decision:  Additional information needed:  Request Denied. Reason for denial:  Request approved. Date(s) approved: From       thru      . Total days approved:  Previous dates approved to date for retainer payments:  Number of days approved for retainer payments: | | |
| Reviewer’s signature: Signature date: | | |