|  |  |
| --- | --- |
| HEALTH SYSTEMS DIVISION  Behavioral Health Programs |  |
|  |

RETAINER PAYMENT FORM

# Request information

|  |  |  |
| --- | --- | --- |
| Date of request: | Contact name: | |
| Contact phone | Contact email: | |
| Requested number of days: | Start date: | End date: |

# Provider information

|  |  |
| --- | --- |
| County: | Provider Medicaid ID: |
| Program name: | Licensing designation: |

# Client information

|  |  |
| --- | --- |
| Name: | |
| Oregon Medicaid ID *(if client has Medicaid)*: | Date of birth: |
| Reason for absence: | |
| List dates and thoroughly describe the events leading to the absence: | |
| When is the individual expected to return to the program? | |
| What issues might cause a delay or require an alternate placement? | |

# 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) \*  Other Clinical Documentation to support request  \*This is required information for requests that are for Medically appropriate absences. This information is not required for other kinds of requests that involve only legal requirements or elopement. | |

# Please answer the following questions:

|  |  |
| --- | --- |
| List the following details about the period previously approved by OHA: | |
|  | Services the client received: |
|  | Total face-to-face contacts with client (list dates): |
|  | Total consultations with providers/support system (list dates): |
| Please describe your transition plan for the client and progress towards completing the transition plan. Include any significant barriers to progress: | |
| What alternatives have you considered? | |
| What is the likelihood client will stay in place vs. needing another placement? | |
| If you are seeking a new placement for the client, describe your progress with referrals and waitlists: | |
| For non-PSRB clients: Describe the status of the wait list review with the client’s CCO/ENCC to determine potential admissions in case the client does not return to the program: | |
| How can OHA help to support your efforts? | |

# Client status: Complete after the approved period ends.

|  |
| --- |
| Returned to program. Return date: |
| Not returning to program. Date of decision: |

|  |  |  |  |
| --- | --- | --- | --- |
| *For Oregon Health Authority use* ***for non-OHP clients*** *only:* | | | |
| Date received: | Date reviewed: | Reviewer name: | |
| HSD decision:  Additional information needed: | | | |
| Request denied. Reason for denial: | | | |
| Request approved. Date(s) approved: From       Thru      . Total days approved: | | | |
| Reviewer’s signature: | | | Signature date: |