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| HEALTH SYSTEMS DIVISIONBehavioral 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:**
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| 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:**
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| 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:**
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| 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*):**
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| 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**
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| 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:            |