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| HEALTH SYSTEMS DIVISIONBehavioral Health Programs |  |
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RETAINER PAYMENT FORM

# Request information

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

# Provider information

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

# Client information

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| 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:

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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) \*[ ]  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:

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| 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.

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

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| *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:      |