Comagine Health

Oregon Behavioral Health Support Program

Plan of Care Authorization
Plan of Care Request for Behavioral Health Residential or Personal Care Services

Form CH-006: PA-BH-Res-PCS

Please submit this form to request an initial determination, 90-day SRTF reauthorization, change in condition assessment and annual redetermination for 1915(i) services. Comagine Health is responsible for notifying providers 60 days prior to the end date of the current service authorization and request annual redetermination documentation. Comagine Health will request documentation for 90-day SRTF Reauthorizations 30 days prior to the end of the current service authorization.

Please send completed requests to Comagine Health via one of the following methods:

Fax: 877-575-8309

Secure email:
ORBHSupport@comagine.org

Mail: Comagine Health – OBHSP
650 NE Holladay St., Suite 1700
Portland, OR 97232

Please Include a copy of the following supporting documentation, if applicable (*denotes required):

Mental/Behavioral Health Assessment signed by Qualified Mental Health Professional (QMHP) within one year of service start date for current authorization*

Residential Care Plan and/or **Treatment Plan which must address all the BH consumer's service needs dated within one year of the authorization start date***

Conditional Release/Community Evaluation for consumers involved with Psychiatric Security Review Board (PSRB)*

Legal Guardianship Paperwork (if applicable)*

Progress Notes-AFH, RTH, RTF (6-12 months if monthly/weekly, most recent 60 days if daily)*

Progress Notes-SRTF (daily clinical, nursing and psychiatric, most recent 90 days)*

Progress Notes-Change in Condition/Status (30+ days)*

Risk Management Plan (for identified risks i.e., suicide, choking, fall, elopement, etc.)*

APD/DD license (for all APD/DD placements)*

Incident Reports (if applicable)*

Nursing Delegation Form(s) CH-011 and supporting documentation (if applicable)

Signed Consent for Release of Information and Participation in the Oregon Behavioral Health Support Program (signed by guardian if applicable)

Individual/Member Information

Last Name: Smith _____ First Name: Jane _____

Date of Birth: 05/20/1990 _____ Primary ICD-10 Diagnosis Code: F25.0 _____

Medicaid ID (prime number): 987654321A _____

Legal Status (select one):

Voluntary Voluntary by Guardian Civil Commitment PSRB 370 Aid and Assist

Guardian Information (if applicable)

Legal Guardian Name: _____

Relationship to Individual: _____

Legal Guardian Address: _____

Legal Guardian Phone: _____

Legal Guardian Email Address: _____

Request Information

This request is for (select one):

● Initial Request (Referral accepted upon admission)

Annual Redetermination (Referral accepted 60 days prior to end of current plan of care)

90-day SRTF Reauthorization (Referral accepted 30 days prior to end of current plan of care)

Change in Condition Request (Referral accepted after 30+ days of change in status)

Date of Admission to Residential Program (MM/DD/YYYY) if applicable: _____

County of Responsibility: _____

Coordinated Care Organization (CCO): _____

Referring Provider

Name: Dr. Alan Grant, LCSW _____

MCD Number: _____ Phone Number: _____

Email Address: _____ Fax Number: _____

Rendering Provider

Name: Dr. Alan Grant, LCSW

MCD Number: _____ Phone Number: _____

Email Address: _____ Fax Number: _____

Level of Care (select one):

AFH RTH ● RTF SRTF DD AFH DD Group Home APD AFH

APD RCF APD Assisted Living Facility (ALF) TAY RTH TAY RTF Independent Living

Procedure Code (select one):

T1020 S5140 S5141 N/A (Independent Living)

Modifiers (select all that applies):

HK HE TG HW

Number of Units Requested (over full duration): _____

Dates of Service: From (MM/DD/YYYY): 03/20/2026 To (MM/DD/YYYY): 09/19/2026

Is the individual/guardian aware this referral is being submitted ontheir behalf? Yes No

Signatures

By signing below, the Community Mental Health Program (CMHP) and provider or staff completing the form have reviewed the above services and recommend them for this member.

_____	_____	_____
Signature CMHP Representative	Name and Title	Date
_____	Dr. Alan Grant, LCSW	03/15/2026
Signature Provider/Staff Submitting Form	Name and Title	Date

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