Instructions for How to Complete the Discharge Incentive Payment Forms - Part 1 and Part 2

To ensure timely processing of Payment Request sent to the Oregon Department of Human Services (ODHS) Aging and People with Disabilities (APD) Central Office, email the completed Discharge Incentive Payment Form (or Payment Form) to: hcbs.oregon@odhsoha.oregon.gov

Requesting 1st Payment? Use Form Part One

Use the 'Discharge Incentive Payment Form – Part One' to request the initial (first) payment. You (the provider) have 30 days from the date the individual discharged from the hospital or (skilled) nursing facility (SNF/NF) to request the first payment.

Box #	Information you need to enter for Form Part 1
	About the Individual
1	Name
2	Date of Birth
3	Insurance (If "Other" is selected, include the Type of insurance)
3a	If individual has Medicaid, put the Medicaid # (or 'Prime #')
4	Did you do an assessment of the individual's needs in the hospital or SNF/NF?
5	Have you done a full assessment of your ability to meet the individual's needs?
6	Name of hospital or SNF/NF
7	Date individual was admitted to that hospital or SNF/NF
8	# of days the individual stayed at the hospital or SNF/NF
9	If individual's discharge was delayed, reason for delay (if known)
10	Date individual is moving in (AFH/RCF) or is starting to receive services (IHCA)
11	Is the individual now going to get hospice care
12	Living situation prior to going to the hospital or SNF/NF
12a	If "Other" is selected, explain

13	Did the individual agree to moving in (AFH/RCF), or starting to receive services (IHCA), himself/herself
14	If he/she is unable to agree to moving in (AFH/ RCF), or starting to receive services (IHCA), was a legal representative involved
14a	Name of the legal representative, if one was involved
15	Name of person who made the decision for the individual to move in (AFH/ RCF), or to start receiving services (IHCA), if the individual couldn't and no legal representative was involved
16	Gender the individual identifies as
17	Race/Ethnicity
17a	American Indian and/or Alaska Native
17b	Asian
17c	Black/African American
17d	Latinx/Hispanic
17e	Middle Eastern or Northern African
17f	Native Hawaiian and/or Pacific Islander
17g	White/Caucasian
17h	Other
18	Does the individual have difficulty communicating or being understood by others
18a	If "Yes", explain reason for difficulty
19	Language(s) he/she speaks
20	Language(s) he/she writes
21	Primary disabilities, if any
About You (the Provider)	
22	Provider type (AFH, RCF or IHCA)
23	Tax ID #
24	Medicaid # (also called Provider #)
25	Provider's full name (e.g., Jane Smith)
26	Name of AFH, RCF or IHCA, if different than #24
27	Phone #
28	Email address
29	Physical address
Bottom of the Form	
	Provider's signature / Date of signature
	Provider's printed name

Requesting 2nd Payment? Use Form Part Two

Use the 'Discharge Incentive Payment Form – Part Two' to request the subsequent (second) payment. When the individual has been living in your home/facility (AFH/RCF) or receiving services from you (IHCA) for at least 90 days after discharging from the hospital or SNF/NF, you may request the second payment.

Box #	Information you need to enter for Form Part Two
	About the Individual
1	Name
2	Date of Birth
3	Date individual is moving in (AFH/RCF) or is starting to receive services (IHCA)
4	Is the individual receiving hospice care now
5	Was the individual referred to hospice care after moving in (AFH/RCF), or starting to receive services (IHCA)?
6	During the 90 days since the individual moved in (AFH/RCF), or started receiving services (IHCA):
6a	Did he/she move out (AFH/RCF), or stop receiving services (IHCA)?
6b	If 6a is "Yes", explain why he/she moved out or stopped receiving services
7	Was moving out (AFH/RCF), or stopping services (IHCA) voluntary, involuntary or a something else (Other)
8	Has he/she passed away
8a	If "Yes", provide date of death
9	Individual's new living situation (if he/she moved out (AFH/RCF), or stopped services (IHCA), if applicable
9a	Adult Foster Home or Adult Group Home
9b	Assisted Living Facility or Residential Care Facility (this includes facilities that are endorsed for Memory Care)
9c	Home (this would include a house, apartment, family's home/apartment, mobile home)
9d	Hospital
9e	Houseless
9f	Skilled Nursing Facility or Nursing Facility
9g	Other
9h	If "Other" for 9g, explain

About You (the Provider)	
10	Provider type (AFH, RCF or IHCA)
11	**For IHCA-only:** Have you attached EVV records for every person who provides services to this individual through your IHCA for the entire time since he/she discharged from the hospital or SNF/NF
12	Tax ID #
13	Medicaid # (also called Provider #)
14	Provider's full name (e.g., Jane Smith)
15	Name of AFH, RCF or IHCA, if different than #24
16	Phone #
17	Email address
18	Physical address
Bottom of the Form	
	Provider's signature / Date of signature
	Provider's printed name

Once APD gets the Payment Request, they will confirm the individual and provider meet the program requirements. Within 10 days of receiving an appropriate request, APD will ask the Office of Financial Services (OFS) to issue a payment.

NOTE: The number of providers participating with this incentive program is large, so allow time for payments to process. If you have not received payment within 30 days, notify APD by emailing: hcbs.oregon@odhsoha.oregon.gov

If you have questions, please contact: hcbs.oregon@odhsoha.oregon.gov