DISCHARGE INCENTIVE PAYMENT FORM
PART TWO

With approval from the Oregon Legislature, the Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA) will be providing discharge incentive payments to any Adult Foster Home (AFH) provider or Residential Care Facility (RCF) that admits a new individual to their facility directly from a hospital or (skilled) nursing facility (SNF/NF). Incentive payments are also available to qualifying In-Home Care Agencies (IHCA) that begin providing in-home services to new individuals directly from a hospital or SNF/NF, as long as the individuals receive Medicaid services through the ODHS Aging and People with Disabilities (APD) program. Incentive payments are independent of the provider's regular rate, whether Medicaid or private pay. *This is the approved Discharge Incentive Payment Request Form.*

Information about the Individual needing AFH/RCF Placement or IHCA Services

1. Individual's name:
2. Date of Birth:
3. Date of admission to this AFH/RCF, or date individual started receiving services from this IHCA:
4. Is the individual receiving hospice care now? ☐ Yes ☐ No
5. Was the individual referred to hospice care after admitting to this AFH/RCF, or since starting services with this IHCA? ☐ Yes ☐ No
6. During the 90 days since the individual admitted to this AFH/RCF, or started receiving IHCA services:
   a. Did the individual discharge from this AFH/RCF, or stop receiving services from this IHCA? ☐ Yes ☐ No ☐ N/A
   b. If 6a is Yes, explain the reason why:
7. For this individual, was this change: ☐ Voluntary ☐ Involuntary ☐ Other
8. Has the individual passed away? ☐ Yes ☐ No 8a. If Yes, date of death:
9. What is the individual's new living situation (if applicable)?
   a. ☐ AFH/AGH
   b. ☐ Assisted Living/Residential Care
   c. ☐ Home
   d. ☐ Hospital
   e. ☐ Houseless
   f. ☐ SNF/NF
   g. ☐ Other
   h. If Other, explain:

Information about the Provider **10. Provider Type: ☐ AFH ☐ RCF ☐ IHCA**

11. **IHCA-only**: Have you provided EVV records? ☐ Yes ☐ No

12. Tax ID:	13. Medicaid Number:
14. Provider Name:	15. Name of AFH, RCF or IHCA, if different:
16. Phone:	17. Email:
18. Address:	

By signing this form, you, as the individual's new provider, attest that the following is true:

- The individual did not move out of this Adult Foster Home (AFH) or Residential Care Facility (RCF) involuntarily; or did not stop receiving services from this IHCA involuntarily during the first 90 days from initial discharge from a hospital or SNF/NF.
- I understand I must request the 2nd incentive payment within 30 days from the '90th day from discharge from the hospital or SNF/NF'.
- I understand that an individual who readmits to the hospital or SNF/NF during the first 90 days from initial discharge has the right to return to this AFH or RCF, or to continue receiving services from this IHCA, upon discharge. However, if the individual chooses to go to a new AFH/RCF, or start with a new IHCA, owned by the same corporate entity/licensee as this AFH, RCF or IHCA, I cannot request or receive another initial payment for the individual. Resident readmissions are excluded from this Incentive Program.
- I understand that if this individual left prior to 90 days because his/her needs were not being met, or if it is later determined that this provider did not meet the individual's needs, I need to refund/return the second incentive payment.
- I understand that if Adult Protective Services (APS) becomes involved due to a failure on the part of this provider toward this individual, and APS confirms or substantiates that failure, this provider must refund/return the second incentive payment.
- I have followed all licensing and compliance requirements, including the discharge process as defined in administrative rules.
- I will refer to the Provider Alert for my provider type for all program requirements.
- **The provider will be required to refund the incentive payment(s) if it is later found that the provider does not qualify for the incentive payment(s). All discharge incentive payments are subject to audit at the discretion of the Oregon Department of Human Services.**

Email the completed form to: HCBS.Oregon@odhsoha.oregon.gov

Signature of Provider *(sign above the line)*	Date
Printed Name *(print above the line)*	

ODHS APD Use Only	For OFS
Date Received:	**Amount Authorized**:
Date Initial Payment:	**PCA: 39093**
Date Final Payment:	**Index: 33930**
Reviewed and Approved By:	**AOBJ: 7927**
MMIS #:	**MMIS Reason Code: 3008**