SRTF STAY FORM

Provider/Contractor: Please complete sections 1 through 3 and submit to:
ABH.ResidentialCapacityReporting@odhsoha.oregon.gov

1. Request information (Provider/Contractor to complete)

Date of Request:	Contact Name:
Contact Phone:	Contact Email:
Date SRTF Denial Initiated:	Date to qualify for non-OHP:

2. Provider – Contractor Contact Information (Provider/Contractor to complete)

County:	Program Name:
Contractor Contact Name:	Program Contact Name:
Contractor Contact Email:	Program Contact Email:

3. Individual not meeting medical necessity information (Provider/Contractor to complete)

Name:
Date of Birth:
Populations/Status: ☐ A&A ☐ Civil ☐ PSRB ☐ Voluntary ☐ Voluntary by Guardian
Reason for not meeting medical necessity:
Why individual is not able to transition to another setting currently?
What has been attempted to aid individual in transition? Is a transition thought possible in near future?

OHA | Behavioral Health Division *use only:* Please complete sections 4 through 5.

4. General Fund Cost Analysis (BHD | Contracts to complete)

LSI Score:	Daily Rate:

Date Range:

Projected Cost:

Utilization Review:

Contract Amendment: ☐ Yes ☐ No ☐ Reallocate to Direct

SE 17-part C by FY and amount:

Date Received: Date Reviewed: Reviewer's Name/Signature:

5. Recommendation and approval (BHD | Program to complete)

Program Recommendation:

Date Received: Date Reviewed: Program's Name/Signature:

References:
CH-009
OAR 410-172-0720
Comagine Health website
Prior Authorization Required for SRTF placement starting 3/1/2024

If you have any question about the SRTF Stay Form section 4, please contact Kelly C. Knight at Kelly.C.Knight@oha.oregon.gov or Beth Branscome at Elizabeth.Branscome@oha.oregon.gov

If you have any questions about the SRTF Stay Form section 5, please contact Lisa Nichols at Lisa.M.Nichols2@oha.oregon.gov, or Richelle Murray at Richelle.E.Murray@oha.oregon.gov