Request for Long-Term Psychiatric Care for Persons Age 17 and Under

Request information

Child's name:		Date received:
Parent/guardian:		
Address:		Phone:
City:	Zip code:	County:
Child's Oregon Medicaid or Prime ID:		Date of Birth:
Coordinated Care Organization (CCO):		Other insurance:
Current program:		Admission date:

Referring agency information

County or CCO:	Contact person:
Phone number:	Fax number:
Date of review:	Reviewed by:

Result of review:

☐ Support referral ☐ Recommended alternative:

☐ Guardian is aware of the expectation for family participation in the program

For Utilization Management Organization completion only:

Reviewed by:	Date of decision:

Result of review:

☐ Support referral ☐ Denied. Reason for denial:

For Oregon Health Authority completion only. *If you have questions about this decision, contact CFBH staff at childrensltpc.referrals@odhsoha.oregon.gov or 503-756-8540. If your request is approved, a Trillium representative will contact your agency regarding timelines and procedures*

Reviewed by: Date of decision:

☐ Summer Hunker ☐

Result of review:

☐ Approved ☐ Denied. Reason for denial:

☐ SCIP referral ☐ SAIP referral

☐ Determination form faxed to Trillium Family Services