

DISCHARGE INCENTIVE PAYMENT FORM

PART ONE

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 long-term services and supports through the ODHS Aging and People with Disabilities (APD) program and Medicaid. 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. Insurance: <input type="checkbox"/> Medicaid - 3.a. Individual's Medicaid ("Prime") #: <input type="checkbox"/> Private Pay <input type="checkbox"/> Other: Type	4. Did you do an assessment of the individual's needs in the hospital or SNF/NF? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Have you done a full assessment of your ability to meet the individual's needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Name of hospital/SNF/NF: 7. Date of admission to hospital/SNF/NF: 8. Length of stay (# of days) at hospital/SNF/NF: 9. Reason for delayed discharge from hospital/SNF/NF, if known:	10. Date of admission to this AFH/RCF, or date started services with this IHCA: 11. Is the individual now going to receive hospice care? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Individual's living situation prior to the hospital/SNF/NF: <input type="checkbox"/> AFH/AGH <input type="checkbox"/> Assisted Living/RCF <input type="checkbox"/> Home <input type="checkbox"/> Houseless <input type="checkbox"/> SNF/NF <input type="checkbox"/> Other 12a. If Other, explain:	
13. Did the individual agree to placement with this AFH/RCF, or to receive services from this IHCA? <input type="checkbox"/> Yes <input type="checkbox"/> No 14. If the individual is unable to agree to placement with this AFH/RCF, or to receive services from this IHCA, was a legal representative involved? <input type="checkbox"/> Yes <input type="checkbox"/> No 14a. If Yes, provide the legal representative's name: 15. If No to both 13 and 14, provide the name of the person who made the decision:	
Individual's Demographic Information 16. Gender this individual identifies as: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other 17. Race/Ethnicity: a. <input type="checkbox"/> American Indian and/or Alaska Native e. <input type="checkbox"/> Middle Eastern or Northern African b. <input type="checkbox"/> Asian f. <input type="checkbox"/> Native Hawaiian and/or Pacific Islander c. <input type="checkbox"/> Black/African American g. <input type="checkbox"/> White/Caucasian d. <input type="checkbox"/> Latinx/Hispanic h. <input type="checkbox"/> Other	

Individual's Demographic Information (continued)18. Does this individual have difficulty communicating or being understood by others? Yes No

18a. If Yes, explain the reason for the difficulty:

19. What language(s) does this individual speak?

20. In what language(s) does this individual write?

21. What are this individual's primary disabilities, if any?

Information about the Provider22. Provider Type: AFH RCF IHCA

23. Tax ID:

24. Medicaid Number:

25. Provider Name:

26. Name of AFH, RCF or IHCA, if different:

27. Phone:

28. Email:

29. Address:

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

- I do not have any restrictions on my license for admissions.
- I understand I have 30 days from the date the individual discharges from the hospital or SNF/NF to request the initial payment.
- To receive the second payment, I will continue to serve this individual for at least 90 days from the date of admission to this AFH or RCF, or from the date this individual started receiving services from this IHCA.
- I will follow 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.govSignature of Provider *(sign above the line)*

Date

Printed Name *(print above the line)***ODHS APD Use Only****For OFS****Date Received:****Amount Authorized:****Date of Initial Payment:**PCA: **39093****Date of Second Payment:**Index: **33930****Reviewed and Approved By:**AOBJ: **7927****MMIS #:**MMIS Reason Code: **3008**