OHSU Health Services

Recuperative Care Program (RCP) Request Form

Please complete all fields and email to ohsuhscareteam@ohsu.edu

Incomplete requests will not be processed.
Please complete as fillable PDF – handwritten requests will not be accepted.

Member and Provider Information

Member Name: ____________________ Date: ____________

Member ID: ____________________ DOB: ____________________

Requestor Name: ____________________ Facility Name: ____________________

Requestor Phone: ____________________ Admit Date(s): ____________________

Admit Diagnoses: ____

Referral Information

Insurance Coverage:

☐ HSO/OHSU Health Services

Request:

☐ Initial Request (30 days) ☐ Extension Request, additional days requested (30-day max): ____________

OHSU Health Services RCP requirements:

☐ Member agrees to go to RCP stay and engage

☐ Member agrees to engage with RCP and Health Services Care Manager during stay

RCP has accepted member: ☐ Yes ☐ No **Anticipated admission date to RCP:** ____________

Please note that motel bridges are not covered by Health-Related Service (HRS) funding prior to RCP admission.

Anticipated goals and objective of stay:

Indicate post-hospital care that is been ordered for member:

☐ Wound care ☐ Home Health ☐ Occupational Therapy ☐ Physical Therapy

☐ OP Infusion ☐ Other: ____________________

Please list any additional referrals or services planned for post-discharge care: