OHSU Health Services

Recuperative Care Program (RCP) Request Form

Please complete all fields and email to ohsuhshrs@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 engage in medical care

☐ 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 care that is been ordered for member:

☐ Wound care ☐ Occupational Therapy ☐ Physical Therapy ☐ OP Infusion

☐ Home Health (list provider): _____ ☐ Other: _____

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