ACT Referral Process and Checklist

Last revised: April 2024

What to include in your referral

- ACT Universal Referral Form
- Most recent assessment
- Medication Administration Record (MAR)
- Last 30 days of clinical notes

Referral process

1. All new referrals for CareOregon Members
    a. Should be submitted via the CareOregon Connect Provider Portal
    b. Referrals may also be submitted via fax to 503-416-4727
    c. All requests should contain the above referenced materials
    d. If submitting via CareOregon Connect please only select “TBD Behavioral Health Providers” in the “Servicing Provider” field
2. Once received your referral will be routed directly to an ACT team for screening and consideration. If there are no teams with openings at the time of your referral you will be offered an option to be added to the wait list.
3. If routed directly to a team you will receive a determination within 14 days of that referral being sent from CareOregon to the corresponding ACT team.
    a. If you opt to be added to the waitlist, we will notify you when your referral can be passed to a team and the referral will follow the aforementioned timeline.
4. The ACT team may request additional information or documentation at the time of their screening and may request an additional 14 days to review and make a determination.
5. Additionally, they may indicate that your referral is pending. Pending status only applies to referrals where the member is currently 60 or more days away from being discharged from an acute care setting.

Grievances and appeals

In addition, if an individual is denied ACT services the individual or their guardian may appeal the decision by filing a grievance in the manner set forth in OAR 309-008-1500 or for an Administrative Hearing which will be documented on The Division’s form number MSC 0443 by either the Program, CCO or The Division and submitted through appropriate channels. OAR 309-019-0248 (7)

CareOregon grievance and appeals

Members or their guardians have the right to file an appeal if a request for the authorization of ACT services is denied by CareOregon. The appeal must be filed within 60 days of the date on the letter that notifies you of the denial.

Members or their guardians have the right to file a grievance with CareOregon if they are dissatisfied with decisions by their providers (such as declining to offer ACT services to the member), any part of the referral process, or the care provided.

Providers do not have the right to file an appeal or a grievance on behalf of the member unless the member or their legal guardian have signed a form allowing the provider to act on their behalf.

To file either a grievance or an appeal, please contact our Customer Service department at 503-416-4100.

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