**Healthcare and Family Services**

**Family Support Program (FSP)**

**FSP Residential Treatment Services**

**Residential Discharge Acknowledgement**

Submit to eQHealth by fax within 3 business days after youth’s discharge

**Fax Number: (800)418-4039**

Subject Line: FSP Residential Discharge Form

eQHealth Solutions requests that residential treatment facilities (RTFs) discharging Family Support Program youth to please complete this form within 3 business days after the youth’s discharge and send to eQHealth by **secure fax at (800)418-4039**. Please contact **(866) 435-8778** if you have any questions.

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| **1.Recipient Information** |
| **Youth First Name:**       | **Youth Last Name:**      | **Date of Birth:**      | **RIN:**      |
|  |  |
| **2. Residential Treatment Provider Information** |
| **Residential Provider Name:**      | **Provider ID:**      |
| **Address:**      | **City:**      | **State:**      | **Zip Code:**      |
| **Provider Contact Name:**       | **Contact Email:**       | **Contact Phone:**      |

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| **3. Discharge Information** |
| **Date of Admission to Facility:**      | **Date of Discharge from Facility:**      |