**Healthcare and Family Services**

**Family Support Program (FSP)**

**FSP Residential Treatment Services**

**Residential Transfer Form**

Submit to eQHealth by fax within 3 business days after youth is admitted

Fax Number: (800) 418-4039

Subject Line: “FSP Residential Transfer Form”

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **1. SASS Provider Information** | | | | | |
| **Agency Name:** | | **FSP Coordinator Name:** | | | **FSP Coordinator Phone Number:** |
| **Address:** | **City:** | | **State:** | **Zip Code:** | |

This is to inform you that the youth mentioned below will be transferring to a new residential treatment provider.

The following information documents the youth’s current provider and the new residential treatment provider.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **2. Recipient Information** | | | | | | | | | | | |
| **Youth First Name:** | **Youth Last Name:** | | | | **Date of Birth:** | | | **RIN (Medicaid ID#):** | | | |
|  | | |  | | | | | | | | |
| **3. Current Residential Treatment Provider Information** | | | | | | | | | | | |
| **Name of RTF:** | | | | **Provider ID:** | | | | | | | |
| **Address:** | | **City:** | | **State:** | | **Zip Code:** | **Date of Discharge:** | | | | |
|  | | |  | | | | | | | | |
| **4. New Residential Treatment Provider Information** | | | | | | | | | | | |
| **Name of RTF:** | | **Provider ID:** | | | | | **Date of Admission:** | | | | |
| **Address:** | | **City:** | | **State:** | | **Zip Code:** | | | | | |
| **Contact Person:** | | **Telephone Number:** | | | | | **Email:** | | | | |
|  | | |  | | | | | | | | |
| **5. Signature** | | | | | | | | | | | |
|  | | | | | | | | |  |  |  |
| **FSP Coordinator Signature** | | | | | | | | |  | **Date** |  |