**Healthcare and Family Services**

**Family Support Program (FSP)**

**FSP Residential Treatment Services**

**Residential Placement Form**

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

Fax Number: (800) 418-4039

Subject Line: “FSP RTF Placement”

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 has been accepted and admitted into residential care, as part of the Family Support Program. The following information documents the youth’s residential treatment provider.

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