

Family Support Program (FSP)

Continued Enrollment Authorization Request Packet

**November 2018**



**Family Support Program (FSP) Continued Enrollment Request Submission Process**

The Department of Healthcare and Family Services (HFS), the state agency responsible for the FSP, has designated eQHealth Solutions, Inc. (eQHealth) to provide administrative and clinical support to the FSP, including reviewing requests for continued FSP enrollment.

The FSP continued enrollment authorization request packet will be considered complete once all of the documentation listed in the FSP Continued Enrollment Authorization Request Checklist is gathered and submitted to eQHealth for review. This includes a signature from the youth or the youth’s legal guardian, when applicable, on Section 6, Request for Continued Eligibility Determination, attesting that the youth or legal guardian has reviewed the entire packet and consents to the submission of the packet to HFS through its designee, eQHealth, for the purpose of determining ongoing eligibility for the Family Support Program.

Requests for continued FSP enrollment may only be submitted to eQHealth during the last 30 days of an FSP youth’s 180-day FSP eligibility period.

Completed FSP applications may be submitted by the youth, the youth’s legal guardian (when applicable) or the youth’s FSP Coordinator at the designated Screening, Assessment and Support Services (SASS) agency.

FSP continued enrollment request packets may be submitted to eQHealth in any of the following ways:

1. By faxing the application to (800) 418-4039 using the subject line “FSP Application for Review;” or,
2. By mailing the application to the following address:

eQHealth Solutions, Inc.

Attn: FSP Technical Coordinator

500 Waters Edge, Suite 125

Lombard, IL 60148



**FSP Continued Enrollment Authorization Request Checklist**

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| 1. | Completed FSP continued enrollment authorization request form including each of the following components: |
|  | Section 1, General Information (p. 4) |
|  | Section 2, Family Financial Information (p. 5), including the following, as applicable:* Copy of the legal guardian’s tax returns for the last calendar year, if filed.
* Copy of the youth’s tax returns for the last calendar year, if filed.
 |
|  | Section 3, Youth’s Behavioral Health Treatment History, covering the last 6 months of behavioral health services the youth received (p. 6) |
|  | Section 4, Progress Note (p. 7) |
|  | Section 5, Acknowledgement of FSP Parent or Guardian Responsibilities (p. 8)* This section is only required if the youth has a legal guardian.
 |
|  | Section 6, Request for Continued Eligibility Determination (p. 9), including:* Signatures from the youth or the youth’s legal guardian that they have reviewed the application for accuracy and completion; and,
* Signature from the youth’s FSP Coordinator if the FSP Coordinator is submitting the request.
 |
| 2. | For youth ages 18 to 21: a completed Attestation of School Enrollment and Attendance form (p. 11) |
| 3. | Copy of the youth’s current Individual Assessment and Treatment Plan, updated within 45 days prior to the submission of the FSP continued enrollment review packet. |
| 4. | If a change in custody or guardianship occurred since the last FSP eligibility review: court order defining custody and/or non-parental guardianship. |

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| **FSP CONTINUED ENROLLMENT REQUEST FORM** |
| **1. GENERAL INFORMATION** |
| **Youth Name** | **Recipient ID #** N/A | **Date of Birth** |
| **Gender** | **Primary Language** | **Phone Number** N/A | **US Citizen**Yes | No |  | **Household Size** |
| **Youth’s Home Address** | **City** | **State** | **ZIP Code** | **County** |
| **Race** | American Indian or Alaska NativeAsianBlack/African American | Hawaiian Native/Other Pacific Islander HispanicWhite | Multi-Race Other:  | **Ethnicity**HispanicNon-Hispanic |
| **Interpreter****Services** | None TDD/TTY American Sign LanguageSpoken Language: Other:  | **Guardianship****Status** | Own guardianLegal guardian | Parent |
| **Parent/ Guardian Information** | **Name** | **Relationship to Youth:**Parent Guardian |  |  |  | **Phone Number** |
| **Address** | **City** |  |  | **State** | **Zip Code** | **County** |
| **Parent/ Guardian Information** | **Name** | **Relationship to Child:**Parent Guardian |  |  |  | **Phone Number** |
| **Address** | **City** |  |  | **State** | **Zip Code** | **County** |
| **Residential Arrangement** | Homeless Independent LivingLives with parent(s), relative(s), or guardian(s)State operated facility (mental health/dev. disability) Jail or correctional facility | Residential/Institutional Setting (residential treatment center, nursing home)Foster Care Other:  |
| **Education Level**(last completed) | Never attended school Preschool/KindergartenGrade 1 | Grade 2Grade 3Grade 4 | Grade 5Grade 6Grade 7 | Grade 8Grade 9Grade 10 |  | Grade 11High school diploma GED certificate |
|  | **School Name** | **Primary Contact Name** | **Primary Contact Role** | **Phone Number** |
| **School****Information**(optional) | **School Main Number** | **School Addre** | **ss** |  |  | **City** |  |  | **Zip Code** |
| **SASS****Provider Information** | **Agency Name** | **FSP Coordinator Name** |  |  | **FSP Coordinator Phone** |
| **Agency Address** | **City** |  |  |  | **Zip** |  | **County** |  |

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| **2. FAMILY FINANCIAL INFORMATION** |
| Please complete this section in its entirety, to the best of your ability. Attach additional pages to this application packet as necessary. |
| **Youth’s Insurance Coverage** (list all types of insurance, including Medicaid/All Kids coverage, when applicable) |
| **Name of Insurance Company/Companies** |  | **Policy Number(s)** |  |  |  |  |  |  |  |
|  **Premium Costs: $** Weekly Every two weeks Twice a month Quarterly Yearly |
| **Is this a retiree health plan?**Yes No Unknown |  | **Is this a COBRA plan?**Yes No Unknown | **Does the plan cover at least 60% of benefit costs?**Yes No Unknown |
| **Please list any properties the parent/guardian or youth owns, such as home, vacation home, time share, building or land.** |
| **Owner Name** |  |  | **Address** |  |  |  | **Type** |  |  | **Current Value** | **Amount Owed** |
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| **Does the parent/guardian or youth own any of the following resources? Check all that apply.** |
| Business Life Estate AnnuityBurial Plot(s) | Inheritance Funeral/Burial Plan Mutual FundsIRA/401K | Savings Account Checking Account Certificates of DepositStocks, Bonds |  | Mineral/Oil Rights Money Market Account Trust FundsNursing Home Account | Promissory Note/Loan Deferred Comp Government BondsReverse Mortgage |
| Other Financial Resources: Please List  |
| **Owner Name** |  |  | **Type of Resource** |  | **Current Value** |  |  | **Name of Bank, Company, etc.** |
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| **Family Income** |
| **Youth’s income for last calendar year:**  | AGI Net | **Youth’s anticipated income for this year:**  |  | AGI Net |
| Youth’s most recent federal tax return attached No federal return filed on behalf of the youth |  |  |
| **Parent/guardian(s) income for last calendar year:**N/A – youth is own guardian | AGI Net | **Parent/guardian(s) anticipated income for this year:** N/A – youth is own guardian | AGI Net |
| Parent/guardian(s) most recent federal tax return(s) attached No federal return filed |  |
| **Please list any public benefits currently received on behalf of the youth, not including Medical Assistance (All Kids) or Medicare.** |
| **Type** |  |  | **Effective Date** |  | **Monthly Benefit Amount** |  |  |  | **Payee** |  |
| Social Security |  |  |  |
| Supplemental Security Income |  |  |  |
| State Cash Assistance (i.e. TANF) |  |  |  |
| Adoption Subsidy |  |  |  |
| Other:  |  |  |  |
| Other:  |  |  |  |
| **Please summarize how the parent(s)/guardian(s) receive income annually.** N/A – youth is own guardian |
| **Type** | **Current Amount** | **Recipients/Payees** |  |  |  |  | **Description** |  |
| Employment |  |  |  |
| Investments |  |  |  |
| Public Benefits |  |  |  |
| Other:  |  |  |  |

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| **3. BEHAVIORAL HEALTH TREATMENT HISTORY** |
| In the appropriate sections below, please list all of the mental health and substance abuse services and supports the youth has received in the last 6 months, including those services and supports received outside of the FSP. Please attach additional pages as needed. |
| **Psychiatric Hospitalization** |
| **Hospital Name** |  | **Location (City, State)** | **Dates Hospitalized** |  |  |  | **Reason for Hospitalization** |
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| **Residential/Group Home Treatment** |
| **Facility Name** |  | **Location (City, State)** |  | **Treatment Dates** |  |  |  | **Reason for Admission (Presenting Problem)** |
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| **Outpatient Mental Health Services/Supports** |
| **Service Name** |  | **Provider Name** |  |  | **Service Frequency** |  | **Service Begin Date** | **Service End Date** |
|  |  |  |  | Service ongoing |
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|  |  |  |  | Service ongoing |
|  |  |  |  | Service ongoing |
|  |  |  |  | Service ongoing |
| **Outpatient Substance Use Services/Supports** |
| **Service Name** |  | **Provider Name** |  |  | **Service Frequency** |  | **Service Begin Date** | **Service End Date** |
|  |  |  |  | Service ongoing |
|  |  |  |  | Service ongoing |
| **Medication(s).** Please list all of the youth’s current medications, as well as any other medications taken in the last 6 months. Include all prescribed and over the counter medications. |
| **Medication Name** | **Prescriber** | **Dosage** |  |  | **Date Started** |  | **Date Ended** |  |  | **Side Effects** |
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Page **6** of **13** FSP Application

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| **4. Progress Note** |
| Please note: this page must be completed by the youth’s assigned SASS agency or the in-network FSP residential provider where the youth is currently receiving treatment services. The reviewing LPHA must provide a contact phone number and must be available to provide a phone consultation as requested by eQHealth as part of the FSP continued enrollment review process. |
| **Provider Type:** SASS FSP Residential |
| **Staff Member Completing Form:** |  | **Agency Name:** |  |
| **FSP Youth Name**: |  | **RIN**: |  |
| **Summary of Progress.** Please identify the progress the FSP youth has made since the youth’s last FSP eligibility review. |
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| **Ongoing Areas of Concern.** Please identify the ongoing behaviors of concern that continue to be the focus of the FSP youth’s treatment. |
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| **Signatures.** |
|  | Phone Number |  |
| Reviewing LPHA (print name) | Signature | Date |

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| **5. Acknowledgement of Continued FSP Parent or Guardian Responsibilities (if applicable)** |
| Participation in the Family Support Program requires that, when applicable, the youth’s parent or guardian continue to agree to meet the FSP parent or guardian responsibilities, which are outlined below. To complete this section, please:1. Review each parent or guardian responsibility carefully;
2. Initial next to each requirement to indicate you have read and agree to meet the standards of parent or guardian participation, should the youth be determined eligible for ongoing participation in the FSP; and
3. Sign and date this Acknowledgement in the appropriate space provided below.

Note: if the youth is his/her own guardian, this section does not need to be completed and submitted as part of the FSP Continued Enrollment Request packet. |
| **FSP Parent or Guardian Responsibilities**If the youth seeking services is found eligible for continued participation in the FSP, I agree to: |
| Initials | 1. Actively participate in the youth’s treatment. |  |
| Initials | 2. Be primarily responsible for any financial obligations associated with participation in the program. This may include being responsible for services not covered by the FSP (e.g. transportation, any necessary equipment). |
| Initials | 3. Assist in identifying and coordinating funding of services from all available sources, including insurance coverage. |
| Initials | 4. Assist in the completion of all applications for public assistance programs, including HFS Medical Assistance, supplemental security income (SSI), Social Security benefits (SSA), and other programs as appropriate. |
| Initials | 5. Complete and submit all forms and documents required by HFS. |
| Initials | 1. Work with my FSP Coordinator to notify HFS of any changes to the following:
	* The financial income or assets of the parent, guardian, or youth;
	* The level of financial support from public sources for the parent, guardian, or youth;
	* The healthcare coverage for the youth;
	* The parent or guardian’s home address; and,
	* The guardianship or legal custody of the youth.
 |
| Initials | 1. In the event the youth receives treatment in a residential treatment setting:
	* Notify HFS of all assets and sources of public financial support of the youth;
	* Make available all sources of public financial support for the youth, including but not limited to SSA and SSI, to be applied to the costs of residential treatment, to the extent provided by law;
	* Coordinate all educational functions, processes, and funding between the youth’s home school district to ensure compliance with the compulsory education attendance requirements that the youth will be attending while in residential treatment;
	* Participate in and cooperate with the residential treatment facility’s requirements for the youth’s care, including treatment and discharge to the family and community;
	* Supply the usual and customary costs of parenthood or guardianship, including: clothing, medical, dental, personal allowance, incidentals, and transportation costs to and from residential treatment; and,
	* Accept the youth back into the home or be solely responsible for establishing residence for the youth upon discharge from residential treatment.
 |
| **Signature** |
| Parent/Legal Guardian (print name) | Signature | Date |

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| **6. Request for Continued Eligibility Determination** |
| **Youth/Legal Guardian Attestation – By signing below, I confirm that:** |
| ● | I have read all of the information in this packet and, to the best of my knowledge, all of the information in this packet is correct. |
| ● | I understand that incomplete requests for continued FSP enrollment will not be reviewed for ongoing FSP eligibility. |
| ● | I have had a chance to ask my FSP Coordinator questions about the FSP continued enrollment request process. |
| ● | I am submitting this packet and all required supporting documentation to Healthcare and Family Services through its designee, eQHealth Solutions, Inc., in order to make a determination of continued eligibility for the FSP. I understand that I may withdraw this application at any time by contacting eQHealth. |
| ● | I understand that if the youth is found eligible for continued participation in the FSP, confidential information about the youth will be shared with the SASS provider assigned to work with my family for the purposes of providing or arranging for FSP services. The type of information that will be disclosed includes the youth’s name, demographic information, my contact information, my family’s financial information, and the youth’s clinical records submitted as part of this packet. |
| ● | I understand that if the youth is found eligible for continued participation in the FSP, he/she will receive 180 days of ongoing program eligibility. I understand that I will be responsible for completing an FSP Continued Enrollment Packet within the last 30 days of the youth’s next eligibility period if I wish for the youth to be authorized for an additional 180 days of eligibility in the FSP. |
|  | Youth/Legal Guardian (print name) |  | Signature |  | Date |
| **FSP Coordinator Attestation – By signing below, I confirm that:** |
| ● | I am the FSP Coordinator that has assisted the youth or the youth’s legal guardian, as necessary, with completing this FSP continued eligibility request packet. |
| ● | I have gone over the criteria for continued FSP eligibility on page 2 with the youth or the youth’s legal guardian, as applicable. |
| ● | I have given the youth or the youth’s legal guardian, as applicable, a chance to ask me questions about the FSP continued enrollment request process. |
| ● | I have informed the youth or the youth’s legal guardian, as applicable, that he/she has the right to inspect and copy the information in this application. |
| ● | I have informed the youth or the youth’s legal guardian, as applicable, about the process for withdrawing this request. |
|  | FSP Coordinator (print name) |  | Signature |  | Date |

# ITEM # 2

**Attestation of School Enrollment and Attendance**

Section Title Page.

Place this title page in front of the content: Attestation of School Enrollment and Attendance Form

**Bruce Rauner, Governor**

Felicia F. Norwood, Director

201 South Grand Avenue East **Telephone:** (217) 782-1200

Springfield, Illinois 62763-0002 **TTY:** (800) 526-5812

**Family Support Program (FSP)**

**Attestation of School Enrollment and Attendance Form**

This form must be completed by an administrator at the school or educational program that the FSP youth currently attends. This form is required for youth ages 18 and older as part of the FSP continued enrollment review process. Questions regarding this form may be addressed to the Bureau of Behavioral Health at the Department of Healthcare and Family Services by calling 217-557-1000 or emailing HFS.BBH@illinois.gov.

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| **Youth Information** |
| **Name:** | **Date of Birth:** |

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| **School Information** |
| **Name:** |  |  | **Dist** | **rict Number** | **:** N/A |
| **Main Phone:** | **Address:** |  |
| **City:** | **State:** |  |  | **Zip code:** |  |
| **School Type:** | Public Private Homeschool Alternative Parochial Charter Other (describe):  |

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| **Attestation of School Enrollment and Attendance** |
| By signing below, I confirm that the following is true to the best of my knowledge: |
| ● | I am currently an administrator at the school identified above. |
| ● | The youth identified above is currently enrolled as a student at the identified school. |
| ● | The youth identified above has not graduated high school, achieved high school graduation equivalency, and does not qualify at this time for high school graduation. |
| ● | The youth identified above was not absent from school without valid cause, as defined in Section 26-2a of the Illinois School Code, for 5% or more of the last 180 school days or since the youth became enrolled in the school, whichever occurred first. |

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| **Signature** |
| School Administrator (print name) |  | Title |
| Signature |  | Date |

# ITEM # 3

**Current Individual Assessment and Treatment Plan**

Section Title Page.

Place this title page in front of the content: Individual Assessment and Treatment Plan

# ITEM # 4

**Court Order Defining Custody and/or Non-Parental Guardianship (if applicable)**

Section Title Page.

Place this title page in front of the content: Court Order