ILLINOIS DEPARTMENT OF Healthcare and Family Services

Prior Authorization #:

FAMILY SUPPORT PROGRAM (FSP) / SPECIALIZED FAMILY SUPPORT PROGRAM (SFSP)

Prior Authorization for Family Support Services

Submit completed form and client IATP to HFS via
fax: Attn: FSP Program Manager (217)-524-1221 or email: HFS.FSP@illinois.gov

Section 1. General Information	**Program Enrollment:** ◯ FSP ◯ SFSP	
Youth Name:	**RIN:**	**Birthdate:**
FSP Coordinator:	**Email:**	
FSP Agency Name:	**HFS Provider ID:**	

Section 2: Service Information		
Service Type: ◯ Family Support ◯ Therapeutic Support	**Dates of Service:** –	
Name of Service:		
Number of Hours to Be Purchased: *# of hours*	**Requested Service Frequency:** *# of Units*	x $ *Per Unit Cost* = $ *Total Cost*

Section 3: Service Justification *Attach additional pages in support of this section, as necessary*

What specific goal on the recipient's Integrated Assessment Treatment Plan does this service apply to?
A copy of the recipient's current Integrated Assessment and Treatment Plan must be submitted along with this form.

How does this service support the target goal on the youth's Integrated Assessment and Treatment Plan?

LPHA Signature:		**Date:**	

HFS Office Use Only

◯ *Approved* ◯ *Denied*	***Reasons for Denial:***
Signature:	***Date:***