

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
2050-10 South Finley Road
Lombard, IL 60148

FSP Continued Enrollment Authorization Request Checklist

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.

FSP CONTINUED ENROLLMENT REQUEST FORM

1. GENERAL INFORMATION

Youth Name		Recipient ID # <input type="checkbox"/> N/A		Date of Birth	
Gender	Primary Language	Phone Number <input type="checkbox"/> N/A	US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		Household Size
Youth's Home Address		City	State	ZIP Code	County
Race	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Hawaiian Native/Other Pacific Islander	<input type="checkbox"/> Multi-Race		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other: _____		
	<input type="checkbox"/> Black/African American	<input type="checkbox"/> White			
Interpreter Services	<input type="checkbox"/> None <input type="checkbox"/> TDD/TTY <input type="checkbox"/> American Sign Language	Guardianship Status		<input type="checkbox"/> Own guardian <input type="checkbox"/> Parent	<input type="checkbox"/> Legal guardian
Parent/ Guardian Information	Name	Relationship to Youth: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		Phone Number	
	Address	City	State	Zip Code	County
	_____	_____	_____	_____	_____
Parent/ Guardian Information	Name	Relationship to Child: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		Phone Number	
	Address	City	State	Zip Code	County
	_____	_____	_____	_____	_____
Residential Arrangement	<input type="checkbox"/> Homeless		<input type="checkbox"/> Residential/Institutional Setting (residential treatment center, nursing home)		
	<input type="checkbox"/> Independent Living		<input type="checkbox"/> Foster Care		
	<input type="checkbox"/> Lives with parent(s), relative(s), or guardian(s)		<input type="checkbox"/> Other: _____		
	<input type="checkbox"/> State operated facility (mental health/dev. disability)				
	<input type="checkbox"/> Jail or correctional facility				
Education Level (last completed)	<input type="checkbox"/> Never attended school	<input type="checkbox"/> Grade 2	<input type="checkbox"/> Grade 5	<input type="checkbox"/> Grade 8	<input type="checkbox"/> Grade 11
	<input type="checkbox"/> Preschool/Kindergarten	<input type="checkbox"/> Grade 3	<input type="checkbox"/> Grade 6	<input type="checkbox"/> Grade 9	<input type="checkbox"/> High school diploma
	<input type="checkbox"/> Grade 1	<input type="checkbox"/> Grade 4	<input type="checkbox"/> Grade 7	<input type="checkbox"/> Grade 10	<input type="checkbox"/> GED certificate
School Information (optional)	School Name	Primary Contact Name	Primary Contact Role	Phone Number	
	School Main Number	School Address	City	Zip Code	
SASS Provider Information	Agency Name	FSP Coordinator Name		FSP Coordinator Phone	
	Agency Address	City	Zip	County	

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

Does the parent/guardian or youth own any of the following resources? Check all that apply.

- Business
- Life Estate
- Annuity
- Burial Plot(s)
- Other Financial Resources: Please List _____
- Inheritance
- Funeral/Burial Plan
- Mutual Funds
- IRA/401K
- Savings Account
- Checking Account
- Certificates of Deposit
- Stocks, Bonds
- Mineral/Oil Rights
- Money Market Account
- Trust Funds
- Nursing Home Account
- Promissory Note/Loan
- Deferred Comp
- Government Bonds
- Reverse Mortgage

Owner Name	Type of Resource	Current Value	Name of Bank, Company, etc.

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: _____			

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

Residential/Group Home Treatment

Facility Name	Location (City, State)	Treatment Dates	Reason for Admission (Presenting Problem)

Outpatient Mental Health Services/Supports

Service Name	Provider Name	Service Frequency	Service Begin Date	Service End Date
				<input type="checkbox"/> Service ongoing
				<input type="checkbox"/> Service ongoing
				<input type="checkbox"/> Service ongoing
				<input type="checkbox"/> Service ongoing
				<input type="checkbox"/> Service ongoing
				<input type="checkbox"/> Service ongoing

Outpatient Substance Use Services/Supports

Service Name	Provider Name	Service Frequency	Service Begin Date	Service End Date
				<input type="checkbox"/> Service ongoing
				<input type="checkbox"/> 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

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.

Ongoing Areas of Concern. Please identify the ongoing behaviors of concern that continue to be the focus of the FSP youth's treatment.

Signatures.

Reviewing LPHA (print name)

Phone Number

Signature

Date

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

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
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.

Youth Information

Name: _____ **Date of Birth:** _____

School Information

Name: _____ **District Number:** _____ N/A

Main Phone: _____ **Address:** _____

City: _____ **State:** _____ **Zip code:** _____

School Type: Public Private Homeschool Alternative Parochial Charter
 Other (describe): _____

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.

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