

**Family Support Program (FSP):
Authorization for Individual Support Days (ISD)**

*Submit completed form to HFS via fax or email:
217-524-1221 • HFS.BHClinical@illinois.gov*

Recipient Name:	RIN:
Residential Facility:	HFS Provider ID:
Request Type: <input type="checkbox"/> Initial <input type="checkbox"/> Continued Authorization	
Requested Begin Date:	Requested End Date:
PRESENTING BEHAVIORS	
<i>In the box below, identify the escalating behaviors the youth is demonstrating that require an increase in the level of supervision and observation. Check all that are applicable.</i>	
<input type="checkbox"/> Restraint <input type="checkbox"/> Seclusion <input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> Damage to Property <input type="checkbox"/> Aggression <input type="checkbox"/> Other (describe): _____	
CLINICAL SUMMARY	
<i>Provide a summary of the youth's presenting problem and behaviors over the last thirty (30) days or, for concurrent reviews, over the past seven (7) days. The summary must include information related to the box(es) checked under the "Presenting Behaviors" section, including a listing of any applicable restraints or seclusions, and must explain how the youth's increase in clinical acuity risks destabilizing the residential placement without additional support.</i>	

CRISIS SAFETY PLAN

Please attach a copy of the most current Crisis Safety Plan to this request.

Date last reviewed/modified: _____

PROVIDER ATTESTATION

I understand that by checking each of the boxes below, I am attesting to the following on behalf of the residential facility for each authorized Individual Support Day for which the residential facility is seeking reimbursement from HFS:

- The youth will have a dedicated staff member present with him/her at all times.
- The youth will have constant supervision from staff capable of responding to his/her needs.
- The youth will have contact at least once per day with a Qualified Mental Health Professional.
- The youth will have a review of his/her medication and Integrated Assessment and Treatment Plan (IATP) within 14 days of the ISD begin date.
- The youth will have an individualized structured daily living/activity plan that is approved by a Licensed Practitioner of the Healing Arts and that is reviewed on a regular basis to ensure the youth's clinical needs are being addressed.

LPHA CONTACT

Please provide the name and contact information of a Licensed Practitioner of the Healing Arts that may be contacted to provide additional information regarding this request.

LPHA Name:

Clinical Credentials:

Phone Number:

SIGNATURES

Staff Signature:

Credentials:

Date:

Return Fax Number:

Staff Phone:

HFS Office Use Only

Approved **Denied** **Dates approved:**

Number of days approved:

Comments:

Reviewer Name:

Signature:

Date: