ILLINOIS DEPARTMENT OF Healthcare and Family Services

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 #** ☐ 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 Native
☐ Asian
☐ Black/African American
☐ Hawaiian Native/Other Pacific Islander
☐ Hispanic
☐ White
☐ Multi-Race
☐ Other: _____

Ethnicity
☐ Hispanic
☐ Non-Hispanic

Interpreter Services
☐ None ☐ TDD/TTY ☐ American Sign Language
☐ Spoken Language: _____ ☐ Other: _____

Guardianship Status
☐ Own guardian ☐ Parent
☐ Legal guardian

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 Living
☐ Lives 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	☐ Grade 2	☐ Grade 5	☐ Grade 8	☐ Grade 11
☐ Preschool/Kindergarten	☐ Grade 3	☐ Grade 6	☐ Grade 9	☐ High school diploma
☐ Grade 1	☐ Grade 4	☐ Grade 7	☐ Grade 10	☐ 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 ☐ Inheritance ☐ Savings Account ☐ Mineral/Oil Rights ☐ Promissory Note/Loan
☐ Life Estate ☐ Funeral/Burial Plan ☐ Checking Account ☐ Money Market Account ☐ Deferred Comp
☐ Annuity ☐ Mutual Funds ☐ Certificates of Deposit ☐ Trust Funds ☐ Government Bonds
☐ Burial Plot(s) ☐ IRA/401K ☐ Stocks, Bonds ☐ Nursing Home Account ☐ Reverse Mortgage
☐ Other Financial Resources: Please List _____

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) most recent federal tax return(s) attached

Parent/guardian(s) anticipated income for this year: _____ ☐ N/A – youth is own guardian ☐ AGI ☐ Net

☐ 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
				☐ Service ongoing
				☐ Service ongoing
				☐ Service ongoing
				☐ 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

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

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
6. 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
7. 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

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

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Bruce Rauner, Governor
Felicia F. Norwood, Director

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