**Healthcare and Family Services**

**Family Support Program (FSP)**

**FSP Residential Treatment Services**

**Residential Transfer Form**

Submit to eQHealth by fax within 3 business days after youth is admitted

Fax Number: (800) 418-4039

Subject Line: “FSP Residential Transfer Form”

|  |
| --- |
| **1. SASS Provider Information** |
| **Agency Name:**      | **FSP Coordinator Name:**       | **FSP Coordinator Phone Number:**       |
| **Address:**      | **City:**      | **State:**      | **Zip Code:**      |

This is to inform you that the youth mentioned below will be transferring to a new residential treatment provider.

The following information documents the youth’s current provider and the new residential treatment provider.

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| **2. Recipient Information** |
| **Youth First Name:**       | **Youth Last Name:**      | **Date of Birth:**      | **RIN (Medicaid ID#):**      |
|  |  |
| **3. Current Residential Treatment Provider Information** |
| **Name of RTF:**      | **Provider ID:**      |
| **Address:**      | **City:**      | **State:**      | **Zip Code:**      | **Date of Discharge:**      |
|  |  |
| **4. New Residential Treatment Provider Information** |
| **Name of RTF:**      | **Provider ID:**      | **Date of Admission:**      |
| **Address:**      | **City:**      | **State:**      | **Zip Code:**      |
| **Contact Person:**      | **Telephone Number:**      | **Email:**      |
|  |  |
| **5. Signature** |
|  |  |       |  |
| **FSP Coordinator Signature** |  | **Date**  |  |