ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Family Support Program (FSP)

Application Packet

June 2018

Family Support Program (FSP) Application Submission

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 submitted FSP applications.

The FSP application will be considered complete once all of the documentation listed in the FSP Application Checklist is gathered and submitted to eQHealth for review. This includes a signature from the parent or guardian on Section 5, Request for Eligibility Determination, attesting that the parent or guardian has reviewed the entire application and consents to the submission of the application to HFS and its designee, eQHealth, for the purpose of determining eligibility for the FSP.

Completed FSP applications may be submitted by the parent or guardian of the youth or, as requested by the parent or guardian, the youth's designated provider of Screening, Assessment and Support Services (SASS). A list of SASS providers can be found on the HFS SASS Provider webpage.

FSP applications 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 Application Checklist

1. Completed FSP application form, including each of the following components:
   - ☐ Section 1, General Information (p. 4), including a verifiable Social Security Number (SSN) for the youth.

     NOTE: Following submission of the application, eQHealth may request a copy of the youth's Social Security Card be faxed to them for verification purposes. Applicants to FSP must be prepared to submit a copy of the youth's SSN within 30 days of notification from eQHealth.
   - ☐ Section 2, Family Financial Information (p. 5), including:
     - Copy of the parent or 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 (p. 6-7)
     - This section must cover at least the last 12 months of mental health services, substance use services, and medications the child received.
   - ☐ Section 4, Acknowledgement of FSP Parent or Guardian Responsibilities (p. 8)
   - ☐ Section 5, Request for Eligibility Determination (p. 9), including:
     - Signatures from the parent or guardian verifying they have reviewed the application for accuracy and completion; and,
     - Signature from the youth's FSP Coordinator if the FSP Coordinator is submitting the application.
2. ☐ Copy of the youth's birth certificate.
3. ☐ Court order defining custody and/or non-parental guardianship, if applicable.
4. ☐ Psychiatric evaluation dated within 90 days of the submission of the application that includes: a mental status examination, a specific principal diagnosis and all other diagnoses, medications, a treatment summary and recommendations.
5. ☐ Copy of the youth's current Mental Health Assessment, dated within 45 days of the submission of the application.

FSP APPLICATION FORM

1. GENERAL INFORMATION

Youth Name	**Recipient ID #** ☐ N/A	**Social Security #:**	**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: _____

Parent/ Guardian Information

Name _____ **Relationship to Child:** ☐ 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 (optional)

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: _____ ☐ AGI ☐ Net **Parent/guardian(s) anticipated income for this year:** _____ ☐ 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.

Type	Current Amount	Recipients/Payees	Description
Employment			
Investments			
Public Benefits			
Other: _____			

3. BEHAVIORAL HEALTH TREATMENT HISTORY

Please list the mental health and substance abuse services and supports the youth has received for at least the last 12 months, in the appropriate sections below. 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
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				☐ Service ongoing
				☐ 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
				☐ Service ongoing
				☐ 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 12 months. Include all prescribed and over the counter medications.

Medication Name	Prescriber	Dosage	Date Started	Date Ended	Side Effects

4. Acknowledgement of FSP Parent or Guardian Responsibilities

Participation in the Family Support Program requires that the parent or guardian 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 parent or guardian responsibilities, should the youth be determined eligible for participation in the FSP; and
3. Sign and date this Acknowledgement in the appropriate space provided below.

FSP Parent or Guardian Responsibilities

If the youth seeking services is found eligible to participate in 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 with the youth's home school district to ensure compliance with the compulsory education attendance requirements as found in Section 26-1 of the Illinois School Code;
   - 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

5. Request for Eligibility Determination

Parent/Guardian Attestation – By signing below, I confirm that:

- I have read all of the information in this application and, to the best of my knowledge, all of the information in this application is correct.
- I understand that incomplete applications will be returned without being reviewed for eligibility.
- I understand that if my child is found eligible for the FSP, the confidential information contained in this application will be shared with the SASS provider assigned to work with my family for the purposes of providing or arranging for FSP services. I understand that I will be notified of the name and contact information for my assigned SASS provider. The type of information that will be disclosed includes my child's name, demographic information, my contact information, my family's financial information, and my child's clinical records submitted as part of this FSP application.
- I understand that if my child is determined eligible for the FSP, he/she will receive 180 days of initial eligibility in the program. I understand that I will be responsible for completing an FSP Continued Enrollment Packet within the last 30 days of my child's eligibility period if I wish for my child to be authorized for an additional 180 days of eligibility in the FSP.

(Choose One)

☐ I have decided to complete this application WITHOUT the assistance of my FSP Coordinator. I am submitting this application and all required supporting documentation to Healthcare and Family Services through its designee, eQHealth Solutions, Inc., in order to make a determination of eligibility for the FSP. I understand that I may withdraw this application at any time by contacting eQHealth.

Parent/Legal Guardian (print name)	Signature	Date

☐ I have decided to complete this application with the assistance of my FSP Coordinator and all the following are true:

- My FSP Coordinator has gone over the FSP eligibility criteria with me;
- I have had a chance to ask my FSP Coordinator questions about the FSP and the application process;
- I have been informed that I have the right to inspect and copy the information in this application;
- I ask that my FSP Coordinator submit this application and all required supporting documentation on my behalf to Healthcare and Family Services through its designee, eQHealth, in order to make a determination of eligibility for the FSP; and
- I understand that I may withdraw this application at any time by contacting eQHealth or my FSP Coordinator.

Parent/Legal Guardian (print name)	Signature	Date

FSP Coordinator Attestation – this section must be completed if the parent/guardian decides to complete this application with the assistance of an FSP Coordinator.

By signing below, I confirm that:

- I am the FSP Coordinator that has assisted the parent/guardian with completing this FSP application;
- I have gone over the FSP eligibility criteria with the parent/guardian;
- I have given the parent/guardian a chance to ask me questions about the FSP and the application process;
- I have informed the parent/guardian that he/she has the right to inspect and copy the information in this application;
- The parent/guardian has asked that I submit this application and all required supporting documentation on his/her behalf to Healthcare and Family Services through its designee, eQHealth, in order to make a determination of eligibility for the FSP; and
- I have informed the parent/guardian about the process for withdrawing this application.

FSP Coordinator (print name)	Signature	Date

ITEM # 2

Copy of the Youth's Birth Certificate

Section Title Page.

Place this title page in front of the content: Birth Certificate

ITEM # 3

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

ITEM # 4

Psychiatric Evaluation

Section Title Page.

Place this title page in front of the content: Psychiatric Evaluation

ITEM # 5

Current Mental Health Assessment

Section Title Page.

Place this title page in front of the content: Mental Health Assessment