**Family Support Program (FSP)**

**Prior Authorization for Bed Hold Days/Notification of Absence**

*Submit completed form to HFS via fax or email:*

*217-524-1221* ***●*** *HFS.FSP@illinois.gov*

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| **Section 1. General Information** |
| **Youth Name:**   | **RIN:**   | **Date of Birth:**   |
| **Facility Name:**   | **HFS Provider ID:**   |
| **Staff Name:**   | **Phone:**   | **Email:**   |

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| **Section 2. Facility Occupancy** |
| Please only report the number of youth currently admitted to the facility. If the facility utilizes multiple HFS Provider IDs, please only report youth admitted to beds associated with the HFS Provider ID reported in Section 1.  |
| **Facility Occupancy:**   | **Total Number of Beds:**   | **Occupancy Percentage:**   |

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| **Section 3a: Bed Hold Request** |
| **Bed Hold Dates:**  –  | **Number of Days Requested:**   |
| **Bed Hold Review Type:** | **Prior Authorization – Planned: Submit 3 business days in advance** |
| [ ]  Planned – Therapeutic (3+ Days) | [ ]  Planned – Non-Therapeutic |
| **Concurrent Review – Unplanned: Submit within 72 hours of leave** |
| [ ]  Family Emergency | [ ]  Non-Psychiatric Hospitalization | [ ]  Other: Enter Text |

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| **Section 3b: Notification of Absence** |
| **Notification of Absence: Submit within 72 hours of beginning of absence** |
| **Dates of Absence:**  **–**   |
| **Absence Type:** | [ ]  Incarceration | [ ]  Elopement |
| [ ]  Psychiatric Hospitalization | [ ]  Other:  |

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| **Section 4. Justification** |
| Provide information to support and justify the youth’s absence from the facility. For unplanned absences, provide 1-2 sentences explaining the reason for the absence. For planned absences, provide a more detailed explanation, tying the reason for the planned absence to a goal(s) in the youth’s treatment plan. A copy of the youth’s treatment plan, crisis safety plan, and/or Family Success Plan must be submitted to support the request. If reporting a youth’s absence from the facility, please provide 1-2 sentences explaining the youth’s absence. |
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| **Attachments:** [ ]  Treatment Plan [ ]  Crisis Safety Plan [ ]  Family Success Plan |
| **Staff Signature:**  | **Credentials:**   | **Date:**  |

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| ***HFS Office Use Only*** |
| ***[ ]  Approved*** | ***Dates approved:***  | ***Number of days approved:***  |
| ***[ ]  Denied*** | ***Reason for Denial:***  |
| ***Reviewer Name:***  | ***Signature:***  | ***Date:***  |