**Family Support Program (FSP)**

**Request for Residential Treatment Selection Exception**

*Submit completed form and a copy of any written in-network residential admissions denials to HFS via fax or email:*

*Attn: FSP Program Manager* **●** *217-524-1221* **●** [*HFS.FSP@illinois.gov*](mailto:HFS.FSP@illinois.gov)

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| **Section 1. General Information** | | |
| **Youth Name:** | **RIN:** | **Birthdate:** |
| **FSP Coordinator:** | **Email:** | |
| **FSP Agency Name:** | **HFS Provider ID:** | |

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| **Section 2. Request Information** | | | | | |
| **Request Type:** | Closest Proximity Exception | Out-of-State Facility | |  | |
| Notification Only – FSP Network Exhausted | | | | |
| **Requested Facility:** |  | | **Anticipated Admission Date:** | |  |
| **Facility Address:** |  | | | | |
| **Intake Coordinator:** |  | | **Phone Number:** | | |

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| **FSP In-Network Residential Facilities** | |
| *For each facility listed, indicate whether the youth was accepted, denied, or not referred for admission. In the space provided, indicate the reason why the youth was denied or not referred for admission.* | |
| **Tier 1 – In-State Residential Providers** | |
| **Allendale** | Accepted  Denied  Not referred  Clinical Note: |
| **Children’s Home Association** | Accepted  Denied  Not referred  Clinical Note: |
| **Cunningham** | Accepted  Denied  Not referred  Clinical Note: |
| **Kemmerer**  **Village** | Accepted  Denied  Not referred  Clinical Note: |
| **NeuroRestorative** | Accepted  Denied  Not referred  Clinical Note: |
| **Onarga Academy** | Accepted  Denied  Not referred  Clinical Note: |
| **Orthogenic School** | Accepted  Denied  Not referred  Clinical Note: |
| **Thresholds** | Accepted  Denied  Not referred  Clinical Note: |
| **Other:** | Accepted  Denied  Not referred  Clinical Note: |
| **Tier 2 – Out of State Residential Provider** | |
| **Change Academy Lake of the Ozarks (CALO)** | Accepted  Denied  Not referred  Clinical Note: |
| **Millcreek of Arkansas** | Accepted  Denied  Not referred  Clinical Note: |
| **Piney Ridge** | Accepted  Denied  Not referred  Clinical Note: |
| **Resolute** | Accepted  Denied  Not referred  Clinical Note: |
| **Resource** | Accepted  Denied  Not referred  Clinical Note: |
| **Other:** | Accepted  Denied  Not referred  Clinical Note: |

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| **Section 3. Supporting Information** |
| **Provide a detailed clinical justification for why this exception is being requested. If admission to a specific Residential Treatment Facility is being requested, the narrative should describe why this facility is best suited to meet the youth’s clinical needs.** |
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| **FSP Coordinator Signature:** |  | **Date:** |  |
| **LPHA Signature:** |  | **Date:** |  |

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| ***HFS Office Use Only*** | | | | |
| ***Approved*** | ***Denied*** | ***Follow Up with FSP Provider (for notifications only)*** | | |
| ***Reasons for Denial:*** | | | | |
| ***Additional Action Required:*** | | | | |
| ***Reviewer Name:*** | | | | |
| ***Signature:*** |  | | ***Date:*** |  |