

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*

Section 1. General Information			
Youth Name:		RIN:	Birthdate:
FSP Coordinator:		Email:	
FSP Agency Name:		HFS Provider ID:	
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:
FSP In-Network Residential Facilities			
<i>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.</i>			
Tier 1 – In-State Residential Providers			
Allendale	Accepted Clinical Note:	Denied	Not referred
Children's Home Association	Accepted Clinical Note:	Denied	Not referred
Cunningham	Accepted Clinical Note:	Denied	Not referred
Kemmerer Village	Accepted Clinical Note:	Denied	Not referred
NeuroRestorative	Accepted Clinical Note:	Denied	Not referred
Onarga Academy	Accepted Clinical Note:	Denied	Not referred
Orthogenic School	Accepted Clinical Note:	Denied	Not referred
Thresholds	Accepted Clinical Note:	Denied	Not referred

Other:	Accepted Clinical Note:	Denied	Not referred
Tier 2 – Out of State Residential Provider			
Change Academy Lake of the Ozarks (CALO)	Accepted Clinical Note:	Denied	Not referred
Millcreek of Arkansas	Accepted Clinical Note:	Denied	Not referred
Piney Ridge	Accepted Clinical Note:	Denied	Not referred
Resolute	Accepted Clinical Note:	Denied	Not referred
Resource	Accepted Clinical Note:	Denied	Not referred
Other:	Accepted Clinical Note:	Denied	Not referred

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.

FSP Coordinator Signature:		Date:	
LPHA Signature:		Date:	

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