



Family Support Program (FSP)

Application Packet

Effective April 1, 2024



Family Support Program (FSP) Application Submission

The Department of Healthcare and Family Services (HFS), the state agency responsible for the FSP, has designated Acentra Health (Acentra) to manage application approval. Acentra is to provide administrative and clinical support to the FSP, including reviewing submitted FSP applications.

The FSP application will be considered complete once all the documentation listed in the FSP Application Checklist is gathered and submitted to Acentra 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, Acentra, for the purpose of determining eligibility for the FSP.

Completed FSP applications may be submitted by the parent or guardian of the youth, or submitted on behalf of the parent or guardian by the youth's designated Care Coordination and Support Organization (CCSO). A list of CCSOs can be found on the HFS Website at the following link:

<https://hfs.illinois.gov/medicalclients/behavioral/familysupportprogram.html>

FSP applications may be submitted to Acentra in any of the following ways:

1. By faxing the application to (800) 418-4039 using the subject line "FSP Application for Review;"
2. By creating a Parent Account and submitting an application directly through eQSuite at the following web address:
<https://il.eqhs.com/FamilySupportProgram/LOGINPARENTLEGALGUARDIAN.aspx>
3. By working with a Care Coordination and Support Organization to submit the FSP Application through eQSuite;
4. By mailing the application to the following address:

Acentra Health
Attn: FSP Technical Coordinator
500 Waters Edge, Suite 125
Lombard, IL 60148

FSP Application Checklist

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, Acentra 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 Acentra.

- Section 2: Family Financial Information, 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
 - 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
- Section 5: Request for Eligibility Determination, 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.
- Attachment #1: A Copy of the Youth's Birth Certificate
- Attachment #2: Court order defining custody and/or non-parental guardianship (if applicable)
- Attachment #3: Copy of the youth's current Mental Health Assessment, dated within 180 days of the submission of the application.



HFS

Illinois Department of
Healthcare and Family Services

FSP APPLICATION FORM						
1. GENERAL INFORMATION						
Youth Name:		Recipient ID#:		Date of Birth:		
Gender:	Primary Language:	Phone Number:	US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No		Household Size:	
Youth's Home Address:		City:	State:	ZIP Code:	County:	
Race:	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian Native/Other <input type="checkbox"/> Multi-Race <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Other:				Ethnicity: <input type="checkbox"/> Hispanic or Latinx <input type="checkbox"/> Non-Hispanic or Latinx <input type="checkbox"/> Unknown	
Interpreter Services:	<input type="checkbox"/> None <input type="checkbox"/> TDD/TTY <input type="checkbox"/> American Sign Language <input type="checkbox"/> Spoken Language: <input type="checkbox"/> Other:		Guardianship Status:		<input type="checkbox"/> Own guardian <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian	
Parent/ Guardian Information:	Name:		Relationship to Youth: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		Phone Number:	
	Address:	City:	State:	Zip Code:	County:	
Parent/ Guardian Information:	Name:		Relationship to Youth: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		Phone Number:	
	Address:	City:	State:	Zip Code:	County:	
Residential Arrangement:	<input type="checkbox"/> Lives Alone <input type="checkbox"/> State operated facility (mental health/dev. disability) <input type="checkbox"/> Homeless <input type="checkbox"/> Jail or correctional facility <input type="checkbox"/> Independent Living <input type="checkbox"/> Residential/Institutional Setting (residential treatment center, nursing home) <input type="checkbox"/> Lives with parent(s), relative(s), or guardian(s) <input type="checkbox"/> Foster Care <input type="checkbox"/> Other:					
Education Level: (last completed)	<input type="checkbox"/> Never attended school <input type="checkbox"/> Grade 2 <input type="checkbox"/> Grade 5 <input type="checkbox"/> Grade 8 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 1 <input type="checkbox"/> Grade 3 <input type="checkbox"/> Grade 6 <input type="checkbox"/> Grade 9 <input type="checkbox"/> High school diploma <input type="checkbox"/> Preschool/Kindergarten <input type="checkbox"/> Grade 4 <input type="checkbox"/> Grade 7 <input type="checkbox"/> Grade 10 <input type="checkbox"/> GED certificate					
Care Coordination and Support Organization (CCSO) Provider Information	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.

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> Business | <input type="checkbox"/> Inheritance | <input type="checkbox"/> Savings Account | <input type="checkbox"/> Mineral/Oil Rights | <input type="checkbox"/> Promissory Note/Loan |
| <input type="checkbox"/> Life | <input type="checkbox"/> Funeral/Burial Plan | <input type="checkbox"/> Checking Account | <input type="checkbox"/> Money Market Account | <input type="checkbox"/> Deferred Comp |
| <input type="checkbox"/> Estate | <input type="checkbox"/> Mutual Funds | <input type="checkbox"/> Certificates of Deposit | <input type="checkbox"/> Trust Fund(s) | <input type="checkbox"/> Government Bonds |
| <input type="checkbox"/> Annuity | <input type="checkbox"/> IRA/401K | <input type="checkbox"/> Stocks/Bonds | <input type="checkbox"/> Nursing Home Account | <input type="checkbox"/> Reverse Mortgage |
| <input type="checkbox"/> Burial Plot(s) | | | | |

Other Financial Resources: Please List:

Owner Name	Type of Resource	Current Value	Name of Bank, Company, etc.

Family Income (complete only if youth or parent/guardian did not file taxes; if the youth or parent/guardian did file taxes, only submit tax documents)

Youth's income for last calendar year:	<input type="checkbox"/> AGI	<input type="checkbox"/> Youth's most recent federal tax return attached
	<input type="checkbox"/> Net	<input type="checkbox"/> No federal return filed on behalf of the youth
Parent/guardian(s) income for last calendar year:	<input type="checkbox"/> AGI	<input type="checkbox"/> Parent/guardian(s) most recent federal tax return(s) attached
	<input type="checkbox"/> Net	<input type="checkbox"/> 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. N/A – youth is own guardian

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



4. ACKNOWLEDGEMENT OF FSP PARENT OR GUARDIAN RESPONSIBILITIES (if applicable)

Participation in the Family Support Program requires that, when applicable, the youth’s parent or guardian continue to 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 standards of parent or guardian participation, should the youth be determined eligible for ongoing 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 for continued participation in the 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: <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> ✓ 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 between the youth’s home school district to ensure compliance with the compulsory education attendance requirements that the youth will be attending while in residential treatment; ✓ 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



ATTACHMENT #1

Copy of the Youth's Birth Certificate

Section Title Page.

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

ATTACHMENT #2

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

ATTACHMENT #3

Current Mental Health Assessment (Dated within the last 180 days)

Section Title Page.

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