HFS
Illinois Department of
Healthcare and Family Services

Family Support Program (FSP)

Application Packet

Effective April 1, 2024

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Illinois Department of
Healthcare and Family Services

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/medicalproviders/behavioral/sass/icg.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

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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.

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FSP APPLICATION FORM

1. GENERAL INFORMATION

Youth Name:		**Recipient ID#:**		**Date of Birth:**
Gender:	**Primary Language:**	**Phone Number:**	**US Citizen:** ☐ Yes ☐ No	**Household Size:**
Youth's Home Address:		**City:**	**State:** / **ZIP Code:**	**County:**

Race:	☐ American Indian/Alaska Native ☐ Hawaiian Native/Other ☐ Multi-Race ☐ Asian ☐ Pacific Islander ☐ Unknown ☐ Black/African American ☐ White ☐ Other:	**Ethnicity:** ☐ Hispanic or Latinx ☐ Non-Hispanic or Latinx ☐ Unknown
Interpreter Services:	☐ None ☐ TDD/TTY ☐ American Sign Language ☐ Spoken Language: ☐ Other:	**Guardianship Status:** ☐ Own guardian ☐ Parent ☐ Legal guardian

Parent/ Guardian Information:	**Name:**	**Relationship to Youth:** ☐ Parent [Guardian	**Phone Number:**		
	Address:	**City:**	**State:**	**Zip Code:**	**County:**
Parent/ Guardian Information:	**Name:**	**Relationship to Youth:** ☐ Parent ☐ Guardian	**Phone Number:**		
	Address:	**City:**	**State:**	**Zip Code:**	**County:**

Residential Arrangement:	☐ Lives Alone ☐ Homeless ☐ Independent Living ☐ Lives with parent(s), relative(s), or guardian(s) ☐ Foster Care ☐ State operated facility (mental health/dev. disability) ☐ Jail or correctional facility ☐ Residential/Institutional Setting (residential treatment center, nursing home) ☐ Other:
Education Level: (last completed)	☐ Never attended school ☐ Grade 1 ☐ Preschool/Kindergarten ☐ Grade 2 ☐ Grade 3 ☐ Grade 4 ☐ Grade 5 ☐ Grade 6 ☐ Grade 7 ☐ Grade 8 ☐ Grade 9 ☐ Grade 10 ☐ Grade 11 ☐ High school diploma ☐ GED certificate

Care Coordination and Support Organization (CCSO) Provider Information	**Agency Name**	**FSP Coordinator Name**	**FSP Coordinator Phone**
	Agency Address	**City**	**Zip** / **County**

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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?	**Is this a COBRA plan?**	**Does the plan cover at least 60% of benefit costs?**
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ 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 ☐ Funeral/Burial Plan ☐ Checking Account ☐ Money Market Account ☐ Deferred Comp
☐ Estate ☐ Mutual Funds ☐ Certificates of Deposit ☐ Trust Fund(s) ☐ Government Bonds
☐ Annuity ☐ IRA/401K ☐ Stocks/Bonds ☐ Nursing Home Account ☐ Reverse Mortgage
☐ 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:	☐ 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) 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. ☐ N/A – youth is own guardian

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

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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
				☐ 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

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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:
   - ✓ 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 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

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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 CCSO 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 CCSO 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.

Sign in Only One Section Below:

✓ 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, Acentra, in order to make a determination of eligibility for the FSP. I understand that I may withdraw this application at any time by contacting Acentra.

_____	_____	_____
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, Acentra, 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 Acentra 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, Acentra, 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

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ATTACHMENT #1

Copy of the Youth's Birth Certificate

Section Title Page. Place this title page in front of the content: Birth Certificate

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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

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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