

Family Support Program (FSP)

FSP Residential Treatment Services Request for Continued Stay

Submit required documents to Acentra Health:

Via eQSuite:

<https://il.eqhs.com/FamilySupportProgram/LOGINPROVIDERONLY.aspx>

Via Fax:

Fax Number: (800) 418-4039

Subject Line: "FSP Residential Continued Stay Request"

Documents Submitted with Continued Stay Request

- Integrated Assessment and Treatment Planning (IATP) or IM+CANS
- Family Success Plan (also known as Discharge Plan)

Acentra Health
500 Waters Edge, Suite 125
Lombard, IL 60148

**Continued Stay Request
Residential Treatment Facility**

1. Youth and Family Information

Youth First Name:	Youth Last Name:	Date of Birth:	RIN:	Gender:
Parent or Guardian Info.	First and Last Name:	Relationship to Client: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		Phone Number:
	Address:	City:	State:	Zip Code:

2. Residential Treatment Provider Information

RTF Name:	Provider ID:	RTF LPHA:	RTF LPHA Phone Number:
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Continued Stay Information

Request Date: _____ **RTF Admission Date:** _____

3. Type of Request

		Start Date	End Date	
<input type="checkbox"/>	30-day continued stay			

4. Progress Note

Please note: This section must be completed by the youth's assigned in-network FSP residential provider where the youth is currently receiving treatment services.

Summary of Progress. Please identify the progress the FSP youth has made since the youth's last FSP review for continued stay.

Ongoing Areas of Concern. Please identify the ongoing behaviors of concern that continue to be the focus of the FSP youth's treatment.

Signatures.

_____ Reviewing LPHA (print name)	_____ Credentials	_____ Signature	_____ Date
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