ILLINOIS DEPARTMENT OF Healthcare and Family Services

FAMILY SUPPORT PROGRAM (FSP)

RESIDENTIAL ADMISSIONS PACKET (RAP)

FY 2019

Residential Admissions Packet (RAP)

The Residential Admissions Packet (RAP) is a standardized packet of information required to refer a youth enrolled in the Family Support Program (FSP) program to an approved, in-network Residential Treatment Facility. The RAP constitutes the complete packet of information needed to make a determination regarding the youth's clinical appropriateness for admission to the facility.

The Family Support Program (FSP) is managed by the Illinois Department of Healthcare and Family Services (HFS). FSP provides access to mental health services and supports for children with severe mental illness. Questions regarding FSP may be directed to HFS via phone (217-557-1000) or email (HFS.BBH@illinois.gov).

RAP Submission: The RAP is considered complete once all of the documentation listed in the RAP Checklist (page 3) is gathered and submitted to a Residential Treatment Facility for review. The RAP must be sent individually to each Residential Treatment Facility to which an FSP enrolled youth is being referred. A list of in-network FSP residential facilities can be found on the FSP Landing Page Update.

A determination of the youth's appropriateness for admission to the Residential Treatment Facility will be made within five (5) days of the facility receiving a completed RAP. The Residential Treatment Facility will notify the parent/legal guardian, and the youth's FSP Coordinator when possible, of any information missing from an incomplete RAP.

Families are strongly encouraged to complete the RAP with the assistance of the FSP Coordinator. The FSP Coordinator is required to submit the RAP at the youth's local Screening Assessment and Support Services (SASS) agency. A list of SASS agencies can be found on the HFS SASS Provider webpage. Families may also call eQHealth, Monday through Friday, 8:30 a.m. to 5:00 p.m., by calling the FSP Helpline at 866-435-8778 for assistance in identifying who their SASS provider is. All other questions about the FSP may be directed to HFS by calling the Bureau of Behavioral Health at 217-557-1000 or by email at HFS.BBH@illinois.gov.

Residential Admissions Packet (RAP) Checklist

Residential Admissions Packets are considered complete when all of the documentation listed below has been gathered and submitted to the Intake/Admissions Coordinator at an approved in-network FSP residential facility.

1. ☐ Copy of the youth's Family Support Program prior authorization for Residential letter from eQHealth
2. ☐ Completed RAP Cover Sheet (p. 4)
3. ☐ A summary of the child's behavioral health treatment history, covering at least the past 12 months (p. 5-6)
4. ☐ Signed and dated parent/legal guardian request for residential admissions review and determination (p. 7)
5. ☐ A copy of the child's psychiatric hospitalization records or discharge summaries, as applicable, covering at least the past 12 months
6. ☐ Psychiatric evaluation dated within the past 12 months
7. ☐ Psychological evaluation dated within the past 5 years
8. ☐ Current Integrated Assessment Treatment Plan (IATP)
19. ☐ Physical examination, dated within the past 18 months
10. ☐ A copy of the child's Individual Education Plan (IEP) or 504 Plan, as applicable
11. ☐ (Optional) Additional assessments included:
    - ☐ Assessment Name: _____
    - ☐ Assessment Name: _____
    - ☐ Assessment Name: _____
    - ☐ Assessment Name: _____
    - ☐ Assessment Name: _____

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Residential Admissions Packet Cover Sheet

1. GENERAL INFORMATION

Child Name		RIN	Social Security Number:		Date of Birth
Age (Years/Months)	**Gender**	**Primary Language**	**Phone Number** ☐ N/A		**Ethnicity** ☐ Hispanic ☐ Non-Hispanic
Child's Address		**City**	**State**	**ZIP Code**	**County**

Race
☐ American Indian or Alaska Native ☐ Hawaiian Native/Other Pacific Islander ☐ Multi-Race
☐ Asian ☐ Hispanic ☐ Other:
☐ Black/African American ☐ White ☐ Unknown

Child's Marital Status
☐ Single ☐ Married
☐ Divorced ☐ Domestic Partnership

Household Size
_____

Child's Method of Communication
☐ No interpreter services required ☐ TDD/TYY
☐ American Sign Language ☐ Spoken Language: _____
☐ Other: _____

Parent/Guardian Information

Name	Relationship to Child: ☐ Parent ☐ Guardian ☐ Other		Phone Number	
Address	**City**		**State**	**Zip Code** / **County**

Parent/Guardian Information

Name	Relationship to Child: ☐ Parent ☐ Guardian ☐ Other		Phone Number	
Address	**City**		**State**	**Zip Code** / **County**

Emergency Contact Information

Name	Relationship to Child		Phone Number	
Address	**City**		**State**	**Zip Code**

Residential Arrangement
☐ Homeless
☐ Independent Living
☐ Lives with parent(s), relative(s), or guardian(s)
☐ State operated facility (mental health/dev. disability)
☐ Jail or correctional facility
☐ Residential/Institutional Setting (residential treatment center, nursing home)
☐ Foster Care
☐ Other: _____
☐ Unknown

Education Level (last completed)
☐ Never attended school ☐ Grade 2 ☐ Grade 5 ☐ Grade 8 ☐ Grade 11 ☐ Unknown
☐ Preschool/Kindergarten ☐ Grade 3 ☐ Grade 6 ☐ Grade 9 ☐ High school diploma
☐ Grade 1 ☐ Grade 4 ☐ Grade 7 ☐ Grade 10 ☐ GED certificate

School Information

Name	District	General Phone Number	Principal Name
Principal Phone Number	**School Address**	**City**	**Zip Code**

FSP Coordinator Information

Agency Name	FSP Coordinator Name	FSP Coordinator Phone	
Agency Address	**City**	**Zip**	**County**

3. BEHAVIORAL HEALTH TREATMENT HISTORY

In the appropriate sections below, please list the mental health and substance use services and any medications the child has received for at least the last 12 months. 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

Outpatient Substance Use Services/Supports

Service Name	Provider Name	Service Frequency	Service Begin Date	Service End Date
				☐ Service ongoing
				☐ Service ongoing
				☐ Service ongoing

Medication(s)

Please list all of the medications the child has received, covering at least the last 12 months. Include all prescribed and over the counter medications.

Medication Name	Prescriber	Dosage	Date Started	Date Ended	Side Effects (including allergies)

4. REQUEST FOR RESIDENTIAL ADMISSION REVIEW AND DETERMINATION

By signing below, I confirm that:

- I have read all of the information in this referral packet.
- To the best of my knowledge, all of the information in this referral packet is correct and complete.
- I understand that incomplete packets may be returned without being reviewed for an admissions determination.
- I understand that residential facilities may require an admissions interview (either in person or by phone) with me and my child prior to making a final admission determination.

Signatures

Child, if over age 12 (print name)	Signature	Date
Parent/Legal Guardian (print name)	Signature	Date
FSP Coordinator (print name)	Signature	Date

RESIDENTIAL OFFICE USE ONLY

Date Received: _____ *Date Reviewed:* _____

Status: ☐ *Approved – anticipated bed availability date:* _____

☐ *Incomplete – additional information required (list):*

_____

☐ *Denied – brief reason for denial:* _____

_____

Date Communicated to Parent/Guardian: _____

Reviewer Name: _____ *Agency:* _____