Family Support Program (FSP)

Prior Authorization for Residential Treatment

Prior Authorization for Residential Treatment Services must be submitted by the FSP Coordinator through eQSuite at the following web address:

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

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| **Documents Submitted with Prior Authorization Request:** |
| Integrated Assessment and Treatment Planning (IATP) dated within 180 days of request  Note: IATP must include a rational for Residential Treatment Services that minimally includes the following:   * Targeted length of stay * Anticipated discharge date * Specific clinical objectives and treatment goals to be addressed during the residential treatment that cannot be achieved within a community-based setting |
| Psychiatric Evaluation dated within 180 days of request |
| Psychological Evaluation – dated within 24 months of date of request |

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| **Prior Authorization for Residential Treatment** | | | | | | | | | | | | | | | | | | | | | | |
| **Youth Name:** | | | | **Recipient ID#:** | | | | | | | | | | | | **Date of Birth:** | | | | | | |
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| **Youth’s Home Address:** | | | | **City:** | | | | | | | | **State:** | | | | | | **ZIP Code:** | | **County:** | | |
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| **Parent/ Guardian Information:** | **Name:** | | | | | | **Relationship to Youth:** | | | | | | | | | | | **Phone Number:** | | | | |
|  | | | | | |  | Parent | | | | |  | Guardian | | | |  | | | | |
| **Address:** | | | **City:** | | | | | | | **State:** | | | | | | | **Zip Code:** | | | **County:** | |
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| **CCSO**  **Provider Information:** | **Agency Name:** | | | **FSP Coordinator Name:** | | | | | | | | | | | | | | **FSP Coordinator Phone:** | | | | |
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| **Agency Address** | | | **City:** | | | | | | **Zip:** | | | | | | | | | | **County:** | | |
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| **Medication(s):** List current and previous medications below, including over-the-counter medications. Attach additional pages as needed. | | | | | | | | | | | | | | | | | | | | | | |
| **Is the individual currently taking any medications for a behavioral health condition?**  Yes  No | | | | | | | | | | | | | | | | | | | | | | |
| **If yes, does the individual regularly receive lab work?**   Yes  No  Not Required  Unknown | | | | | | | | | | | | | | | | | | | | | | |
| **Medication Name** | | | **Prescriber** | | | **Dosage** | | | | | | | | | **Date Started** | | | | **Date Ended** | | | **Medication Issues** |
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| Behavioral Health Treatment History | | | | | | | | | | | | | | | | | | | | | | |
| **Prior Behavioral Health Services:** Yes  No | | | | | | | | |  | | | | | | | | | | | | | |
| **Inpatient Hospitalization History** | | | | | | | | | | | | | | | | | | | | | | |
| **When** | | **Where** | | | **Admit Date** | | | | | | | | | | | | **Reason** | | | | | |
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| **Partial Hospitalization / Day Treatment Service History** | | | | | | | | | | | | | | | | | | | | | | |
| **When** | | **Where** | | | **With Whom** | | | | | | | | | | | | **Reason** | | | | | |
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| **Community-based Service History** | | | | | | | | | | | | | | | | | | | | | | |
| **When** | | **Where** | | | **With Whom** | | | | | | | | | | | | **Reason** | | | | | |
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| **Substance Use Disorder Service History** | | | | | | | | | | | | | | | | | | | | | | |
| **When** | | **Where** | | | **With Whom** | | | | | | | | | | | | **Reason** | | | | | |
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| **Other Service History (Including Primary Care and Education)** | | | | | | | | | | | | | | | | | | | | | | |
| **When** | | **Where** | | | **With Whom** | | | | | | | | | | | | **Reason** | | | | | |
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