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 requestNote: 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:** |
|   |   |   |
| **Youth’s Home Address:** | **City:** | **State:** | **ZIP Code:** | **County:** |
|   |   |   |   |   |
| **Parent/ Guardian Information:** | **Name:** | **Relationship to Youth:** | **Phone Number:** |
|  |   |[ ]  Parent |[ ]  Guardian |   |
|  | **Address:** | **City:** | **State:** | **Zip Code:** | **County:** |
|  |   |   |   |   |   |
| **CCSO****Provider Information:** | **Agency Name:** | **FSP Coordinator Name:** | **FSP Coordinator Phone:** |
|  |   |   |   |
|  | **Agency Address** | **City:** | **Zip:** | **County:** |
|  |   |   |   |   |
| **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** |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
| Behavioral Health Treatment History |
| **Prior Behavioral Health Services:** [ ] Yes [ ]  No |  |
| **Inpatient Hospitalization History** |
| **When** | **Where** | **Admit Date** | **Reason** |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| **Partial Hospitalization / Day Treatment Service History** |
| **When** | **Where** | **With Whom** | **Reason** |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| **Community-based Service History** |
| **When** | **Where** | **With Whom** | **Reason** |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| **Substance Use Disorder Service History** |
| **When** | **Where** | **With Whom** | **Reason** |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| **Other Service History (Including Primary Care and Education)** |
| **When** | **Where** | **With Whom** | **Reason** |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |