ILLINOIS DEPARTMENT OF Healthcare and Family Services

Specialized Family Support Program (SFSP) Parent Agreement

Youth Name: ______________________ **Date of Birth** ______________________

SFSP Begin Date: ______________________ **SFSP End Date:** ______________________

If your child experiences a mental health crisis at any time during enrollment in the SFSP, please refer to your crisis safety plan or contact the CARES Line: 1-800-345-9049.

________ **Parent Initials**

Goals – I understand the goals of the SFSP are to:

1. Prevent youth at risk of custody relinquishment from entering the child welfare system solely to access behavioral health services;
2. Provide crisis stabilization services to these youth and their families;
3. Determine the most appropriate treatment services for these youth through a comprehensive and standardized assessment process; and
4. Link these youth and their families to the right level and intensity of services in a timely manner.

________ **Parent Initials**

Services – I understand the following will be made available to my child and family through the SFSP:

1. My child's SFSP eligibility will last for 90 days, as listed above;
2. Mental health services and supports will be made available to my child during his/her SFSP eligibility based upon a completed mental health assessment and treatment plan;
3. Services may include, but are not limited to: therapy/counseling, crisis intervention and stabilization, assessment services, community support, and respite;
4. I will be assigned a coordinator through a local Screening, Assessment, and Support Services (SASS) agency, who is available to answer questions I have about the SFSP and provide assistance in accessing services.

________ **Parent Initials**

Parent/Guardian Participation – I understand that parent or guardian participation is a requirement for enrollment in the SFSP. Parent or guardian participation includes, but is not limited to:

1. Being willing to accept my child back into a home setting or arrange for appropriate care as a condition of participation in the SFSP;
2. Actively working with my assigned coordinator to safely transition my child out of the hospital back into a home or community setting;
3. Completing all necessary paperwork and providing all information required by the SFSP or as part of my child's treatment;
4. Actively participating in my child's treatment;
5. Communicating with my assigned coordinator, no less than once per week throughout my son/daughter's participation in the SFSP; and,
6. Reporting any significant changes in my family's circumstances that might impact my child's eligibility for the SFSP to my assigned coordinator, such as changes in my address or the custody or guardianship of my child.

________ **Parent Initials**

SFSP Family Guide – I acknowledge that a copy of the SFSP Parent/Guardian Guide is available online at: www.illinois.gov/hfs. My Coordinator has shown me how to access a copy of the SFSP Parent/Guardian Guide.

I acknowledge and understand that participation in the SFSP is voluntary, and if I choose to participate I will be required to meet the standards of Parent/Guardian Participation. I have had a chance to review this Parent Agreement and have had any questions I have answered. Furthermore, I understand that if I do not meet the requirements set forth in this agreement, it may result in a referral to the Department of Children and Family Services (DCFS) Child Abuse Hotline as a follow up to the psychiatric lockout event.

Parent/Legal Guardian (Print Name)	Signature	Date
Parent/Legal Guardian (Print Name)	Signature	Date
SASS Worker/Coordinator (Print Name)	Signature	Date