ILLINOIS DEPARTMENT OF Healthcare and Family Services

Family Support Program (FSP)

Prior Authorization for Bed Hold Days/Notification of Absence

Submit completed form to HFS via fax or email:
217-524-1221 ● HFS.FSP@illinois.gov

Section 1. General Information		
Youth Name:	**RIN:**	**Date of Birth:**
Facility Name:		**HFS Provider ID:**
Staff Name:	**Phone:**	**Email:**

Section 2. Facility Occupancy		
Please only report the number of youth currently admitted to the facility. If the facility utilizes multiple HFS Provider IDs, please only report youth admitted to beds associated with the HFS Provider ID reported in Section 1.		
Facility Occupancy:	**Total Number of Beds:**	**Occupancy Percentage:**

Section 3a: Bed Hold Request		
Bed Hold Dates: –	**Number of Days Requested:**	
Bed Hold Review Type:	**Prior Authorization – Planned: Submit 3 business days in advance**	
	◯ Planned – Therapeutic (3+ Days)	◯ Planned – Non-Therapeutic
	Concurrent Review – Unplanned: Submit within 72 hours of leave	
	◯ Family Emergency	◯ Non-Psychiatric Hospitalization ◯ Other:

Section 3b: Notification of Absence		
Notification of Absence: Submit within 72 hours of beginning of absence		
Dates of Absence: –		
Absence Type:	◯ Incarceration	◯ Elopement
	◯ Psychiatric Hospitalization	◯ Other:

Section 4. Justification

Provide information to support and justify the youth's absence from the facility. For unplanned absences, provide 1-2 sentences explaining the reason for the absence. For planned absences, provide a more detailed explanation, tying the reason for the planned absence to a goal(s) in the youth's treatment plan. A copy of the youth's treatment plan, crisis safety plan, and/or Family Success Plan must be submitted to support the request. If reporting a youth's absence from the facility, please provide 1-2 sentences explaining the youth's absence.

Attachments: ◯ Treatment Plan ◯ Crisis Safety Plan ◯ Family Success Plan

Staff Signature: **Credentials:** **Date:**

HFS Office Use Only		
◯ ***Approved***	***Dates approved:***	***Number of days approved:***
◯ ***Denied***	***Reason for Denial:***	
Reviewer Name:	***Signature:***	***Date:***