**Healthcare and Family Services**

**Family Support Program (FSP)**

**FSP Residential Treatment Services**

**Residential Discharge Acknowledgement**

Submit to eQHealth by fax within 3 business days after youth’s discharge

**Fax Number: (800)418-4039**

Subject Line: FSP Residential Discharge Form

eQHealth Solutions requests that residential treatment facilities (RTFs) discharging Family Support Program youth to please complete this form within 3 business days after the youth’s discharge and send to eQHealth by **secure fax at (800)418-4039**. Please contact **(866) 435-8778** if you have any questions.

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| --- | --- | --- | --- | --- | --- | --- |
| **1.Recipient Information** | | | | | | |
| **Youth First Name:** | **Youth Last Name:** | | | **Date of Birth:** | | **RIN:** |
|  | | |  | | | |
| **2. Residential Treatment Provider Information** | | | | | | |
| **Residential Provider Name:** | | | | | **Provider ID:** | |
| **Address:** | | **City:** | | | **State:** | **Zip Code:** |
| **Provider Contact Name:** | | **Contact Email:** | | | **Contact Phone:** | |

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| --- | --- |
| **3. Discharge Information** | |
| **Date of Admission to Facility:** | **Date of Discharge from Facility:** |