

**SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS**  
**PURCHASING CARD REQUEST FOR PURCHASE**  
 (This form is applicable to DDSN Regional Centers only)

Person's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Residence: \_\_\_\_\_

REQUESTED ITEMS	VENDOR	EST. COST
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
	Total	\$

\_\_\_\_\_  
 Requested by (Staff Representative)      Date

\_\_\_\_\_  
 Program Administrator or Residential Director      Date  
*(Only necessary if \$200 or more)*

\_\_\_\_\_  
 Approved by Residential Manager or QIDP      Date

\_\_\_\_\_  
 Facility Administrator      Date  
*(Only necessary if \$500 or more)*