SOUTH CAROLINA
DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Service Agreement and Permission to Evaluate

I, _____(print applicant's legal name), am requesting the following services from the South Carolina Department of Disabilities and Special Needs (DDSN)

☐ DDSN Eligibility Determination ☐ Other Evaluations and Services

I understand that DDSN may obtain and review existing available medical/service records and, if necessary, require psychological evaluations or other evaluations of me to establish or rule out my eligibility for the requested service.

I understand that if I meet the criteria for eligibility for any of the above services, my eligibility to continue receiving those services may be re-evaluated, particularly when there are indications of improvement in my ability to do things for myself.

I understand that being approved for DDSN eligibility does not guarantee that I will receive specific services as these will be dependent upon documentation of my need and upon availability of a program/service or availability of a program/service opening. I understand that in the absence of a program/service opening, I may be placed on a waiting list for that program/service.

I further understand that if approved for DDSN eligibility and I have a need for placement in a DDSN sponsored residential setting that such placement will be dependent upon demonstration of my need for placement and dependent upon the availability of a bed in a DDSN sponsored residential setting most appropriate to my need.

I also understand that DDSN may bill private insurance, Medicare, Medicaid, and/or any other third party payer for any covered services provided by DDSN and that neither my parents nor my legal guardian (if either are applicable) will be held responsible for costs not covered by that payer.

_____ Date:_____
Applicant's Signature

_____ Date:_____
Parent/Legal Guardian's Signature
(For applicant under 18 years or legally incompetent)