SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

MINUTES

April 20, 2017

The South Carolina Commission on Disabilities and Special Needs met on Thursday, April 20, 2017, at 10:00 a.m. at the Department of Disabilities and Special Needs Central Office, 3440 Harden Street Extension, Columbia, South Carolina.

The following were in attendance:

COMMISSION

Present:
Eva Ravenel, Vice Chairman
Gary Lemel – Secretary
Mary Ellen Barnwell
Sam Broughton, Ph.D.
Katie Fayssoux
Vicki Thompson

Absent:
Bill Danielson, Chairman

DDSN Administrative Staff
Dr. Buscemi, State Director; Mr. David Goodell, Associate State Director, Operations; Mrs. Susan Beck, Associate State Director, Policy; Mr. Tom Waring, Associate State Director, Administration; Ms. Tana Vanderbilt (For other Administrative Staff see Attachment 1 – Sign In Sheet).

Guests
(See Attachment 1 Sign-In Sheet)

Coastal Regional Center (via videoconference)
(See Attachment 2 Sign-In Sheet)

Georgetown County DSN Board

Pee Dee Regional Center (via videoconference)
(See Attachment 4 Sign-In Sheet)

Pickens County DSN Board (via videoconference)
(See Attachment 5 Sign-In Sheet)

Whitten Regional Center (via videoconference)
(See Attachment 6 Sign-In Sheet)

York County DSN Board (via videoconference)
(See Attachment 7 Sign-In Sheet)

Jasper County DSN Board (via videoconference)

News Release of Meeting

Vice Chairman Ravenel called the meeting to order and Commissioner Lemel read a statement of announcement about the meeting that was mailed to the appropriate media, interested persons, and posted at the Central Office and on the website in accordance with the Freedom of Information Act.

Adoption of the Agenda

The Commission adopted the April 20, 2017 Meeting Agenda by unanimous consent. (Attachment A)

Invocation

Commissioner Thompson gave the invocation.

Approval of the Minutes of the March 16, 2017 Commission Meetings

The Commission approved the March 16, 2017 Commission Meeting minutes with a change by unanimous consent.

Public Input

The following individual spoke during Public Input: Carolyn O'Connel, Deborah McPherson, and Patricia Harrison.

Commissioners' Update

There were no Commissioner's Update.

Policy Committee Report

Committee Chairman Ravenel gave a report of the Policy Committee Meeting that was held Tuesday, April 18, 2017. She stated that no actions were taken on the agenda items that were discussed so therefore the Commission would not be voting on the items today. Mr. Waring will provide additional information on the provider contracts at the May Commission Meeting. Dr. Buscemi will speak further on the proposed changes to the RFP for the DDSN Residential High Management Homes as it is on today's agenda.

State Director's Report

Dr. Buscemi reported on the following:

Legislative Reports – The Senate Oversight is ongoing and the Program Evaluation Report of the agency is due May 1, 2017 to the House Oversight Committee. The Commission will be notified of any upcoming public meetings regarding the reports.

Remote Sites Locations for Commission Meetings – Scheduling the June Commission Meeting at the Georgetown County DSN Board that was previously discussed may not be an option as the staff are unsure of the video capability, however, the issue is being reviewed.

Autism State Plan – The current plan is to sunset the PDD Waiver by December 31, 2017. There is discussion on raising the payment rate in the new waiver to match the rate in the ASD State Plan. Progress is being made.

Autism Spectrum Awareness Month

Mr. Daniel Davis, DDSN Autism Division Director, spoke of how the prevalence of Autism Spectrum Disorder has changed. He shared data and other information including the fact that twenty-five percent of the individuals served by DDSN have Autism Spectrum Disorder. Mr. Davis also recognized the efforts of the staff across the state that assist individuals with Autism Spectrum Disorder and their families; he went on to thank the Commission for their support.

Waiting List Reduction Efforts

Mrs. Beck gave a brief update on the Waiting List Reduction Efforts. Since the onset of the project, significant numbers of waiting individuals have been removed from the lists although new people are constantly added to the lists. She stated that individuals are not being denied residential services due to the capacity level remaining while the State is awaiting renewal of the ID/RD Waiver. (Attachment B)

Financial Update

Mr. Waring gave an overview of the agency's financial activity through March 31, 2017 and the agency's current financial position. The agency's operating cash balance as of March 31, 2017 is $46,191,461. Mr. Waring also provided an analysis of expenditures from July 1, 2106 through March 31, 2017 of the Regional Centers. A SCEIS report reflecting budget verses actual expenditures through March 2017 was also provided. Discussion followed. As requested, Mr. Waring will provide an update of the spending plan and a detailed report as to where the agency is on capital improvement/expansion projects. It was also requested that the Finance and Audit Committee review the FY 2018 Spending Plan before it is brought forth to the full Commission for approval. (Attachment C)

Budget Update

Mr. Waring gave an update of the FY 2017-2018 budget request. The Senate's version appropriates $9,000,000 in new recurring state funds to the agency to address workforce needs. It also provides $500,000 to the Greenwood Genetic Center as well as a potential bonus to permanent state employees in full-time positions up to $500 for qualifying employees earning $50,000 or less. The Senate also approved funding to cover the increased cost of health insurance. (Attachment D)

Consideration of Bid

Mr. Waring presented information for Commission approval for generators for emergency services-community providers (Aiken, Berkeley, Colleton, and Lexington Counties). Discussion followed. Commissioner Broughton motioned to approve the recommendation to award the contract to DNB Electric Inc. of West Columbia, South Carolina to include all four location Base Bids and all four location Alternates for a total contract award of $706,200.00. The motion was seconded and passed. As requested, Mr. Waring will provide a future update on the status of completing the generator projects. (Attachment E)

High Management Residential Homes RFP

Mr. Goodell spoke of the High Management Residential Homes RFP bidding process. The agency's five-year contact will expire this year. He presented information on the new requirements of this RFP for Commission approval. He noted that the new requirements relate to staffing levels maintained by the High Management providers. Failure to comply with these requirements will result in financial sanction. Discussion followed. Dr. Buscemi stated the current contract would most likely be extended due to the workload of the State Procurement Office. Commissioner Lemel sought confirmation that DDSN would comply with these new staffing requirements in the High Management homes that DDSN will be directly operating. Commissioner Thompson motioned to approve the new requirements of the High Management Residential Homes RFP. The motion was seconded and passed.

Non-Emergency Respite

Mr. Goodell presented information on non-emergency overnight respite for Commission approval. He stated this is a very important service. DDSN solicited proposals to deliver this service from all DDSN residential providers; however, the only proposal received was from Lutheran Services. Discussion followed. Mr. Goodell assured that DDSN would closely monitor the program and re-evaluate if necessary. Commissioner Lemel motioned to approve the contract for Lutheran Services to provide non-emergency overnight respite services. The motion was seconded and passed.

House Bill H4013 Adult Health Care Consent Act

Ms. Lois Park Mole presented information regarding the Adult Health Care Consent Act and House Bill 4013. She presented the flow chart which depicts DDSN's current practice in that the Adult Health Care Consent Act is followed when there is no family or representative on behalf of the individual to make health care decisions. She stated that last year when H. 3999 was introduced, it struck a reference to another section of the law so the agency requested new legislation be introduced this year (H. 4013) to reinsert the line. Discussion followed. Commissioner Thompson made the motion to have staff recommend to the General Assembly that DDSN be placed as number 8 as it was in 2015. The motion was seconded and passed.

Commission Representative for Greenwood Genetic Center Board

Commissioner Ravenel appointed herself as the Commission Representative for the Greenwood Genetic Center Board.

DDSN Employee of the Year

Mr. David Goodell stated that the Regional Center employees provide a wide array of services to the consumers 24-hours a day, 7-days a week and are extremely dedicated to our individuals that live at the Regional Centers. They truly are heroes. There is a small group that rise above the rest of the staff and are recognized through the Employee of the Year program. He added that Mrs. Deirdre Blake-Sayers chairs the Employee of the Year Selection Committee and it is a very difficult task choosing the overall Employee of the Year from the five Regional Centers. The following announcements were made:

Mr. John Hitchman announced Ms. Angel T. Profit as Employee of the Year for the Pee Dee Regional Center. Ms. Profit performs duties as a Human Services Assistant and has been employed at the Pee Dee Regional Center for 20 years. Commissioner Broughton presented a Commission resolution to Ms. Profit.

Mr. Wes Leonard announced Mr. Roger Darrell Vicars as Employee of the Year for the Whitten Regional Center. Mr. Vicars performs duties as a House Keeping Manager and has been employed at the Whitten Regional Center for almost 24 years. Commissioner Fayssoux presented a Commission resolution to Mr. Vicars.

Ms. Becky Hill announced Ms. Angela Brockington as Employee of the Year for the Coastal Regional Center. Ms. Brockington performs duties as a Human Services Assistant Charge and has been employed at the Coastal Regional Center for 16 years. Commissioner Ravenel presented a Commission resolution to Ms. Brockington.

Mr. John Hitchman announced Ms. Mattie L. Bennett as Employee of the Year for the Saleeby Regional Center. Ms. Bennett serves as Lead Supervisor of the Central Kitchen and has been employed at the Saleeby Regional Center for 29 years. Commissioner Thompson presented a Commission resolution to Ms. Bennett.

Ms. Angela Wright announced Ms. Doris Nash as Employee of the Year for the Midlands Regional Center. Ms. Nash performs duties as a Human Services Assistant and has been employed at the Midlands Regional Center for 24 years. Commissioner Barnwell presented a Commission resolution to Ms. Nash.

Commissioner Ravenel announced Mr. Vicars as the statewide 2016 DDSN Employee of the Year and presented him with a plaque. Dr. Buscemi presented Mr. Vicars with a monetary award.

Executive Session

On motion of Commissioner Lemel, seconded and passed, the Commission entered into Executive Session to discuss a pending contractual matter with DHHS.

Enter into Public Session

The Commission entered into Public Session. It was noted that no action was taken in the Executive Session.

Next Regular Meeting

May 18, 2017

Submitted by,

Sandra J. Delaney

Approved:

Commissioner Gary Lemel
Secretary

SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS

Commission Meeting

April 20, 2017

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1. CHUCK NORMAN — DDSN
2. Suzanne Johnson — Coastal Center Parent
3. Angela Brockington — Coastal Center
4. Valerie Varner — Coastal Center
5. Judy Johnson, Babcock
6. Deborah + Heather McPherson, Richland County
7. Rebecca D. Hill — Coastal Center.
8. Elaine Thom — PCBDSN
9. Wes Leonard — WC
10. Roger Vicars — WC
11. DeDeah Walsh — Jasper DSN
12. Jerry C Mize — Oconee DSN
13. Mike Moss — Calhoun DSNB
14. Marty Rawls — DDSN
15. Patti Hanson — educat
16. Sherry Pressley — LSC
17. Stephanie Williams — CCDSNB
18. ELLIN YACOBI — DDSN
19. Joe White — Cherokee Co. DSNB
20. Mike Keith — Marion-Dillon DSN

SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS

Commission Meeting

April 20, 2017

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

21. Melissa Ritter — DDSN
22. Daniel Davi — Autism
23. Philip Willis — SC Senate
24. Thom Mobley — Proj Hope
25. Dorothy Goodwin — Community Options
27. Kallie Roberts — Whitten Center SCPADD
28. Angel Proft — PeeDee Center
29. Mattie Bennett — Saleeby Center
30. John Hitchcock — SCDDSN
31. Bob Jones — Newberry DSN
32. John Long — SCDDSN
33. Ann Dalton — DDSN
34. Traci Rabon — DDSN
35. Margie Williamson — The Arc of SC
36. LaShannon Stephens — DDC
37. Ray Miller — DDC
38. Mary J. Boykin — Midlands Center family Council
39. Teri Todd — Bright Start
40. Angela Wright
41. Doris Nash
42. Joyce Davis
43. Angela Rodrigues
44. Ralph Cantrell

SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
April 20, 2017

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1. Evelyn Turner Dis Board Chas Co
2. Susan Todd Path Finders
3. Felita Martino Dist II DDSN
4. Ronda Ritchie District II
5. Rufus Britt District II
6. Heather Swannamaker DH
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SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
April 20, 2017

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1. Deborah K. Smith — SCDDSN - DISTRICT II
2. Susan Ihn — Horry Co. DSN
3. Dion Coard — Horry Co. DSN
4. Mary Mack — Lee Co. DSN Board
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SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
April 20, 2017

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1. Phyllis Corder
2. Tyler Rex ACDSNB
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SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
April 20, 2017

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1. PAT PAGAN SCDDSN
2. JIMMY BURTON BURTON CENTER
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SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
April 20, 2017

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1. Mary Poole
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SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

A G E N D A

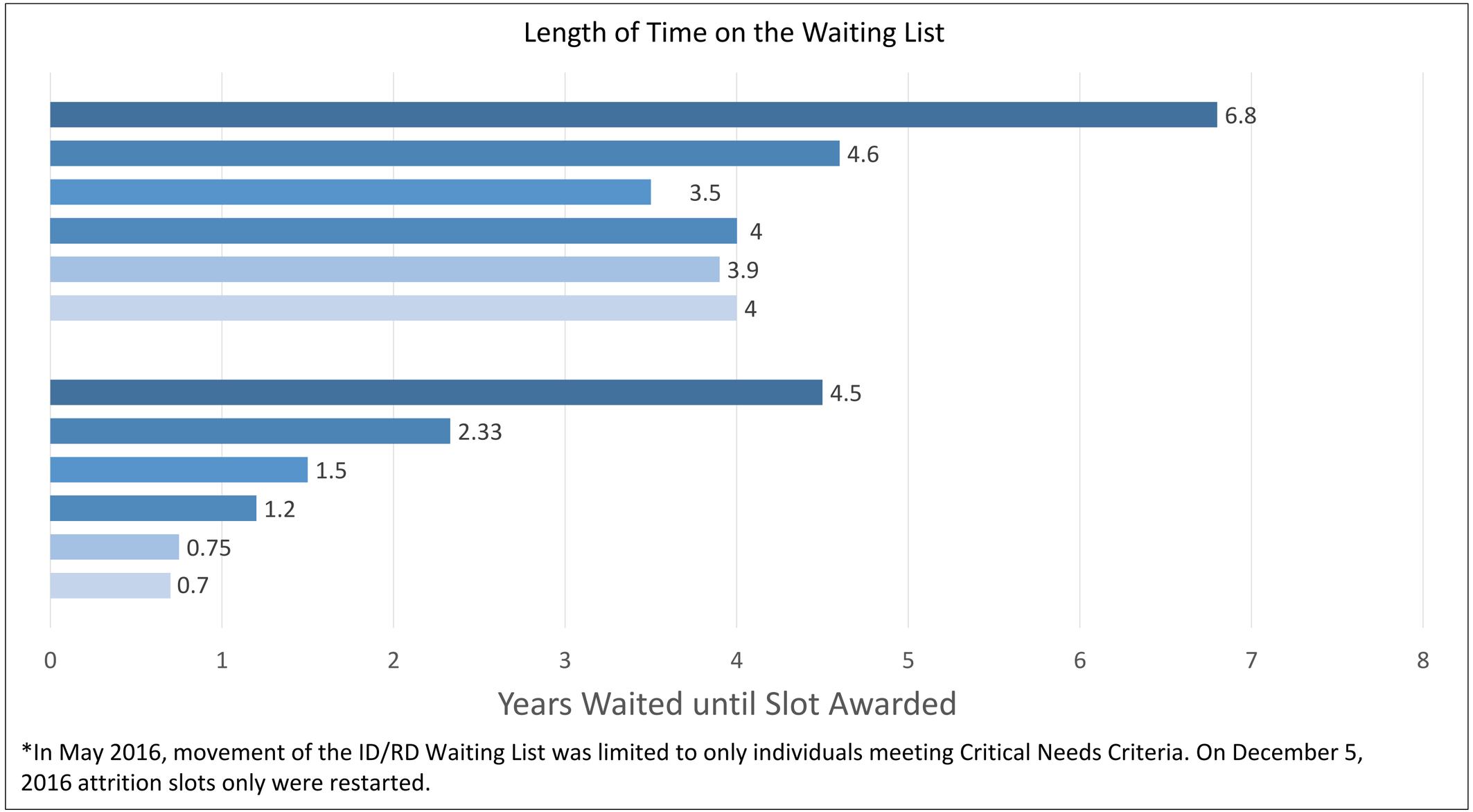
South Carolina Department of Disabilities and Special Needs
3440 Harden Street Extension
Conference Room 251
Columbia, South Carolina

April 20, 2017 **10:00 A.M.**

1. Call to Order — *Vice Chairman Eva Ravenel*
2. Welcome - Notice of Meeting Statement — *Commissioner Mary Ellen Barnwell*
3. Invocation — *Commissioner Vicki Thompson*
4. Introduction of Guests
5. Adoption of Agenda
6. Approval of the Minutes of the March 16, 2017 Commission Meeting
7. Public Input
8. Commissioners' Update — *Commissioners*
9. Policy Committee Report — *Committee Chairman Eva Ravenel*
10. State Director's Report — *Dr. Beverly Buscemi*
11. Business:
    - A. Autism Spectrum Awareness Month — *Mr. Daniel Davis*
    - B. Waiting List Reduction Efforts — *Mrs. Susan Beck*
    - C. Financial Update — *Mr. Tom Waring*
    - D. Budget Update — *Mr. Tom Waring*
    - E. Consideration of Bid – Phase II Generators for Emergency Services-Community Providers — *Mr. Tom Waring*
    - F. High Management Residential Homes RFP — *Mr. David Goodell*
    - G. Non-Emergency Respite — *Mr. David Goodell*
    - H. House Bill H4013 Adult Health Care Consent Act — *Ms. Lois Park Mole*
    - I. Commission Representative for Greenwood Genetic Center Board — *Dr. Beverly Buscemi*
    - J. DDSN Employee of the Year — *Mr. David Goodell* *Ms. Deirdre Blake-Sayers*
12. Executive Session
13. Next Regular Meeting (May 18, 2017)
14. Adjournment

SC Department of Disabilities and Special Needs

Attachment B

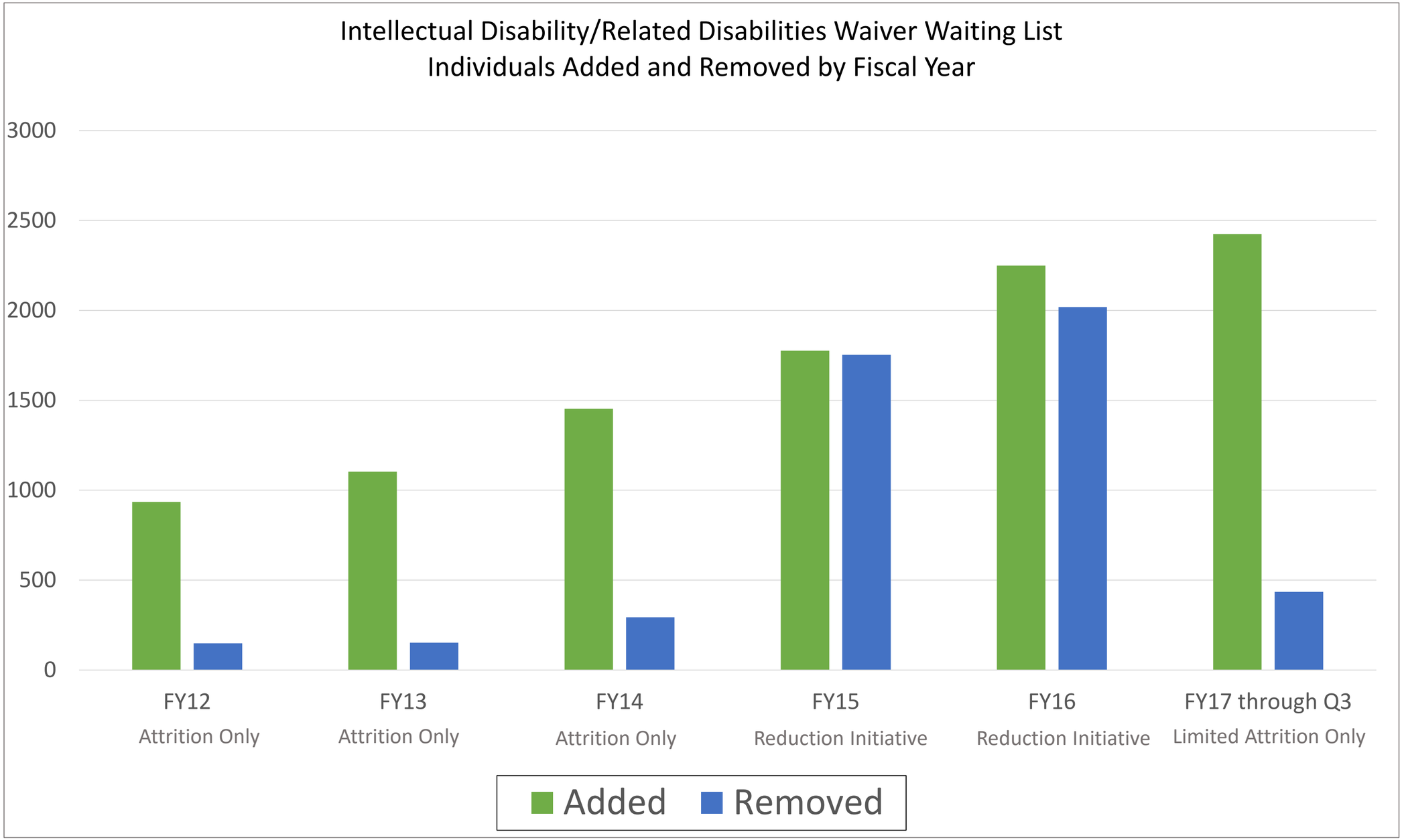


*In May 2016, movement of the ID/RD Waiting List was limited to only individuals meeting Critical Needs Criteria. On December 5, 2016 attrition slots only were restarted.

ID/RD – Intellectual Disability/Related Disabilities Waiver
CS – Community Supports Waiver

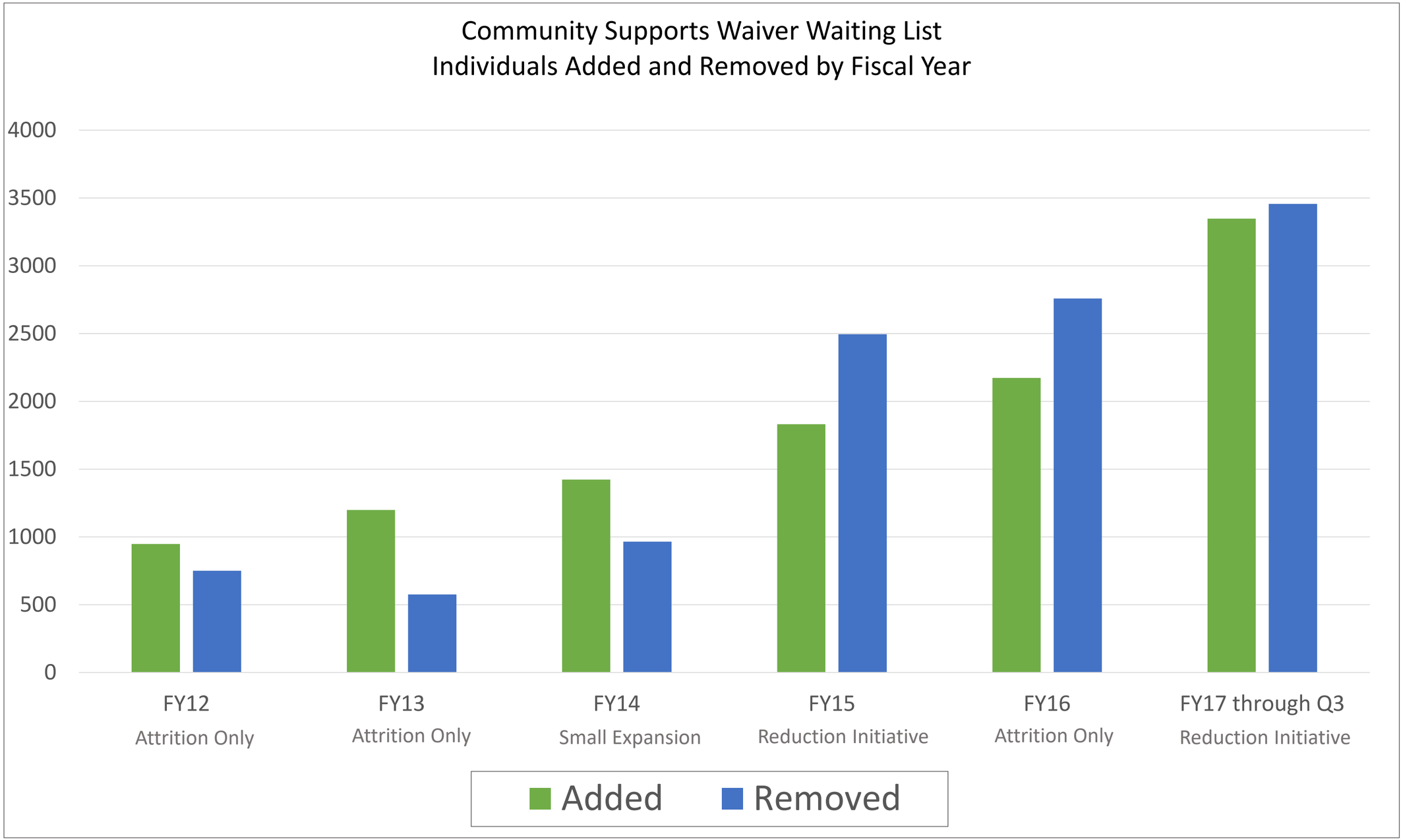
*As of April 1, 2017

SC Department of Disabilities and Special Needs



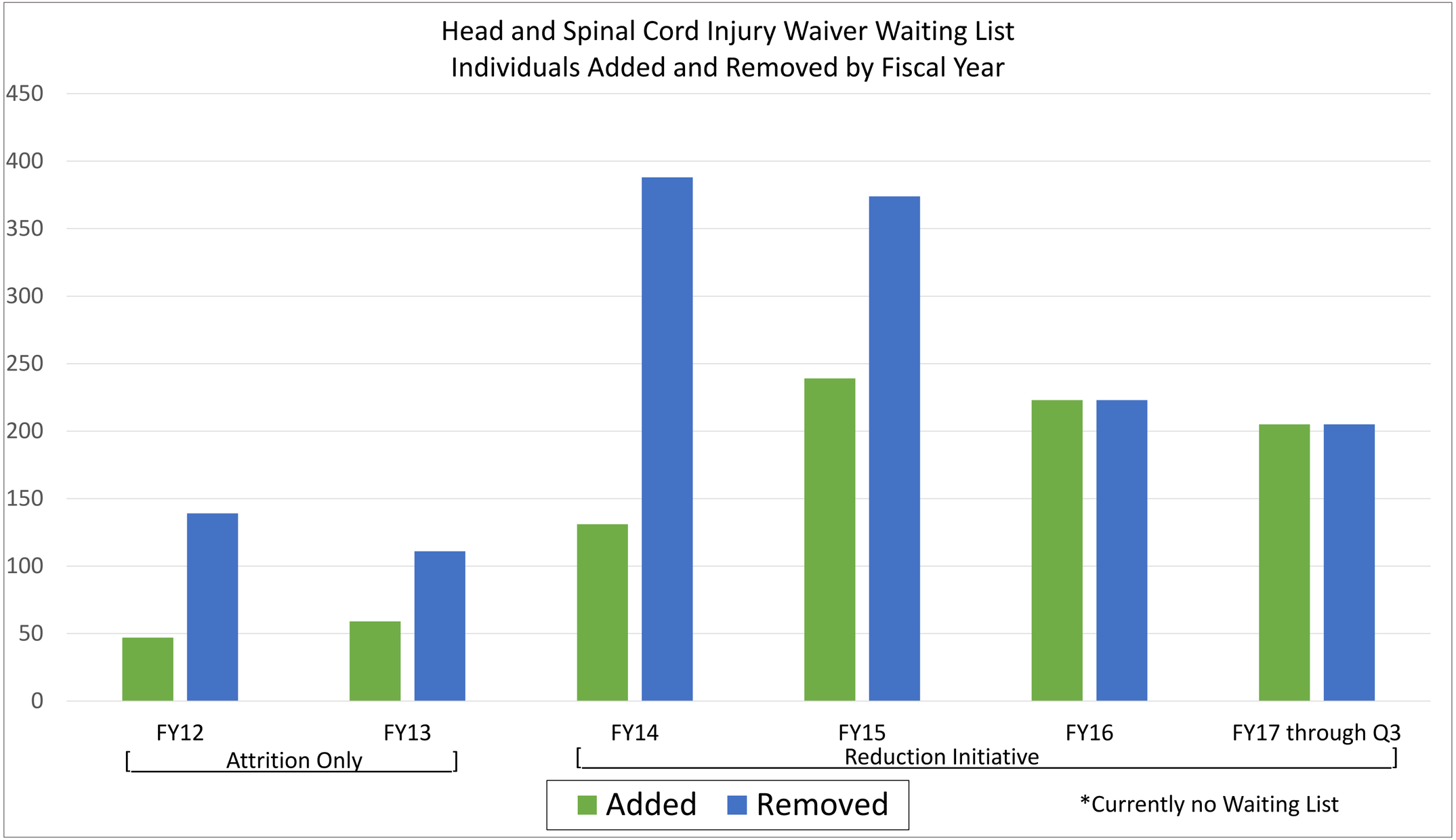
*As of April 1, 2017

SC Department of Disabilities and Special Needs



*As of April 1, 2017

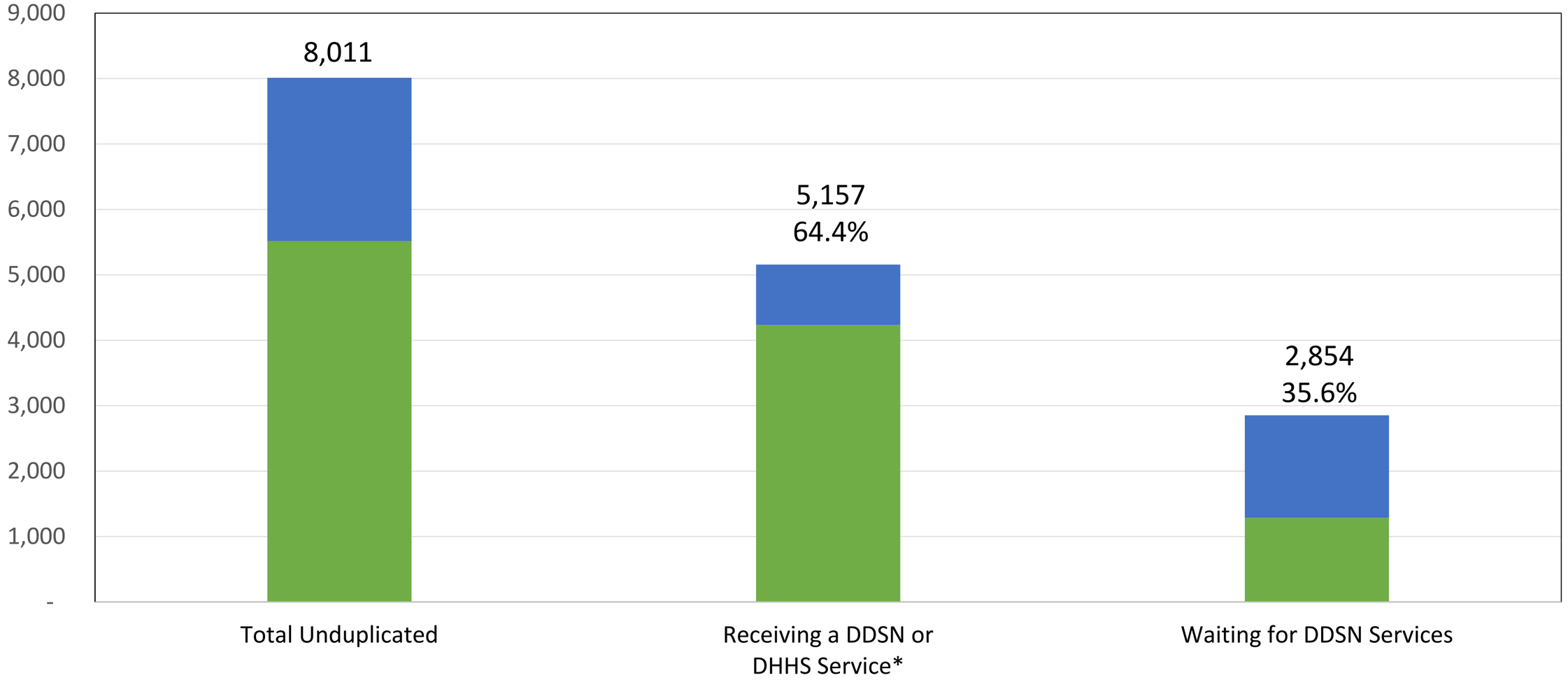
SC Department of Disabilities and Special Needs



*As of April 1, 2017

SC Department of Disabilities and Special Needs

Additional Analysis of the Number of Individuals Waiting for DDSN Services



*These services may include: DDSN Family Support Funding, DDSN Family Arranged Respite Funding, and/or Medicaid Services such as prescriptions, personal care, nursing, incontinence supplies, dental, vision, medically necessary Durable Medical Equipment services, etc.

*As of April 1, 2017

SC Department of Disabilities and Special Needs
Waiting List Reduction Efforts
As of April 1, 2017 (run on April 3, 2017)

Waiting List	Number of Individuals Removed from Waiting Lists	Consumer/Family Determination		Number of Individuals Services are Pending
		Number of Individuals Enrolled in a Waiver	Number of Individuals Opted for Other Services/ Determined Ineligible	
Intellectual Disability/Related Disabilities (As of July 1, 2014)	1,438 (FY15) 2,109 (FY16) 253 (FY17) 3,800	713 (FY15) 1,048 (FY16) 176 (FY17) 1,937	533 (FY15) 946 (FY16) 47 (FY17) 1,526	46 (FY15) 146 (FY16) 145 (FY17) 337
Community Supports (As of July 1, 2014)	2,429 (FY15) 1,838 (FY16) 3,918 (FY17) 8,185	698 (FY15) 640 (FY16) 855 (FY17) 2,193	1,518 (FY15) 1,040 (FY16) 1,841 (FY17) 4,399	17 (FY15) 154 (FY16) 1,422 (FY17) 1,593
Head and Spinal Cord Injury (As of Oct 1, 2013)	962	441	319	202
		4,571	6,244	
Total	12,947	10,815		2,132

Waiting List *	Number of Individuals Added Between July 1, 2014 and April 1, 2017	Number of Individuals Waiting as of April 1, 2017
Intellectual Disability/Related Disabilities	6,348 (2,425 since 7/1/16)	7,692
Community Supports	7,227 (3,347 since 7/1/16)	3,025
Head and Spinal Cord Injury	0	0
Total	13,575	10,717

* There is currently no Head and Spinal Cord Injury (HASCI) Waiver waiting list.

** There are 8,011 unduplicated people on a waiver waiting list. Approximately 25.3 percent of the 10,717 names on the combined waiting lists are duplicates.

SC Department of Disabilities and Special Needs

Waiting List Reduction Efforts

		2016								2017			
Row #	Total Numbers At Beginning of the Month	May	June	July	August	September	October	November	December	January	February	March	April
1	Intellectual Disability/Related Disabilities Waiver Waiting List Total	5,312	5,545	5,702	5,815	6,059	6,207	6,362	6,539	6,689	7,099	7,430	7,692
2	Community Supports Waiver Waiting List Total	3,734	3,563	3,028	3,010	2,862	2,788	2,600	2,303	2,418	2,680	3,004	3,025
3	Head and Spinal Cord Injury Waiting List Total	0	0	0	0	0	0	0	0	0	0	0	0
4	Critical Needs Waiting List Total	129	137	149	160	147	131	136	136	121	130	117	123
5	Total Number Added to the ID/RD, HASCI, and CS Waiting Lists	602	456	452	346	615	553	450	512	558	1,111	993	859
6	Total Number Removed from the ID/RD, HASCI, and CS Waiting Lists	313	394	830	251	596	381	484	632	293	439	338	576
7	Number of Individuals Enrolled in a Waiver by Month	138	126	139	119	125	128	92	143	97	160	137	136
8	Number of Individuals Opted for Other Services/Determined Ineligible by Month	158	74	100	625	256	176	240	280	103	144	53	38
9	Total Number of Individuals Removed from Waiting Lists (Running Total)	8,229	8,676	9,412	9,650	10,154	10,667	10,934	11,550	11,822	12,210	12,497	12,947
10	Total Number of Individuals Pending Waiver Services (Running Total)	1,598	1,736	2,084	1,999	2,059	2,251	2,220	2,396	2,341	2,247	2,111	2,132
11	Total Unduplicated Individuals on the Waiver Waiting Lists (*Approximate)	5,879	6,148	6,129	6,246	6,425	6,588	6,663	6,824	6,996	7,409	7,827	8,011

** There are 8,011 unduplicated people on a waiver waiting list. Approximately 25.3 percent of the 10,717 names on the combined waiting lists are duplicates.

PDD Waiting List Information

12	PDD Program Waiting List Total	1,679	1,653	1,639	1,630	1,607	1,596	1,583	1,539	1,514	1,443	1,397	1,317
13	Total Number Added to the PDD Waiting List	69	34	62	44	50	44	38	22	53	26	18	20
14	Total Number Removed from the PDD Waiting List	49	60	76	53	73	55	51	66	78	97	64	100
15	Number of Individuals Enrolled in the PDD State Funded Program by Month	256	253	241	227	214	206	190	184	189	195	191	182
16	Number of Individuals Pending Enrollment in the PDD Waiver by Month	97	110	137	143	164	169	181	202	221	239	240	271
17	Number of Individuals Enrolled in the PDD Waiver by Month	671	656	631	625	605	591	573	555	536	518	502	484

Updated 4/1/2017

South Carolina Department Of Disabilities & Special Needs
As Of March 31, 2017

Service List	02/28/17	Added	Removed	03/31/17
Critical Needs	117	35	29	123
Pervasive Developmental Disorder Program	1397	20	100	1317
Intellectual Disability and Related Disabilities Waiver	7430	325	63	7692
Community Supports Waiver	3004	489	468	3025
Head and Spinal Cord Injury Waiver	0	45	45	0

Report Date: 4/5/17

SC Department of Disabilities and Special Needs
FY 2017 Monthly Financial Summary - Operating Funds
Month Ended: March 31, 2017

	General Fund (Appropriations)	Medicaid Fund	Other Operating Funds	Federal and Restricted Funds	Total
FY 2016 Unreserved Cash Brought Forward	**$ 939,561**	**$ 527,877**	**$ 877,569**	**$ 16,190**	**$ 2,361,197** [1]
FY 2017 YTD Activity					
Receipts/Transfers					
Revenue	$ 240,453,324	$ 283,553,206	$ 6,035,121	$ 418,075	$ 530,459,726
Interfund Transfers	$ (33,000,000)	$ 33,000,000	$ -	$ -	$ -
Total Receipts/Transfers	**$ 207,453,324**	**$ 316,553,206**	**$ 6,035,121**	**$ 418,075**	**$ 530,459,726**
Disbursements					
Personal Services	$ (37,436,840)	$ (12,059,095)	$ (41,758)	$ (161,324)	$ (49,699,017)
Fringe Benefits	$ (15,508,879)	$ (5,218,981)	$ -	$ (67,389)	$ (20,795,249)
Other Operating Expense	$ (119,762,879)	$ (294,410,000)	$ (1,656,409)	$ -	$ (415,829,288)
Capital Outlays	$ -	$ (126,441)	$ (66,916)	$ -	$ (193,357)
Total Disbursements	**$ (172,708,598)**	**$ (311,814,517)**	**$ (1,765,083)**	**$ (228,713)**	**$ (486,516,911)**
Outstanding Accounts Payable Balance	**$ -**	**$ (110,546)**	**$ (2,005)**	**$ -**	**$ (112,551)**
Unreserved Cash Balance - 3/31/2017	**$ 35,684,287**	**$ 5,156,020**	**$ 5,145,602**	**$ 205,552**	**$ 46,191,461**

1 $5,000,000 of the total cash balance has been reserved for future Medicaid Settlements

FM Budget vs Actual

Author JGRANT **Status of Data** 4/10/2017 04:48:12

Filter Information

Table

Fiscal year	Business area	Funded Program - Bud	Original Budget	Budget Adjustments	Current Budget	YTD Actual Expense	Balance Before Commitments	Commitments and Other Transactions	Remaining Balance
2017	DDSN	ADMINISTRATION	$ 7,278,969.00	$ 172,575.00	$ 7,451,544.00	$ 5,124,053.80	$ 2,327,490.20	$ 313,580.96	$ 2,013,909.24
		PREVENTION PROGRAM	$ 257,098.00	$ 195,902.00	$ 453,000.00	$ 19,200.00	$ 433,800.00	$ 433,000.00	$ 800.00
		GREENWOOD GENETIC CENTER	$ 11,358,376.00	$ 0.00	$ 11,358,376.00	$ 9,801,248.00	$ 1,557,128.00	$ 1,479,733.00	$ 77,395.00
		CHILDREN'S SERVICES	$ 14,859,135.00	$ 7,251,573.00	$ 22,110,708.00	$ 9,794,847.27	$ 12,315,860.73	$ 2,225.00	$ 12,313,635.73
		BabyNet	$ 9,312,500.00	$ 0.00	$ 9,312,500.00	$ 8,750,951.00	$ 561,549.00	$ 0.00	$ 561,549.00
		IN-HOME FAMILY SUPP	$ 102,211,827.00	-$ 14,282,694.81	$ 87,929,132.19	$ 37,939,476.72	$ 49,989,655.47	$ 7,596,931.53	$ 42,392,723.94
		ADULT DEV&SUPP EMPLO	$ 67,475,832.00	$ 12,540,225.00	$ 80,016,057.00	$ 59,639,641.18	$ 20,376,415.82	-$ 4,678.00	$ 20,381,093.82
		SERVICE COORDINATION	$ 22,707,610.00	$ 50,145.00	$ 22,757,755.00	$ 14,831,982.25	$ 7,925,772.75	$ 664,518.73	$ 7,261,254.02
		AUTISM SUPP PRG	$ 14,113,306.00	$ 22,720.00	$ 14,136,026.00	$ 8,091,148.86	$ 6,044,877.14	$ 704,889.23	$ 5,339,987.91
		Pervasive Developmental Disorder (PDD)	$ 10,780,880.00	-$ 500,000.00	$ 10,280,880.00	$ 3,830,065.09	$ 6,450,814.91	$ 1,189,072.25	$ 5,261,742.66
		HD&SPINL CRD INJ COM	$ 3,040,532.00	$ 673,210.00	$ 3,713,742.00	$ 2,906,522.89	$ 807,219.11	$ 0.00	$ 807,219.11
		REG CTR RESIDENT PGM	$ 73,912,065.00	$ 1,495,925.00	$ 75,407,990.00	$ 51,772,412.89	$ 23,635,577.11	$ 3,272,171.32	$ 20,363,405.79
		HD&SPIN CRD INJ FAM	$ 26,258,987.00	$ 2,438,539.00	$ 28,697,526.00	$ 13,541,302.26	$ 15,156,223.74	$ 3,313,875.10	$ 11,842,348.64
		AUTISM COMM RES PRO	$ 23,557,609.00	$ 900.00	$ 23,558,509.00	$ 11,007,022.09	$ 12,551,486.91	$ 59,643.96	$ 12,491,842.95
		INTELL DISA COMM RES	$ 311,439,097.00	-$ 92,956.00	$ 311,346,141.00	$ 228,476,213.34	$ 82,869,927.66	$ 17,810,822.79	$ 65,059,104.87
		STATEWIDE CF APPRO		$ 0.00	$ 0.00		$ 0.00		$ 0.00
		STATEWIDE PAY PLAN		$ 0.00	$ 0.00		$ 0.00		$ 0.00
		STATE EMPLOYER CONTR	$ 29,857,979.00	$ 737,492.00	$ 30,595,471.00	$ 20,795,249.18	$ 9,800,221.82	$ 0.00	$ 9,800,221.82
		DUAL EMPLOYMENT				$ 8,124.96	-$ 8,124.96	$ 0.00	-$ 8,124.96
		Lander University Equestrian		$ 300,000.00	$ 300,000.00	$ 300,000.00	$ 0.00	$ 0.00	$ 0.00
		Result	**$ 728,421,802.00**	**$ 11,003,555.19**	**$ 739,425,357.19**	**$ 486,629,461.78**	**$ 252,795,895.41**	**$ 36,835,785.87**	**$ 215,960,109.54**

South Carolina Department of Disabilities & Special Needs
Analysis of Expenditures July 1, 2016 through March 31, 2017
Regional Centers

Description	Annual Budget	YTD Expenditures	YTD Balance	% Expended
Regional Centers				
Personal Services	$ 51,321,644	$ 40,837,331	$ 10,484,313	80%
Other Operating	$ 14,433,279	$ 10,889,274	$ 3,544,005	75%
Total Regional Centers	$ 65,754,923	$ 51,726,605	$ 14,028,318	79%
Midlands Center				
Personal Services	$ 10,627,641	$ 8,215,651	$ 2,411,990	77%
Other Operating	$ 3,847,177	$ 3,134,295	$ 712,882	81%
Total Midlands Center	$ 14,474,818	$ 11,349,946	$ 3,124,872	78%
Whitten Center				
Personal Services	$ 15,047,712	$ 12,264,061	$ 2,783,651	82%
Other Operating	$ 4,175,403	$ 2,877,802	$ 1,297,601	69%
Total Whitten Center	$ 19,223,115	$ 15,141,863	$ 4,081,252	79%
Coastal Center				
Personal Services	$ 11,984,964	$ 9,404,696	$ 2,580,268	78%
Other Operating	$ 3,040,227	$ 2,279,483	$ 760,744	75%
Total Coastal Center	$ 15,025,191	$ 11,684,179	$ 3,341,012	78%
Pee Dee Center				
Personal Services	$ 13,661,327	$ 10,952,923	$ 2,708,404	80%
Other Operating	$ 3,370,472	$ 2,597,694	$ 772,778	77%
Total Pee Dee Center	$ 17,031,799	$ 13,550,617	$ 3,481,182	80%

Attachment D

Beverly A. H. Buscemi, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Susan Kreh Beck
Associate State Director
Policy
Thomas P. Waring
Associate State Director
Administration

SOUTH CAROLINA Department OF Disabilities AND Special Needs

3440 Harden Street Ext (29203)
PO Box 4706, Columbia, South Carolina 29240
803/898-9600
Toll Free: 888/DSN-INFO
Website: www.ddsn.sc.gov

MEMORANDUM

TO: Service Providers, Families and Advocates

FROM: Beverly A. H. Buscemi, Ph.D.
State Director

RE: DDSN FY 2017-2018 Budget Update

DATE: April 11, 2017

Last Thursday the South Carolina Senate gave final passage to its state budget plan for Fiscal Year 2017-2018. The Senate's version is very good for the DDSN service delivery system as it appropriates $9,000,000 in new recurring state funds to the Department of Disabilities and Special Needs to address workforce needs. The Senate budget plan also provides $500,000 to the Greenwood Genetic Center.

Addressing workforce issues is the greatest need within our DDSN service delivery system today. The generous appropriations of recent years to reduce waiting lists have helped thousands of people. However, direct care staffing is at a crisis level and we must be competitive in the job market. New or expanded services cannot be provided without a strong workforce. The potential of this new funding is a very important first step in a multi-year effort to increase the hiring wage for Direct Support Professionals to the $12.00 to $13.00 per hour range. A new appropriation of $9 million supports moving toward that goal by increasing the hiring wage to $11.00 per hour. This represents an 8.8 percent increase from the current $10.11 per hour.

The Senate also approved funding to cover the increased cost of health insurance. There would be no increase in deductible and/or co-pays. No across the board pay increase was recommended. The Senate budget includes a potential bonus to permanent state employees in full-time positions up to $500 for qualifying employees earning $50,000 or less. The possible bonus is entirely dependent upon surplus funds being available based on the Comptroller General's certification which usually occurs in August.

The potential bonus would only apply to qualifying state employees. It does not include employees of DDSN's provider network, local aging agencies, local alcohol and drug abuse agencies and other groups. The House budget does not include a potential bonus. The bonus and other differences between the House and Senate versions of the budget bill are yet to be worked out by a conference committee. We will keep you informed.

The DDSN Commission and staff greatly appreciate the leadership and hard work that is required during the budget process. The efforts of many legislators ensured services for individuals with disabilities and their families remain a very high priority in the budget plan for FY 2017-2018. Please take time to thank your Senator and your Representative for his/her outstanding support of DDSN and services provided across the state. Thank you all for your continued work and advocacy on behalf of those we serve.

cc: DDSN Commission

CONSIDERATION OF BID

FOUR GENERATORS FOR EMERGENCY SHELTERS – AIKEN, BERKELEY, COLLETON, & LEXINGTON COUNTIES
FEMA-17-02 (D, E, F, G)

The project scope is installation of emergency generators at four sites. This is the second group to bid, leaving sixteen remaining sites to design and procure of the twenty-three statewide locations that will provide reliable and continuous power for special needs shelters during emergency situations. Tri-Development Center West in Beech Island will receive a 200 KW diesel generator, Berkeley Industries in Moncks Corner will receive a 250 KW diesel generator, Colleton Day Program Center in Walterboro will receive a 125 KW diesel generator, and Babcock Center's Batesburg-Leesville Work Activity Center will receive a 100 KW natural gas generator. Alternates include the controls packages, which are an important feature that will assist the local Disabilities & Special Needs Boards with the routine exercise, maintenance, and record keeping for the generators.

Costs at each location will be shared by SCDDSN with 75% of the estimated cost provided by Federal Emergency Management Agency's (FEMA) Federal Mitigation Grant Program. DDSN is a Sub-Recipient of the FEMA grant awarded to South Carolina Emergency Management Division (SCEMD).

Two bids were received on Thursday, April 13, 2017. It is recommended that a contract be awarded to **DNB ELECTRIC INC. OF WEST COLUMBIA, SC** to include all four location Base Bids and all four location Alternates for a total contract award of **$706,200.00**. DDSN has worked with **DNB ELECTRIC INC.** on previous projects, and DDSN has found this contractor to be responsible.

ATTACHMENT: BID TABULATION
FUNDS: FEMA, DDSN (Electrical Consultant), and SCDDSN's Match
Bid Date: April 13, 2017
Date: April 13, 2017

PROJECT NO.: FEMA-17-02 (D,E,F,G)
PROJECT NAME: Four Generators for Emergency Shelters -Aiken, Berkeley, Colleton & Lexington Counties
BID DATE: April 13, 2017
TIME: 2:00 p.m.
LOCATION: SCDDSN, Rm. 247

SCDDSN Engineering and Planning
3440 Harden St. Extension
Columbia, SC 29203
Phone: (803) 898-9796
Fax: (803) 832-8188

BID TABULATION

	CONTRACTOR	Adden. One		(D) AIKEN		(E) BERKELEY		(F) COLLETON		(G) LEXINGTON	TOTAL
1	Burriss Electrical		Base Bid D	$ 273,000.00	Base Bid E	$ 248,000.00	Base Bid F	$ 197,000.00	Base Bid G	$ 208,000.00	$ 974,000.00
			Alternate 1	$ 12,000.00	Alternate 2	$ 12,000.00	Alternate 3	$ 12,000.00	Alternate 4	$ 12,000.00	
			(D) Total	$ 285,000.00	(E) Total	$ 260,000.00	(F) Total	$ 209,000.00	(G) Total	$ 220,000.00	
			Electrical Sub	Burriss Electrical	Electrical Sub	Burriss Electrical	Electrical Sub	Burriss Electrical	Electrical Sub	Burriss Electrical	
			Electrical Sub Alt 1	Burriss Electrical	Electrical Sub Alt 2	Burriss Electrical	Electrical Sub Alt 3	Burriss Electrical	Electrical Sub Alt 4	Burriss Electrical	
2	DNB Electric		Base Bid D	$ 257,500.00	Base Bid E	$ 175,700.00	Base Bid F	$ 109,900.00	Base Bid G	$ 139,900.00	$ 706,200.00
			Alternate 1	$ 5,800.00	Alternate 2	$ 5,800.00	Alternate 3	$ 5,800.00	Alternate 4	$ 5,800.00	
			(D) Total	$ 263,300.00	(E) Total	$ 181,500.00	(F) Total	$ 115,700.00	(G) Total	$ 145,700.00	
			Electrical Sub	DNB Electric	Electrical Sub	DNB Electric	Electrical Sub	DNB Electric	Electrical Sub	DNB Electric	
			Electrical Sub Alt 1	Generator Services	Electrical Sub Alt 2	Generator Services	Electrical Sub Alt 3	Generator Services	Electrical Sub Alt 4	Generator Services	

Project Manager - Read Marshall

Witness

SCDDSN RESIDENTIAL HABILITATION HIGH MANAGEMENT/COURT INVOLVED SERVICES

Overview

In an effort to enhance services provided to individuals served through the DDSN Residential Habilitation High Management/Court Involved contracts, DDSN is recommending the establishment of additional requirements when services are solicited at the end of the current contract period (6/30/17).

New Requirements

- Providers will be required to have at least two awake on-duty direct support staff serving the individuals from each facility during those times when individuals are typically awake and not on approved leave. This will include those times that the individuals are on a community activity but will not be required if the individuals are in a DDSN licensed day program, being served by Vocational Rehabilitation, employed or attending school. Provider will be considered in compliance with the direct support staffing requirement if no more than 1 hour gap per day in coverage occurs (documentation of reason for staffing gap must be maintained). When, during awake times, two or fewer individuals are present, only one awake on-duty staff must be present. At least one awake, on-duty staff must be present at each home when individuals are present and asleep.

- Providers will be required to assure that an appropriately credentialed professional specializing in behavior analysis or individualized behavioral intervention provides an average of 2.5 hours of service per month supporting each individual served.

- DDSN may grant individual consumer and time limited exemptions to these requirements when individual needs warrant.

Requirement Non-compliance

- For each day in which the provider fails to provide the required number of direct support staff serving individuals from each facility, a recoupment will be collected for failure to provide services as required in the contract. The recoupment amount will be $75 per day per facility the provider failed to meet staffing requirements (e.g., if a provider failed to have the required number of direct support staff for individuals at five facilities for five days, a $1,875 recoupment would occur).

- For each month in which the provider does not maintain an average of 2.5 hours of service from an appropriately credentialed professional specializing in behavior analysis, a recoupment will be collected for failure to provide services as required in the contract. The recoupment amount will be $45 per hour below the established requirement for each individual (e.g., if a provider supplies a monthly average of 2 hours of behavior support service for 3 months to 30 individuals requiring a BSP, a $2,025 recoupment would occur).

Monitoring

- In addition to the established licensing, contract compliance and residential observation reviews conducted by DDSN's QIO, DDSN staff will conduct unannounced visits to provider homes multiple times per year to assess compliance with requirements (direct support and behavior analysis).

- During every twelve month period, every home will be monitored at least one time.

- Providers will be provided written findings of these reviews and offered an opportunity to appeal any adverse findings.

- Providers will be offered technical assistance and training from DDSN staff to address any adverse findings.

DDSN Operated High Management Facilities

- The High Management facilities directly operated by DDSN will be subject to the same staffing requirements as applied to the community providers of these services.

Updated 4/19/17

South Carolina Department of Disabilities and Special Needs

NON-EMERGENCY OVERNIGHT RESPITE PROGRAM

April 18, 2017

Families of individuals with disabilities must assure that their loved one receives appropriate support and supervision 24 hours a day/365 days a year. When these individuals are school aged children, they spend a large portion of this time at school. When they reach adulthood some are able to work or attend DDSN funded day programs. However, there is still a significant demand on families even when their family member with a disability is able to attend school or a day program or work. One of the services most requested by families is non-emergency or planned respite. Inability to access planned respite can be a significant contributor to disintegration of families and the need for out of home services for the person with disabilities.

Over the past several years DDSN has taken steps to increase access to hourly non-emergency respite provided in the family home or family approved locations. The agency requested and received additional funding from the Governor and General Assembly which allowed a $2.00 per hour increase in the rate paid for respite. The agency also collaborated with the South Carolina Respite Coalition to develop a standardized and competency-based respite worker training program to better assure the respite workers have the skills and knowledge needed. These actions have increased the amount of hourly respite received by families.

The current respite service system emphasizes the provision of respite on an hourly basis in the home of the family or family approved locations. This type of respite is more responsive to the needs of the family. However, there are times that families need to be able to receive extended out of home overnight respite. For example, if a relative who lives out of state passes away, the family may not be able to take the family member with a disability with them to the funeral. Historically the regional centers have provided planned overnight respite to many individuals. Our community residential homes can also provide some planned overnight respite, but it is difficult to match the needs of the individuals residing in these homes with the needs of the individuals requiring respite. Consequently, there is an inadequate supply of non-emergency overnight respite.

DDSN requested and received $500,000 from the Governor and General Assembly to expand the non-emergency overnight respite capacity in the current year's budget. DDSN has solicited proposals on providing non-emergency overnight respite from all of its community residential providers. Providers were encouraged to either dedicate a bed in an existing home or establish a new home strictly devoted to providing non-emergency respite. To offset the cost of dedicating bed space to respite, providers were allowed to propose both an unoccupied payment rate as well as an occupied payment rate.

DDSN received only one non-emergency respite proposal. The proposal is from Lutheran Family Services of the Carolinas (LFS), a qualified private residential provider which offers both CTH II and CTH I services to approximately 65 DDSN consumers. The LFS proposal offers the use of a four bed home located in the Columbia area to be exclusively dedicated to offering non-emergency overnight respite. Dedicating an entire home to provide respite avoids the problem of infringing upon consumers who are living in a home (which would occur if you use only one bed in an otherwise occupied home to provide respite). This home would be licensed by DDSN as a CTH II. LFS has agreed to charge $33.94 per day per

bed when unoccupied and $195.15 per day per bed when occupied. LFS will staff the home with one direct support staff when one or two consumers are present and one or two direct support staff if three or four consumers are present depending upon needs and abilities of the individuals. LFS would be responsible for marketing the availability of non-emergency overnight respite to all DDSN providers and case managers and would also be responsible for coordinating the scheduling of the respite. While LFS would generally be expected to respond to requests for non-emergency respite, this service is primarily intended for individuals who do not have significant medical or behavioral needs.

DDSN is proposing to contract with LFS to provide non-emergency overnight respite in accordance with the terms above. As a trial program DDSN will evaluate the aspects of the service which work, and aspects that do not work, and modify the program accordingly. After evaluation DDSN will determine the options within allocated funding amounts for additional proposals for non-emergency respite.

South Carolina Department of Disabilities and Special Needs

Regional Center Current Procedure for Insuring Informed Consent

- Consumer is suspected of not being able to make an informed decision about healthcare

- Two physicians evaluate consumer and determine ability to consent for healthcare decisions and make written record of findings

- When consumer is found to not be able to make informed consent about healthcare decisions, surrogate consent giver is selected following the hierarchy in DDSN Consent Directive (535-07-DD), selecting the highest individual on the hierarchy that is applicable
    1. Legal guardian
    2. Attorney appointed by consumer when competent
    3. A person given priority by another statute to make decisions (e.g., DSS)
    4. Spouse
    5. Parent or adult child
    6. Adult sibling
    7. Other relative
    8. A person given authority to make healthcare decisions by other statute (e.g., DDSN)

- The person identified as the surrogate consent giver is recorded in the consumer's medical record so all staff will know

- Any time a healthcare decision needs to be made, the designated consent giver is contacted and is provided with the risks and benefits of the proposed healthcare procedure

- Surrogate consent giver approves or denies proposed healthcare procedure in writing

- Regional Center staff follow directions of surrogate consent giver

Attachments

1. SC Law AHCC Act in 2015 Before Changes Made in 2016
2. SC law relating to DDSN
3. Legislation As Introduced in 2015 to Amend the AHCC Law
4. Current SC Law After Changes in made in 2016 by passage of H.3999
5. New bill introduced in 2017 to correct
6. DDSN Directive 535-07-DD Obtaining Consent for Minors and Adults
7. Attachments to DDSN Directive 535-07-DD

April 2017

CHAPTER 66
Adult Health Care Consent Act

SECTION 44-66-10. Short title.

This chapter may be cited as the "Adult Health Care Consent Act".

HISTORY: 1990 Act No. 472, Section 1.

SECTION 44-66-20. Definitions.

As used in this chapter:

(1) "Health care" means a procedure to diagnose or treat a human disease, ailment, defect, abnormality, or complaint, whether of physical or mental origin. Health care also includes the provision of intermediate or skilled nursing care; services for the rehabilitation of injured, disabled, or sick persons; and the placement in or removal from a facility that provides these forms of care.

(2) "Health care provider" or "provider" means a person, health care facility, organization, or corporation licensed, certified, or otherwise authorized or permitted by the laws of this State to administer health care.

(3) "Health care professional" means an individual who is licensed, certified, or otherwise authorized by the laws of this State to provide health care to members of the public.

(4) "Patient" means an individual sixteen years of age or older who presents or is presented to a health care provider for treatment.

(5) "Person" includes, but is not limited to, an individual, a state agency, or a representative of a state agency.

(6) "Physician" means an individual who is licensed to practice medicine or osteopathy pursuant to Chapter 47, Title 40.

(7) "Treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care that may be extended to a patient to diagnose and treat a human disease, ailment, defect, abnormality, or complaint, whether of physical or mental origin. Treatment includes, but is not limited to, psychiatric, psychological, substance abuse, and counseling services.

(8) "Unable to consent" means unable to appreciate the nature and implications of the patient's condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner. This term does not apply to minors, and this chapter does not affect the delivery of health care to minors unless they are married or have been determined judicially to be emancipated. A patient's inability to consent must be certified by two licensed physicians, each of whom has examined the patient. However, in an emergency the patient's inability to consent may be certified by a health care professional responsible for the care of the patient if the health care professional states in writing in the patient's record that the delay occasioned by obtaining certification from two licensed physicians would be detrimental to the patient's health. A certifying physician or other health care professional shall give an opinion regarding the cause and nature of the inability to consent, its extent, and its probable duration. If a patient unable to consent is being admitted to hospice care pursuant to a physician certification of a terminal illness required by Medicare, that certification meets the certification requirements of this item.

HISTORY: 1990 Act No. 472, Section 1; 1992 Act No. 306, Section 3; 2002 Act No. 351, Sections 2, eff July 20, 2002; 2013 Act No. 39, Section 2, eff January 1, 2014.

Effect of Amendment

The 2002 amendment, in paragraph (6), added the last sentence relating to certification requirements for a hospice patient unable to consent.

The 2013 amendment substituted "Health care" for "It" in the second sentence in paragraph (1); inserted new text in paragraph (4) and redesignated former paragraphs (4) and (5) as paragraph (5) and (6); inserted paragraph (7); redesignated former paragraph (6) as paragraph (8); substituted "pursuant to Chapter 47,

Title 40" for "under Chapter 47 of Title 40" in paragraph (6); and substituted "This term does not apply to minors" for "This definition does not include minors" in paragraph (8).

SECTION 44-66-30. Persons who may make health care decisions for patient who is unable to consent; order of priority; exceptions.

(A) Where a patient is unable to consent, decisions concerning his health care may be made by the following persons in the following order of priority:

(1) a guardian appointed by the court pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of the guardianship;

(2) an attorney-in-fact appointed by the patient in a durable power of attorney executed pursuant to Section 62-5-501, if the decision is within the scope of his authority;

(3) a person given priority to make health care decisions for the patient by another statutory provision;

(4) a spouse of the patient unless the spouse and the patient are separated pursuant to one of the following:

(a) entry of a pendente lite order in a divorce or separate maintenance action;

(b) formal signing of a written property or marital settlement agreement;

(c) entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties;

(5) a parent or adult child of the patient;

(6) an adult sibling, grandparent, or adult grandchild of the patient;

(7) any other relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient;

(8) a person given authority to make health care decisions for the patient by another statutory provision.

(B) If persons of equal priority disagree on whether certain health care should be provided to a patient who is unable to consent, an authorized person, a health care provider involved in the care of the patient, or any other person interested in the welfare of the patient may petition the probate court for an order determining what care is to be provided or for appointment of a temporary or permanent guardian.

(C) Priority under this section must not be given to a person if a health care provider responsible for the care of a patient who is unable to consent determines that the person is not reasonably available, is not willing to make health care decisions for the patient, or is unable to consent as defined in Section 44-66-20(6).

(D) An attending physician or other health care professional responsible for the care of a patient who is unable to consent may not give priority or authority under subsections (A)(5) through (8) to a person if the attending physician or health care professional has actual knowledge that, before becoming unable to consent, the patient did not want that person involved in decisions concerning his care.

(E) This section does not authorize a person to make health care decisions on behalf of a patient who is unable to consent if, in the opinion of the certifying physicians, the patient's inability to consent is temporary, and the attending physician or other health care professional responsible for the care of the patient determines that the delay occasioned by postponing treatment until the patient regains the ability to consent will not result in significant detriment to the patient's health.

(F) A person authorized to make health care decisions under subsection (A) of this section must base those decisions on the patient's wishes to the extent that the patient's wishes can be determined. Where the patient's wishes cannot be determined, the person must base the decision on the patient's best interest.

(G) A person authorized to make health care decisions under subsection (A) of this section either may consent or withhold consent to health care on behalf of the patient.

HISTORY: 1990 Act No. 472, Section 1; 1992 Act No. 306, Section 4.

SECTION 44-66-40. Provision of health care without consent where there is serious threat to health of patient, or to relieve suffering; person having highest priority to make health care decision.

(A) Health care may be provided without consent to a patient who is unable to consent if no person authorized by Section 44-66-30 to make health care decisions for the patient is available immediately, and in the reasonable medical judgment of the attending physician or other health care professional responsible for the care of the patient, the delay occasioned by attempting to locate an authorized person, or by continuing to attempt to locate an authorized person, presents a substantial risk of death, serious permanent disfigurement, or loss or impairment of the functioning of a bodily member or organ, or other serious threat to the health of the patient. Health care for the relief of suffering may be provided without consent at any time that an authorized person is unavailable.

(B) Health care decisions on behalf of a patient who is unable to consent may be made by a person named in Section 44-66-30 if no person having higher priority under that section is available immediately, and in the reasonable medical judgment of the attending physician or other health care professional responsible for the care of the patient, the delay occasioned by attempting to locate a person having higher priority presents a substantial risk of death, serious permanent disfigurement, loss or impairment of the functioning of a bodily member or organ, or other serious threat to the health of the patient.

HISTORY: 1990 Act No. 472, Section 1.

SECTION 44-66-50. Provision of health care without consent to relieve suffering, restore bodily function, or to preserve life, health or bodily integrity of patient.

Health care may be provided without consent to a patient who is unable to consent if no person authorized by Section 44-66-30 to make health care decisions for the patient is reasonably available and willing to make the decisions, and, in the reasonable medical judgment of the attending physician or other health care professional responsible for the care of the patient, the health care is necessary for the relief of suffering or restoration of bodily function or to preserve the life, health, or bodily integrity of the patient.

HISTORY: 1990 Act No. 472, Section 1.

SECTION 44-66-60. No authority to provide health care to patient who is unable to consent where health care is against religious beliefs of patient, or patients prior instructions.

(A) Unless the patient, while able to consent, has stated a contrary intent to the attending physician or other health care professional responsible for the care of the patient, this chapter does not authorize the provision of health care to a patient who is unable to consent if the attending physician or other health care professional responsible for the care of the patient has actual knowledge that the health care is contrary to the religious beliefs of the patient.

(B) This chapter does not authorize the provision of health care to a patient who is unable to consent if the attending physician or other health care professional responsible for the care of the patient has actual knowledge that the health care is contrary to the patient's unambiguous and uncontradicted instructions expressed at a time when the patient was able to consent.

(C) This section does not limit the evidence on which a court may base a determination of a patient's intent in a judicial proceeding.

HISTORY: 1990 Act No. 472, Section 1.

SECTION 44-66-70. Person who makes health care decision for another not subject to civil or criminal liability, nor liable for costs of care; health care provider not subject to civil or criminal liability.

(A) A person who in good faith makes a health care decision as provided in Section 44-66-30 is not subject to civil or criminal liability on account of the substance of the decision.

(B) A person who consents to health care as provided in Section 44-66-30 does not by virtue of that consent become liable for the costs of care provided to the patient.

(C) A health care provider who in good faith relies on a health care decision made by a person authorized under Section 44-66-30 is not subject to civil or criminal liability or disciplinary penalty on account of his reliance on the decision.

(D) A health care provider who in good faith provides health care pursuant to Sections 44-66-40 or 44-66-50 is not subject to civil or criminal liability or disciplinary penalty on account of the provision of care. However, this section does not affect a health care provider's liability arising from provision of care in a negligent manner.

HISTORY: 1990 Act No. 472, Section 1.

SECTION 44-66-75. Designating a family member with whom provider may discuss medical condition; exemptions.

(A) A health care provider or the provider's agent shall provide on the patient information form or by electronic health records, the opportunity for the patient to designate a family member or other individual they choose as a person with whom the provider may discuss the patient's medical condition and treatment plan.

(B) The authorization provided for in subsection (A):

(1) satisfies the requirements of Title 42 of the Code of Federal Regulations, relating to public health, and the privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

(2) must present the question in bold print and capitalized, or by electronic means: "DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"; and

(3) must specify that the patient may revoke or modify an authorization with regard to any family member or other individual designated by the patient in the authorization and that the revocation or modification must be in writing.

(C) A health care provider may disclose information pursuant to an authorization unless the provider has actual knowledge that the authorization has been revoked or modified.

(D) A health care provider who in good faith discloses information in accordance with an authorization signed by a patient pursuant to this section is not subject to civil liability, criminal liability, or disciplinary sanctions because of this disclosure.

(E) Nothing in this section may be construed to:

(1) require a health care provider to disclose information that he otherwise may withhold or limit;

(2) limit or prevent a provider from disclosing information without written authorization from the patient if this disclosure is otherwise lawful or permissible;

(3) prohibit a provider from receiving and using information relevant to the safe and effective treatment of the patient from family members; and

(4) conflict with an individual's health care power of attorney as provided for in the South Carolina Probate Code.

(F) Notwithstanding any other provision of this chapter, this section does not apply to nursing homes, as defined in Section 44-7-130 or a dentist, dental hygienist, or dental technician licensed or registered in Chapter 15, Title 40.

HISTORY: 2013 Act No. 39, Section 1, eff January 1, 2014.

SECTION 44-66-80. Other laws mandating or allowing testing or treatment without consent unaffected.

No provision in this chapter affects the ability of a state agency or health care provider working in conjunction with a state agency to conduct testing or provide treatment which is mandated or allowed by other provisions of law.

HISTORY: 1990 Act No. 472, Section 1.

SC law relating to DDSN.
Please see highlighted areas which corresponded to the AHCC Act before changes made in 2016.

CHAPTER 26
Rights of Clients with Intellectual Disability

Effect of Amendment
The 2011 amendment substituted "Clients with Intellectual Disability" for "Mental Retardation Clients".

SECTION 44-26-10. Definitions.

As used in this chapter:

(1) "Aversive stimuli" means a clinical procedure which staff apply, contingent upon the exhibition of maladapted behavior, startling, unpleasant, or painful stimuli or stimuli that have a potentially noxious effect.

(2) "Client" means a person who is determined by the South Carolina Department of Disabilities and Special Needs to have intellectual disability or a related disability and is receiving services or is an infant at risk of having intellectual disability or a related disability and is receiving services.

(3) "Client's representative" means the client's parent, guardian, legal counsel, or other person who acts on behalf or in the best interest of a person with intellectual disability or a related disability.

(4) "Director" means the South Carolina Director of Disabilities and Special Needs.

(5) "Court" means a probate court of appropriate jurisdiction unless specified otherwise.

(6) "Department" means the South Carolina Department of Disabilities and Special Needs.

(7) "Facility" means a residential setting operated, assisted, or contracted out by the department that provides twenty-four hour care and supervision.

(8) "Habilitation" means the attempt to remedy the delayed learning process to develop maximum growth potential by the acquisition of self-help, language, personal, social, educational, vocational, and recreational skills.

(9) "Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(10) "Intellectual disability professional" means a person responsible for supervising a client's plan of care, integrating various aspects of the program, recording progress, and initiating periodic review of each individual plan of habilitation.

(11) "Interdisciplinary team" means persons drawn from or representing the professional disciplines or service areas included in the individual habilitation plan.

(12) "Major medical treatment" means a medical, surgical, or diagnostic intervention or procedure proposed for a person with intellectual disability or a related disability, where a general anesthetic is used or which involves a significant invasion of bodily integrity requiring an incision, producing substantial pain, discomfort, debilitation, or having a significant recovery period. It does not include routine diagnosis or treatment such as the administration of medications or nutrition or the extractions of bodily fluids for analysis or dental care performed with a local anesthetic or a nonpermanent procedure designed for the prevention of pregnancy.

(13) "Plan of habilitation" means a written plan setting forth measurable goals or behaviorally stated objectives in prescribing an integrated program of individually designed activities or therapies necessary to achieve the goals and objectives.

(14) "Planned exclusionary time-out" means the technique of behavior modification in which a client is removed from the immediate environment to a physically safe, lighted, and normal temperature room for a specific period of time not to exceed one hour under the direct continued observation of staff.

HISTORY: 1992 Act No. 366, Section 1; 1993 Act No. 181, Section 1088; 2011 Act No. 47, Section 6, eff June 7, 2011.

Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."

Effect of Amendment
The 2011 amendment substituted "intellectual disability" for "mental retardation" throughout, inserted definitions for "Intellectual disability" and "Intellectual disability professional" in subsections (9) and (10), redesignated former subsections (9) and (10) as subsections (11) and (12), and deleted the definitions for "Mental retardation" and "Mental retardation professional".

SECTION 44-26-20. Right to writ of habeas corpus.

Clients have the right to a writ of habeas corpus.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."
Effect of Amendment
The 2011 amendment reenacted this section with no apparent change.

SECTION 44-26-30. Right to representation by counsel.

A person with intellectual disability has the right to be represented by counsel when involuntarily committed to the department pursuant to Section 44-20-450.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."
Effect of Amendment
The 2011 amendment substituted "person with intellectual disability" for "mentally retarded person".

SECTION 44-26-40. Determination of competency to consent to or refuse major medical treatment.

If a client resides in a facility operated by or contracted to by the department, the determination of that client's competency to consent to or refuse major medical treatment must be made pursuant to Section 44-66-20(6) of the Adult Health Care Consent Act. The department shall abide by the decision of a client found competent to consent.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."
Effect of Amendment
The 2011 amendment reenacted this section with no apparent change.

SECTION 44-26-50. Health care decisions of client found incompetent to consent to or refuse major medical treatment.

If the client is found incompetent to consent to or refuse major medical treatment, the decisions concerning his health care must be made pursuant to Section 44-66-30 of the Adult Health Care Consent Act. An authorized designee of the department may make a health care decision pursuant to Section

44-66-30(8) of the Adult Health Care Consent Act. The person making the decision must be informed of the need for major medical treatment, alternative treatments, and the nature and implications of the proposed health care and shall consult the attending physician before making decisions. When feasible, the person making the decision shall observe or consult with the client found to be incompetent.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."
Effect of Amendment
The 2011 amendment reenacted this section with no apparent change.

SECTION 44-26-60. Health care decisions of minor clients.

(A) If the client is a minor, the decisions concerning his health care must be made by the following persons in the following order of priority:

(1) legal guardian;

(2) parent;

(3) grandparent or adult sibling;

(4) other relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the client;

(5) other person who reasonably is believed by the health care professional to have a close personal relationship with the client;

(6) authorized designee of the department.

(B) If persons of equal priority disagree on whether certain health care must be provided to a client who is a minor, a person authorized in subsection (A), a health care provider involved in the care of the client, or another person interested in the welfare of the client may petition the probate court for an order determining what care is to be provided or for appointment of a temporary or permanent guardian.

(C) Priority under this section must not be given to a person if a health care provider, responsible for the care of a client who is unable to consent, determines that the person is not reasonably available, is not willing to make health care decisions for the client, or is unable to consent as defined in Section 44-66-20(6) of the Adult Health Care Consent Act.

(D) In an emergency health care may be provided without consent pursuant to Section 44-66-40 of the Adult Health Care Consent Act to a person found incompetent to consent to or refuse major medical treatment or who is incapacitated solely by virtue of minority.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.
Editor's Note
2011 Act No. 47, Section 13, provides as follows:
"SECTION 13. In Sections 1 through 6 of this act, the terms 'intellectual disability' and 'person with intellectual disability' have replaced and have the same meanings as the former terms 'mental retardation' and 'mentally retarded'."
Effect of Amendment
The 2011 amendment reenacted this section with no apparent change.

SECTION 44-26-70. Human rights committees.

(A) Human rights committees must be established for each regional center and for each county/multicounty program to:

(1) review and advise the regional center or the county/multicounty board on the policies pertaining to clients' rights policies;

Legislation as introduced in 2015 to amend the law.
Please note underlined portions are new proposed language.
Please note highlighted area on page 2 which struck existing language impacting DDSN.

South Carolina General Assembly
121st Session, 2015-2016

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Bill 3999

~~Indicates Matter Stricken~~
Indicates New Matter

(Text matches printed bills. Document has been reformatted to meet World Wide Web specifications.)

A BILL

TO AMEND SECTION 44-66-30, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO PERSONS WHO MAY MAKE HEALTH CARE DECISIONS FOR PATIENTS WHO ARE UNABLE TO PROVIDE CONSENT, SO AS TO CHANGE THE PROCESS FOR CERTAIN RELATIVES AND OTHER INDIVIDUALS TO MAKE THESE HEALTH CARE DECISIONS, TO ADD ADDITIONAL CLASSES OF PERSONS WITH THE AUTHORITY TO MAKE THESE HEALTH CARE DECISIONS, TO REQUIRE A BIOETHICS COMMITTEE TO SELECT CERTAIN DECISION MAKERS, TO ENABLE CERTAIN DECISION MAKERS TO CONSULT WITH A SECOND PHYSICIAN BEFORE MAKING A HEALTH CARE DECISION, TO REQUIRE THAT DECISIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES BE REVIEWED BY A BIOETHICS COMMITTEE, AND TO REQUIRE CERTAIN DOCUMENTATION RELATED TO SELECTION OF A DECISION MAKER.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Section 44-66-30 of the 1976 Code is amended to read:

"Section 44-66-30. (A) Where a patient is unable to consent, decisions concerning his health care may be made by the following persons in the following order of priority:

(1) a guardian appointed by the court pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of the guardianship;

(2) an attorney-in-fact appointed by the patient in a durable power of attorney executed pursuant to Section 62-5-501, if the decision is within the scope of his authority;

(3) a person given priority to make health care decisions for the patient by another statutory provision;

(4) a spouse of the patient unless the spouse and the patient are separated pursuant to one of the following:

(a) entry of a pendente lite order in a divorce or separate maintenance action;

(b) formal signing of a written property or marital settlement agreement; or

(c) entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties;

(5) ~~a parent or~~ an adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;

(6) a parent of the patient;

~~(6)~~(7) an adult sibling~~, grandparent, or adult grandchild~~ of the patient, or if the patient has more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation;

(8) a grandparent of the patient, or if the patient has more than one grandparent, a majority of the grandparents who are reasonably available for consultation;

~~(7)~~(9) any other adult relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient, or if the patient has more than one other adult relative, a majority of those other adult relatives who are reasonably available for consultation;

~~(8)~~(10) ~~a person given authority to make health care decisions for the patient by another statutory provision~~ a close friend of the patient who is an adult and reasonably is believed by the health care professional to have a close personal relationship with the patient;

(11) a clinical social worker licensed pursuant to Chapter 63, Title 40, or an individual who is a graduate of a court-approved guardianship program.

(B) A person serving as a decision maker pursuant to subsection (A)(11) must be selected by the provider's bioethics committee and must not be employed by the provider. If the provider does not have a bioethics committee, the provider's governing body shall designate a committee of the governing body comprised of at least three members to select the person who shall serve as the decision maker pursuant to subsection (A)(11) and who must not be employed by the provider. The person serving as the decision maker must be notified that, upon request, the provider shall make available a second physician, not involved in the patient's care, to assist the person in evaluating treatment options. A decision to withhold or withdraw life-prolonging procedures must be reviewed by the provider's bioethics committee or the committee designated by the provider's governing body pursuant to this subsection. Documentation of efforts to locate a decision maker who is a person identified in subsections (A)(1) through (A)(10) must be recorded in the patient's medical record.

~~(B)~~(C) If persons of equal priority disagree on whether certain health care should be provided to a patient who is unable to consent, an authorized person, a health care provider involved in the care of the patient, or any other person interested in the welfare of the patient may petition the probate court for an order determining what care is to be provided or for appointment of a temporary or permanent guardian.

~~(C)~~(D) Priority ~~under~~ pursuant to this section must not be given to a person if a health care provider responsible for the care of a patient who is unable to consent determines that the person is not reasonably available, is not willing to make health care decisions for the patient, or is unable to consent as defined in Section 44-66-20~~(6)~~(8).

~~(D)~~(E) An attending physician or other health care professional responsible for the care of a patient who is unable to consent may not give priority or authority ~~under~~ pursuant to subsections (A)(5) through ~~(8)~~ (A)(10) to a person if the attending physician or health care professional has actual knowledge that, before becoming unable to consent, the patient did not want that person involved in decisions concerning his care.

~~(E)~~(F) This section does not authorize a person to make health care decisions on behalf of a patient who is unable to consent if, in the opinion of the certifying physicians, the patient's inability to consent is temporary, and the attending physician or other health care professional responsible for the care of the patient determines that the delay occasioned by postponing treatment until the patient regains the ability to consent will not result in significant detriment to the patient's health.

~~(F)~~(G) A person authorized to make health care decisions ~~under~~ pursuant to subsection (A) ~~of this section must~~ shall base those decisions on the patient's wishes to the extent that the patient's wishes can be determined. Where the patient's wishes cannot be determined, the person ~~must~~ shall base the decision on the patient's best interest.

~~(G)~~(H) A person authorized to make health care decisions ~~under~~ pursuant to subsection (A) ~~of this section~~ either may consent or withhold consent to health care on behalf of the patient."

SECTION 2. This act takes effect upon approval by the Governor.

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This web page was last updated on April 16, 2015 at 10:33 AM

Current SC law after changes made in 2016 by passage of H.3999.

CHAPTER 66
Adult Health Care Consent Act

SECTION 44-66-10. Short title.

This chapter may be cited as the "Adult Health Care Consent Act".

HISTORY: 1990 Act No. 472, Section 1.

SECTION 44-66-20. Definitions.

As used in this chapter:

(1) "Health care" means a procedure to diagnose or treat a human disease, ailment, defect, abnormality, or complaint, whether of physical or mental origin. Health care also includes the provision of intermediate or skilled nursing care; services for the rehabilitation of injured, disabled, or sick persons; and the placement in or removal from a facility that provides these forms of care.

(2) "Health care provider" or "provider" means a person, health care facility, organization, or corporation licensed, certified, or otherwise authorized or permitted by the laws of this State to administer health care.

(3) "Health care professional" means an individual who is licensed, certified, or otherwise authorized by the laws of this State to provide health care to members of the public.

(4) "Patient" means an individual sixteen years of age or older who presents or is presented to a health care provider for treatment.

(5) "Person" includes, but is not limited to, an individual, a state agency, or a representative of a state agency.

(6) "Physician" means an individual who is licensed to practice medicine or osteopathy pursuant to Chapter 47, Title 40.

(7) "Treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care that may be extended to a patient to diagnose and treat a human disease, ailment, defect, abnormality, or complaint, whether of physical or mental origin. Treatment includes, but is not limited to, psychiatric, psychological, substance abuse, and counseling services.

(8) "Unable to consent" means unable to appreciate the nature and implications of the patient's condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner. This term does not apply to minors, and this chapter does not affect the delivery of health care to minors unless they are married or have been determined judicially to be emancipated. A patient's inability to consent must be certified by two licensed physicians, each of whom has examined the patient. However, in an emergency the patient's inability to consent may be certified by a health care professional responsible for the care of the patient if the health care professional states in writing in the patient's record that the delay occasioned by obtaining certification from two licensed physicians would be detrimental to the patient's health. A certifying physician or other health care professional shall give an opinion regarding the cause and nature of the inability to consent, its extent, and its probable duration. If a patient unable to consent is being admitted to hospice care pursuant to a physician certification of a terminal illness required by Medicare, that certification meets the certification requirements of this item.

HISTORY: 1990 Act No. 472, Section 1; 1992 Act No. 306, Section 3; 2002 Act No. 351, Sections 2, eff July 20, 2002; 2013 Act No. 39, Section 2, eff January 1, 2014.

Effect of Amendment

The 2002 amendment, in paragraph (6), added the last sentence relating to certification requirements for a hospice patient unable to consent.

The 2013 amendment substituted "Health care" for "It" in the second sentence in paragraph (1); inserted new text in paragraph (4) and redesignated former paragraphs (4) and (5) as paragraph (5) and (6); inserted paragraph (7); redesignated former paragraph (6) as paragraph (8); substituted "pursuant to Chapter 47,

Title 40" for "under Chapter 47 of Title 40" in paragraph (6); and substituted "This term does not apply to minors" for "This definition does not include minors" in paragraph (8).

SECTION 44-66-30. Persons who may make health care decisions for patient who is unable to consent; order of priority; exceptions.

(A) Where a patient is unable to consent, decisions concerning his health care may be made by the following persons in the following order of priority:

(1) a guardian appointed by the court pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of the guardianship;

(2) an attorney-in-fact appointed by the patient in a durable power of attorney executed pursuant to Section 62-5-501, if the decision is within the scope of his authority;

(3) a person given priority to make health care decisions for the patient by another statutory provision;

(4) a spouse of the patient unless the spouse and the patient are separated pursuant to one of the following:

(a) entry of a pendente lite order in a divorce or separate maintenance action;

(b) formal signing of a written property or marital settlement agreement; or

(c) entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties;

(5) an adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;

(6) a parent of the patient;

(7) an adult sibling of the patient, or if the patient has more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation;

(8) a grandparent of the patient, or if the patient has more than one grandparent, a majority of the grandparents who are reasonably available for consultation;

(9) any other adult relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient, or if the patient has more than one other adult relative, a majority of those other adult relatives who are reasonably available for consultation.

(B) Documentation of efforts to locate a decision maker who is a person identified in subsection (A) must be recorded in the patient's medical record.

(C) If persons of equal priority disagree on whether certain health care should be provided to a patient who is unable to consent, an authorized person, a health care provider involved in the care of the patient, or any other person interested in the welfare of the patient may petition the probate court for an order determining what care is to be provided or for appointment of a temporary or permanent guardian.

(D) Priority pursuant to this section must not be given to a person if a health care provider responsible for the care of a patient who is unable to consent determines that the person is not reasonably available, is not willing to make health care decisions for the patient, or is unable to consent as defined in Section 44-66-20(8).

(E) An attending physician or other health care professional responsible for the care of a patient who is unable to consent may not give priority or authority pursuant to subsections (A)(5) through (A)(10) to a person if the attending physician or health care professional has actual knowledge that, before becoming unable to consent, the patient did not want that person involved in decisions concerning his care.

(F) This section does not authorize a person to make health care decisions on behalf of a patient who is unable to consent if, in the opinion of the certifying physicians, the patient's inability to consent is temporary, and the attending physician or other health care professional responsible for the care of the patient determines that the delay occasioned by postponing treatment until the patient regains the ability to consent will not result in significant detriment to the patient's health.

(G) A person authorized to make health care decisions pursuant to subsection (A) shall base those decisions on the patient's wishes to the extent that the patient's wishes can be determined. Where the patient's wishes cannot be determined, the person shall base the decision on the patient's best interest.

(H) A person authorized to make health care decisions pursuant to subsection (A) either may consent or withhold consent to health care on behalf of the patient.

HISTORY: 1990 Act No. 472, Section 1; 1992 Act No. 306, Section 4; 2016 Act No. 226 (H.3999), Section 1, eff June 3, 2016.
Effect of Amendment
2016 Act No. 226, Section 1, rewrote the section, making changes to the order of priority, adding classes of persons with the authority to make health care decisions, and for other purposes.

SECTION 44-66-40. Provision of health care without consent where there is serious threat to health of patient, or to relieve suffering; person having highest priority to make health care decision.

(A) Health care may be provided without consent to a patient who is unable to consent if no person authorized by Section 44-66-30 to make health care decisions for the patient is available immediately, and in the reasonable medical judgment of the attending physician or other health care professional responsible for the care of the patient, the delay occasioned by attempting to locate an authorized person, or by continuing to attempt to locate an authorized person, presents a substantial risk of death, serious permanent disfigurement, or loss or impairment of the functioning of a bodily member or organ, or other serious threat to the health of the patient. Health care for the relief of suffering may be provided without consent at any time that an authorized person is unavailable.

(B) Health care decisions on behalf of a patient who is unable to consent may be made by a person named in Section 44-66-30 if no person having higher priority under that section is available immediately, and in the reasonable medical judgment of the attending physician or other health care professional responsible for the care of the patient, the delay occasioned by attempting to locate a person having higher priority presents a substantial risk of death, serious permanent disfigurement, loss or impairment of the functioning of a bodily member or organ, or other serious threat to the health of the patient.

HISTORY: 1990 Act No. 472, Section 1.

SECTION 44-66-50. Provision of health care without consent to relieve suffering, restore bodily function, or to preserve life, health or bodily integrity of patient.

Health care may be provided without consent to a patient who is unable to consent if no person authorized by Section 44-66-30 to make health care decisions for the patient is reasonably available and willing to make the decisions, and, in the reasonable medical judgment of the attending physician or other health care professional responsible for the care of the patient, the health care is necessary for the relief of suffering or restoration of bodily function or to preserve the life, health, or bodily integrity of the patient.

HISTORY: 1990 Act No. 472, Section 1.

SECTION 44-66-60. No authority to provide health care to patient who is unable to consent where health care is against religious beliefs of patient, or patients prior instructions.

(A) Unless the patient, while able to consent, has stated a contrary intent to the attending physician or other health care professional responsible for the care of the patient, this chapter does not authorize the provision of health care to a patient who is unable to consent if the attending physician or other health care professional responsible for the care of the patient has actual knowledge that the health care is contrary to the religious beliefs of the patient.

(B) This chapter does not authorize the provision of health care to a patient who is unable to consent if the attending physician or other health care professional responsible for the care of the patient has actual knowledge that the health care is contrary to the patient's unambiguous and uncontradicted instructions expressed at a time when the patient was able to consent.

(C) This section does not limit the evidence on which a court may base a determination of a patient's intent in a judicial proceeding.

HISTORY: 1990 Act No. 472, Section 1.

SECTION 44-66-70. Person who makes health care decision for another not subject to civil or criminal liability, nor liable for costs of care; health care provider not subject to civil or criminal liability.

(A) A person who in good faith makes a health care decision as provided in Section 44-66-30 is not subject to civil or criminal liability on account of the substance of the decision.

(B) A person who consents to health care as provided in Section 44-66-30 does not by virtue of that consent become liable for the costs of care provided to the patient.

(C) A health care provider who in good faith relies on a health care decision made by a person authorized under Section 44-66-30 is not subject to civil or criminal liability or disciplinary penalty on account of his reliance on the decision.

(D) A health care provider who in good faith provides health care pursuant to Sections 44-66-40 or 44-66-50 is not subject to civil or criminal liability or disciplinary penalty on account of the provision of care. However, this section does not affect a health care provider's liability arising from provision of care in a negligent manner.

HISTORY: 1990 Act No. 472, Section 1.

SECTION 44-66-75. Designating a family member with whom provider may discuss medical condition; exemptions.

(A) A health care provider or the provider's agent shall provide on the patient information form or by electronic health records, the opportunity for the patient to designate a family member or other individual they choose as a person with whom the provider may discuss the patient's medical condition and treatment plan.

(B) The authorization provided for in subsection (A):

(1) satisfies the requirements of Title 42 of the Code of Federal Regulations, relating to public health, and the privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

(2) must present the question in bold print and capitalized, or by electronic means: "DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"; and

(3) must specify that the patient may revoke or modify an authorization with regard to any family member or other individual designated by the patient in the authorization and that the revocation or modification must be in writing.

(C) A health care provider may disclose information pursuant to an authorization unless the provider has actual knowledge that the authorization has been revoked or modified.

(D) A health care provider who in good faith discloses information in accordance with an authorization signed by a patient pursuant to this section is not subject to civil liability, criminal liability, or disciplinary sanctions because of this disclosure.

(E) Nothing in this section may be construed to:

(1) require a health care provider to disclose information that he otherwise may withhold or limit;

(2) limit or prevent a provider from disclosing information without written authorization from the patient if this disclosure is otherwise lawful or permissible;

(3) prohibit a provider from receiving and using information relevant to the safe and effective treatment of the patient from family members; and

(4) conflict with an individual's health care power of attorney as provided for in the South Carolina Probate Code.

(F) Notwithstanding any other provision of this chapter, this section does not apply to nursing homes, as defined in Section 44-7-130 or a dentist, dental hygienist, or dental technician licensed or registered in Chapter 15, Title 40.

HISTORY: 2013 Act No. 39, Section 1, eff January 1, 2014.

SECTION 44-66-80. Other laws mandating or allowing testing or treatment without consent unaffected.

No provision in this chapter affects the ability of a state agency or health care provider working in conjunction with a state agency to conduct testing or provide treatment which is mandated or allowed by other provisions of law.

HISTORY: 1990 Act No. 472, Section 1.

New bill introduced in 2017 to correct.
Please note highlighted areas.

South Carolina General Assembly
122nd Session, 2017-2018

Download This Bill in Microsoft Word format

~~Indicates Matter Stricken~~
Indicates New Matter

H. 4013

STATUS INFORMATION

General Bill
Sponsors: Rep. G.M. Smith
Document Path: l:\council\bills\cc\15121vr17.docx

Introduced in the House on March 21, 2017
Currently residing in the House Committee on **Judiciary**

Summary: Health care decisions for adults unable to consent

HISTORY OF LEGISLATIVE ACTIONS

Date	Body	Action Description with journal page number
3/21/2017	House	Introduced and read first time (House Journal-page 121)
3/21/2017	House	Referred to Committee on **Judiciary** (House Journal-page 121)

View the latest legislative information at the website

VERSIONS OF THIS BILL

3/21/2017

(Text matches printed bills. Document has been reformatted to meet World Wide Web specifications.)

A BILL

TO AMEND SECTION 44-66-30, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO PERSONS WHO MAY MAKE HEALTH CARE DECISIONS FOR ADULTS UNABLE TO CONSENT, SO AS TO ADD A PERSON GIVEN THE AUTHORITY TO MAKE THOSE HEALTH CARE DECISIONS PURSUANT TO ANOTHER STATUTORY PROVISION; AND TO AMEND SECTIONS 44-26-40, 44-26-50, AND 44-26-60, ALL AS AMENDED, ALL RELATING TO RIGHTS OF CLIENTS OF THE SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS, SO AS TO MAKE CONFORMING CHANGES.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Section 44-66-30(A) of the 1976 Code, as last amended by Act 226 of 2016, is further amended to read:

"(A) Where a patient is unable to consent, decisions concerning his health care may be made by the following persons in the following order of priority:

(1) a guardian appointed by the court pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of the guardianship;

(2) an attorney-in-fact appointed by the patient in a durable power of attorney executed pursuant to Section 62-5-501, if the decision is within the scope of his authority;

(3) a person given authority to make health care decisions for the patient by another statutory provision;

(4) a person given priority to make health care decisions for the patient by another statutory provision;

~~(4)~~(5) a spouse of the patient unless the spouse and the patient are separated pursuant to one of the following:

(a) entry of a pendente lite order in a divorce or separate maintenance action;

(b) formal signing of a written property or marital settlement agreement; or

(c) entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties;

~~(5)~~(6) an adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;

~~(6)~~(7) a parent of the patient;

~~(7)~~(8) an adult sibling of the patient, or if the patient has more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation;

~~(8)~~(9) a grandparent of the patient, or if the patient has more than one grandparent, a majority of the grandparents who are reasonably available for consultation;

~~(9)~~(10) any other adult relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient, or if the patient has more than one other adult relative, a majority of those other adult relatives who are reasonably available for consultation."

SECTION 2. Section 44-26-40 of the 1976 Code, as last amended by Act 47 of 2011, is further amended to read:

"Section 44-26-40. If a client resides in a facility operated by or contracted to by the department, the determination of that client's competency to consent to or refuse major medical treatment must be made pursuant to ~~Section 44-66-20(6) of~~ the Adult Health Care Consent Act. The department shall abide by the decision of a client found competent to consent."

SECTION 3. Section 44-26-50 of the 1976 Code, as last amended by Act 47 of 2011, is further amended to read:

"Section 44-26-50. If the client is found incompetent to consent to or refuse major medical treatment, the decisions concerning his health care must be made pursuant to ~~Section 44-66-30 of~~ the Adult Health Care Consent Act. An authorized designee of the department may make a health care decision pursuant to Section 44-66-30~~(8)~~(3) of the Adult Health Care Consent Act. The person making the decision must be informed of the need for major medical treatment, alternative treatments, and the nature and implications of the proposed health care and shall consult the attending physician before making decisions. When feasible, the person making the decision shall observe or consult with the client found to be incompetent."

SECTION 4. Section 44-26-60(C) of the 1976 Code, as last amended by Act 47 of 2011, is further amended to read:

"(C) Priority under this section must not be given to a person if a health care provider, responsible for the care of a client who is unable to consent, determines that the person is not reasonably available, is not willing to make health care decisions for the client, or is unable to consent as defined in Section 44-66-20~~(6)~~(8) of the Adult Health Care Consent Act."

SECTION 5. This act takes effect upon approval by the Governor.

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Beverly A. H. Buscemi, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Susan Kreh Beck
Associate State Director
Policy
Thomas P. Waring
Associate State Director
Administration

3440 Harden Street Ext (29203)
PO Box 4706, Columbia, South Carolina 29240
803/898-9600
Toll Free: 888/DSN-INFO
Website: www.ddsn.sc.gov

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Title Document:	Obtaining Consent for Minors and Adults
Date of Issue:	January 20, 1989
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Date of Last Revision:	May 16, 2014 **(REVISED)**
Applicability:	DDSN Regional Centers, DSN Boards and Contract Service Providers

PURPOSE

The purpose of this directive is to implement the Adult Health Care Consent Act. This directive establishes procedure for offering the opportunity for people to authorize to whom health care information can be disclosed and establishes procedures to identify persons required to give legally valid consent for health care for people, including minors, receiving services from the South Carolina Department of Disabilities and Special Needs (DDSN) when it is determined that a person may be unable to give consent for a specific decision concerning his or her healthcare or participation in restrictive programs or more restrictive placements. This directive is applicable to persons voluntarily or judicially admitted to DDSN and residing in a Regional Center, community residence, or other setting operated by or under contract with DDSN.

PHILOSOPHY

People who have intellectual disabilities or related disabilities, autism, head and spinal cord injuries, or other similar disabilities are fully entitled to all the human and legal rights available to other citizens. They may elect to accept or refuse to participate in any requested activity. Blanket, "all or none" approaches to informed consent may result in denial of dignity and rights of individual persons and shall not occur. All persons are to be presumed competent. The

presence of a disability is not in and of itself, a reason to seek a surrogate. Because, however, a person's disability may adversely impact his/her decision process, close scrutiny must be given when consent from a person with a disability is required for a proposed activity or procedure that will:

1. create significant risks or harm,

2. have a potentially irreversible impact, or

3. intrude physically, psychologically or socially on the person

The level of scrutiny required to determine the need to obtain a surrogate must be balanced by the risk of the proposed health care against the person's ability to understand it, e.g. a person may understand the need to take insulin, but may not understand the need to have a particular type of surgery. In all cases where consent is required, the person with a disability must provide the consent, unless there is a legally recognizable exception or substitution, which, under the circumstances, is authorized or otherwise permissible.

DEFINITIONS

Adult Health Care Consent Act: This statute provides a legally recognized method of obtaining valid consent from an authorized person or other consent giver when the person is unable to consent on his/her own behalf. The Act is found at S.C. Code Ann. § 44-66-10 (Supp. 2010).

Authorization to Disclose: A health care provider or the provider's agents must provide to the patient, the opportunity to designate a family member or other individual they choose as a person with whom the provider may discuss the patient's medical condition and treatment plan.

Authorized Person: An "authorized person" is a person listed in the priority of consent givers for minor and adult consents pursuant to S.C. Code Ann. § 44-26-60 and § 44-66-30 (Supp. 2010).

Behavior Support and Restrictive Program: These are defined in DDSN Directive 600-05-DD: Behavior Support Plans.

Consent: As used in this directive, "consent" means the voluntary agreement to proposed health care by a person or authorized person with sufficient mental ability to make an intelligent choice. Consent is an active acquiescence as distinguished from "assent" which is a silent acquiescence. It is a process, not a form. Consent is the dialogue between the person or authorized person and the health care provider, both exchanging information, culminating in their agreeing to the proposed health care. It has three essential characteristics: capacity, information and voluntariness.

Department: "Department" means the S.C. Department of Disabilities and Special Needs, also referred to as "DDSN."

Emergency: In context of the Adult Health Care Consent Act, an "emergency" is a situation where a person is in immediate need of specific health care to prevent death, permanent disfigurement, loss or impairment of the functioning of a bodily member/organ, or other serious threat to the health of the person. The immediate need for such care would override any delay caused by attempting to locate an authorized person to give consent for the proposed health care and/or in locating two licensed physicians to certify the person as unable to consent.

Guardian: A "guardian" is a person appointed by a court to act and make decisions on behalf of another (ward). Sometimes this type of guardianship is referred to as a "guardian of the person." A guardian generally can make health care decisions on behalf of the ward. The court order appointing the guardian should be read carefully to determine if any limitations have been placed on the guardian. However, a "conservator" is a person appointed solely to conserve and protect the ward's estate and property. A conservator does not have authority to make health care decisions for the ward.

Health Care: As described in the Adult Heath Care Consent Act, "health care" means a procedure to diagnose or treat a disease, ailment, defect, abnormality or complaint, whether of physical or mental origin. It includes the provision of intermediate or skilled nursing care; services for the rehabilitation of injured, disabled, or sick persons; and may include if indicated by this directive the placement in or removal from a facility that provides these forms of care.

Health Care Provider: The Department is a "health care provider." The definition includes a person, health care facility, organization, or corporation licensed, certified or otherwise authorized or permitted by the laws of this State to administer health care.

Health Care Professional: A physician or dentist employed by DDSN is a "health care professional." This definition includes persons who are licensed, certified or otherwise permitted by the laws of this State to provide health care to members of the public. Nurses, nurse practitioners and other departmental personnel may be included as well. The key to the definition is that the person by virtue of a license, certification or permit be able to provide health care to the public, notwithstanding their employment with DDSN.

Minor: A person under the age of 18 is considered a "minor" in South Carolina, excluding a person who has been legally married or emancipated as decreed by the family court, S.C. Code Ann. § 63-1-40 (1) (Supp. 2010). A minor under the age of 16 is deemed unable to give consent for health care by virtue of the status of his/her age. A minor who has reached the age of 16 may consent to any health service except operations, unless the operation is essential to the health or life of the minor in the opinion of the attending physician and a consultant physician, if one is available, S.C. Code Ann. § 63-5-340 and § 63-5-350 (Supp. 2010).

Patient: An individual sixteen years of age or older who presents or is presented to a health care provider for treatment.

Power of Attorney (POA): A person (principal) may designate another (agent) to make health care decisions on their behalf. The agent is often called "attorney-in-fact." Normally, when the principal becomes incapacitated to the extent that he/she cannot manage his estate, the Power of

Attorney would automatically become ineffective. However, if the principal executed a "durable power of attorney" [S.C. Code Ann. § 62-5-501 (Supp. 2010)] with the special provisions that the power becomes effective only upon physical or mental incapacity, then the Power of Attorney would allow the attorney-in-fact to make health care decisions even though the principal might be incapacitated. These Powers of Attorney are also known as "health care power of attorney" or "durable power of attorney." These documents are complex and should be reviewed by the Department's legal counsel prior to implementing the provisions of the Power of Attorney.

Surrogate: This term is used to denote a person authorized to consent on behalf of another. Another term used in this context is "consent giver." Within the meaning of the Adult Health Care Consent Act, a surrogate is a person that fits into one of the listed priorities and can legally make health care decisions for someone unable to consent. Normally, a surrogate provides substitute judgment; that is, be guided by what the person would have wanted when competent. However, when those wishes are unknown, then the surrogate must decide based on the person's best interest.

Treatment: The broad range of emergency, outpatient, intermediate, and inpatient services and care that may be extended to a patient to diagnose and treat a human disease, ailment, defect, abnormality or complaint, whether of physical or mental origin. Treatment includes, but is not limited to - psychiatric, psychological, substance abuse, and counseling services.

Unable to Consent: This concept is at the heart of the Adult Health Care Consent Act. It means that the person is unable to appreciate the nature of his/her condition and the proposed health care, or to make a reasoned decision concerning the proposed health care, or to communicate his/her health care decision in an unambiguous manner. This definition does not include minors since their inability is based on their age status, irrespective of the fact that the minor may also be cognitively unable to consent.

Behavior support and restrictive program: These are defined in DDSN Directive 600-05-DD: Behavior Support Plans.

I. AUTHORIZATION TO DISCLOSE

Title 42 of the Code of Federal Regulations, relating to public health, and the privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require that the health care provider or agent of the provider offer the patient the opportunity to designate a family member or other individual with whom the provider may discuss the patient's medical condition and treatment plan.

This opportunity must be provided upon determination of eligibility for DDSN services, admission to any service and/or change in service provider, on a patient information form or by electronic means and must present the question in bold print and capitalized as follows: **"DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?**

The authorization to disclose must be offered to all persons and the form will be signed by the patient, guardian or surrogate.

This authorization must specify that the patient may revoke or modify an authorization with regard to any family member or other individual designated by the patient and the revocation or modification must be in writing.

A health care provider may disclose information pursuant to an authorization unless the provider has actual knowledge that the authorization has been revoked or modified.

A health care provider who in good faith discloses information in accordance with an authorization signed by a patient is not subject to civil liability, criminal liability, or disciplinary sanctions because of this disclosure.

The requirement for authorization to disclose is **not** to be construed to:

1. Require a health care provider to disclose information that he otherwise may withhold or limit;

2. Limit or prevent a provider from disclosing information without written authorization from the patient if this disclosure is otherwise lawful or permissible;

3. Prohibit a provider from receiving and using information relevant to the safe and effective treatment of the patient from family members; and

4. Conflict with an individual's health care power of attorney as provided for in the South Carolina Probate Code.

II. HEALTH CARE CONSENT

Essential Characteristics of Consent

Consent is a legal concept defined by law. It is composed of three elements - capacity, information, and voluntariness. **Capacity** refers to the ability to do something. It is defined with respect to a person's age, a person's competence, and the particular situation. Generally, a person below the age of 18 is deemed legally incompetent. Instead, parents, a legal guardian or persons standing in loco parentis (as a parent) are empowered by law to give or withhold consent on the minor's behalf, S.C. Code Ann. § 44-26-60 (Supp. 2013). Even though a minor's consent may be given by a substitute or surrogate consentor, the standards governing consent – capacity, information and voluntariness – still apply.

For Adults, those 18 or older, capacity is usually determined by cognitive processes and references to whether the person has the ability to manage his/her affairs with ordinary or reasonable prudence, has demonstrated rational understanding or intellectual comprehension, or has substantial ability to understand and appreciate the nature and consequences of a specific act.

Capacity includes the ability to communicate one's choices. Without communication, cognitive processes cannot be determined and, thus, intellectual ability will be negated.

The particular situation where consent is required may dictate the degree of ability necessary to make a decision or consent to an act. A person's ability to consent, must take into account his/her adaptive behavior and measured intelligence. A person with an intellectual or related disability may not be wholly competent or wholly incompetent. These persons may have the capacity in some situations, but not in others. The "situational capacity" approach may frequently result in the same person being found competent, for example, to purchase a shirt, but not the sale of his/her real estate. The "all or nothing" concept should be rejected, thus, allowing the person to experience growth depending on his/her developmental level.

Consent is ineffective unless the person or surrogate consent giver has sufficient **information** upon which to make a rational and informed decision. Information as a prerequisite for consent consists of two elements: the substance of the information and the manner in which the information is communicated. Thus, the focus is on "what" information is given and "how" it is given.

Effective and informed consent requires disclosure of the nature of the proposed health care, its importance and its possible consequences. Facts concerning the care must be revealed, its risks and benefits, the duration of the care, possible discomforts or adverse side effects. Available alternate heath care and its potential risks and benefits should also be made known.

This information must be received and understood. The explanation of the proposed health care should be at an appropriate comprehension level and in the language and terms that is likely to be understood. The person or surrogate consent giver must have an opportunity to digest the information or to consult with others.

Voluntariness is normally presumed unless it is shown that the person giving consent was unable to exercise freedom of choice. The person should have sufficient autonomy to make a choice without duress. There must be an absence of overbearing coercion, duress, threats, inducements or undue influence. For persons with an intellectual or related disability, the voluntariness of consent may be suspect because of his/her placement in a facility, his/her lack of experiences for independent action, his/her eagerness to please and be accepted and his/her susceptibility to authority figures. Voluntariness also incorporates the notion that the consent giver is aware that the requested consent may be withheld or if given, it may be withdrawn.

INITIAL PROCESS

Normally, the Service Coordinator, the interdisciplinary team or the attending physician will initially raise the question of a person's competence to give valid consent for health care. The issue would not arise in isolation, but in connection with a proposed or "triggering" health care treatment or program. For the purpose of this directive, healthcare is grouped into four categories:

1. medical/diagnostic care, studies and procedures,

2. psychotropic medication,

3. restrictive programming/behavior support plan, and

4. admission/placement/discharge.

When health care is proposed for a person, consent must be obtained prior to implementation of the care. This directive sets forth procedures to obtain consent for health care for children and adults. The law designates who may give consent on behalf of children. For adults who are unable to consent, again the law designates who may consent for them, and how a surrogate consent giver is selected. This process is described herein for both emergency and non-emergency situations where consent is needed for health care. Once it is decided who will be the consent giver, whether it is the person himself/herself or his/her surrogate, then this directive describes the process required to obtain valid consent, highlighting the three essential characteristics of consent.

The Service Coordinator and attending physician are the key players in this process. They must take the lead and ensure that the requirements of this directive are met. If the health care is based in traditional medical activities, treatment/diagnostic procedures, or psychotropic medications, then the attending physician must be responsible for the consent process. However, if the required consent involves restrictive programming/behavior support plans or admission/placement/discharge to or from any departmental entity/program, then the Service Coordinator should ensure compliance with this directive. This is a team effort monitored by the interdisciplinary team or key staff. This does not negate a person's rights to privacy under the Health Insurance Portability and Accountability Act (HIPAA).

SURROGATE SELECTION

I. Children

Children (below the age of 18) have only a limited capacity to consent to health care. Unless there are exceptional circumstances, parents should always be involved with their child's health care. There are some special situations where the age of the "minor" is different than 18 years. However, these situations are not encountered with any frequency with persons receiving treatment or habilitation from DDSN. If a person is a minor, decisions concerning his/her health care must be made by the following persons in the following order of priority:

1. legal guardian with court order,

2. parent,

3. grandparent or adult sibling,

4. other relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the child,

5. other person who reasonably is believed by the health care professional to have a close relationship with the child, or

6. authorized designee of DDSN (i.e., the Facility Administrator of a DDDSN Regional Center, Executive Director of a DSN Board, or Executive Director of one of the four DSN Board-like entities (i.e., Babcock Center, Charles Lea Center, Tri Development Center, and Berkeley Citizens)

The above list of priorities is found at S.C. Code Ann. § 44-26-60 (Supp. 2013). This law provides that if persons of equal priority disagree on whether certain health care should be provided, the health care provider or any person interested in the welfare of the person may petition the probate court for an order to determine what care should be provided or for the appointment of a temporary or permanent guardian.

Priority should not be given to a person who the health care provider determines is not reasonably available, unwilling or unable to make health care decisions for the person.

In an emergency, health care may be provided to a child without consent under the same emergency provision applicable to adults, even where the incapacity of the child is based solely on the child's minority.

II. Adults

The Adult Health Care Consent Act, S.C. Code Ann. § 44-66-10 (Supp. 2010), sets forth a process for obtaining consent when an adult is unable to consent. Usually, an adult is presumed competent to make decisions concerning his/her own health care. This presumption may fail, however, in light of the adult's intellectual or related disability in effect at the time consent is needed.

If there is a question concerning a person's competency or ability to make his/her own health care decisions, then the Adult Health Care Consent Act process must be followed to determine competency and to select a surrogate consent giver. A person is unable to consent to health care when he/she is unable to:

1. appreciate the nature and implication of his/her condition and proposed health care,

2. make a reasoned decision concerning the proposed health care, or

3. communicate a decision in an unambiguous manner.

When the question of inability to consent arises, two licensed physicians must examine the person and independently conclude that he/she is unable to give valid consent. The physicians must certify the inability and give an opinion regarding the cause and nature of the inability, its extent and its probable duration. The opinion becomes part of the person's medical chart. The Adult Health Care Consent Act does not restrict a treating physician from being one of the two certifying physicians. However, **in an emergency** the person's inability to consent may be certified by a health care professional responsible for the care of the person if the health care

professional states in writing in the person's medical record/chart that the delay occasioned by obtaining certification from two licensed physicians would be detrimental to the person's health. Once the person is certified as unable to give consent, a surrogate consent giver is selected and recognized. The Adult Health Care Consent Act sets forth a list of surrogates in the order of their priority of selection:

1. A guardian appointed by the court, if the decision is within the scope of guardianship;

2. An attorney-in-fact appointed by the person with power to make health decisions;

3. A person given priority to make health care decisions by another statutory provision, such as when the Department of Social Services (DSS) has taken custody of a vulnerable adult (see item #8);

4. The spouse of the person unless they are separated due to:

   a) divorce proceeding,
   b) a written separation agreement, or
   c) an order of divorce or separate maintenance;

5. A parent or adult child of the person;

6. An adult sibling, grandparent or adult grandchild of the person;

7. Any other relative by blood or marriage who reasonably is believed by the heath care professional to have a close personal relationship with the person, or

8. A person given authority to make health care decisions for the person by another statutory provision.

The last priority designation (#8) is designed to address situations of persons unable to consent for needed health care and who have no relatives or none who are willing or able to provide health care decisions. This provision allows DDSN's State Director, or her designee (i.e., the Facility Administrator, Executive Director of a DSN Board, or Executive Director of one of the four DSN Board-like entities (i.e., Babcock, Charles Lea Center, Tri Development Center and Berkeley Citizens) to make health care decisions when no one else stands in a higher level of priority, S.C. Code Ann. § 44-26-50 (Supp. 2013). Priority #8 should not be confused with priority #3. The only time a DDSN designee would make a health care decision would be in the capacity of priority #8.

ASSESSMENT OF ABILITY TO CONSENT

The process of obtaining consent involves a verbal dialogue that is usually reduced to a written consent form. With persons who have an intellectual or related disability, autism, head or spinal cord injuries, or other similar disabilities, this dialogue must be tailored to the person's intellectual level. Normally, the discussion will focus on the following topics:

1. the person's current condition or problem,
2. the intended or proposed health care,

3. the anticipated benefits of the health care,
4. the potential risks, adverse outcomes or side effects,
5. possible alternative approaches and their risks and benefits, and
6. risks/benefits of not having the proposed health care.

The physician or health care professional must make a judgment about the person's ability to understand the information needed for valid consent. The Adult Health Care Consent Act gives very little guidance other than that specified in the definition of "unable to consent." Assessing the person's ability or inability will necessitate the physician or health care professional asking a series of questions and weighing the answers. Thus, the assessment occurs and is a part of the dialogue required to inform the person of the proposed treatment as stated above. Care must be given to determine if the person is unable to either appreciate the nature of his/her condition and the proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate his/her health care decision in an unambiguous manner.

In traditional medical consent situations, the physician would inform the patient about the proposed treatment, its benefits and risks, then discuss the matter answering all the questions posed by the patient. With intellectual or related disabled persons it may be necessary for the physician or health care professional to be more pro-active and present questions that will elicit a dialogue. By allowing the person an opportunity to express himself/herself, a fair and accurate assessment can be made of the person's ability to consent. There is no formula to assist the physician or health care professional in determining the level of mental capacity needed to consent to specific procedures. **Generally, a high threshold is not necessary to demonstrate a person's understanding of his/her condition, the proposed treatment and its risks and benefits. However, as the proposed health care becomes more risky, intrusive or irreversible, the more scrutiny and inquiry of the person's understanding is required.**

EMERGENCY CONSENT

Health care for the relief of pain and suffering may be provided without consent at any time that an authorized person in the priority list is unavailable.

In emergency situations, heath care may be provided without consent if no person on the priority list is immediately available, and in the reasonable medical judgment of the attending physician or other health care professional responsible for the care of the person, the delay occasioned by attempting to locate an authorized person to make the health care decision would present a substantial risk of death, permanent disfigurement, impairment of a bodily member/organ, or other serious threat to the health of the person.

Also, health care decisions on behalf of a person who is unable to consent may be made by a consent giver on the priority list if no consent giver having a higher priority is available immediately, and in the reasonable medical judgment of the attending physician or other health care professional responsible for the care of the person, a delay occasioned by attempting to locate a consent giver having a higher priority presents a substantial risk or serious threat to the health of the person.

Health care may be provided without consent where there is no person on the list of priority who is reasonably available and willing to make the decision, and in the reasonable medical judgment of the attending physician or other health care professional responsible for the care of the person, the health care is necessary for the relief of suffering, restoration of bodily function or to preserve the life, health or bodily integrity of the person.

ADDITIONAL NOTES

The Adult Health Care Consent Act does not authorize the provision of health care where the attending physician or other responsible health care professional has actual knowledge that the health care is contrary to the religious beliefs of the person, unless the person while able to consent stated contrary intent to the physician or health care professional.

Nor does the Adult Health Care Consent Act authorize health care to a person unable to consent if the attending physician or responsible health care professional has actual knowledge that the proposed health care is contrary to the person's unambiguous and uncontradicted instructions expressed at the time when the person was able to consent.

A person who in good faith makes a health care decision as provided in the Adult Health Care Consent Act is not subject to civil or criminal liability on account of the substance of the decision. A person who consents on behalf of a person unable to consent does not by virtue of that consent become liable for the costs of the health care provided to the person.

The Adult Health Care Consent Act protects the heath care provider, DDSN, DSN Boards and DSN Board-like entities (i.e., The Babcock Center, Charles Lea Center, Tri Development and Berkeley Citizens) who in good faith rely on a health care decision made by an authorized person from civil and criminal liability or disciplinary penalty on account of reliance on the decision. This protection also applies in emergency situations.

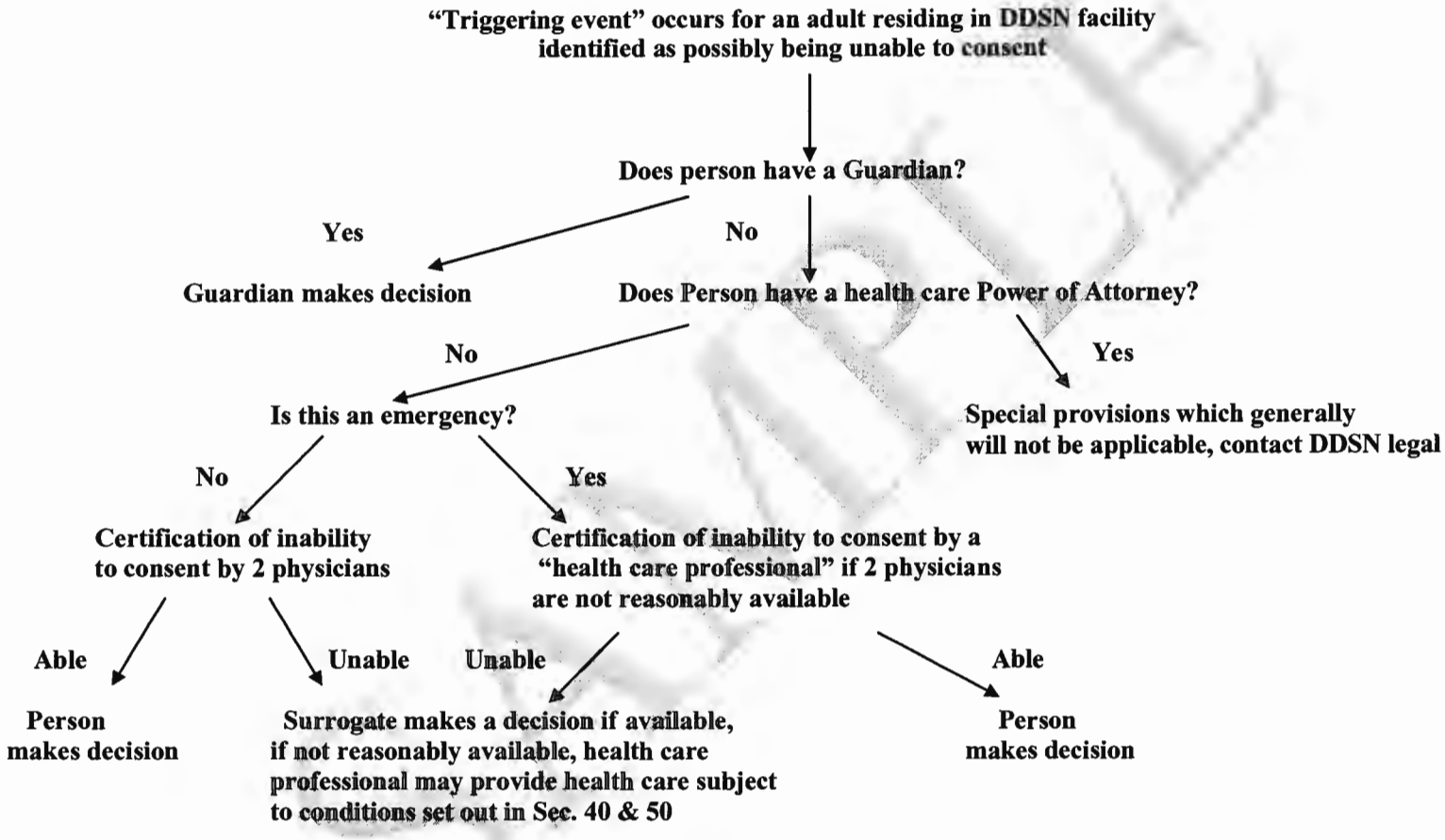
Susan Kreh Beck, Ed.S., NCSP
Associate State Director-Policy

Beverly A.H. Buscemi, Ph.D.
State Director

To access the following attachments, please see the agency website page "Attachments to Directives" under this directive number.

Attachment 1	Health Care Consent Act Flow Chart
Attachment 2	Instruction Sheet for Health Care Consent Form
Attachment 3	Health Care Consent Form
Attachment 4	Instructions for Authorization to Disclose Protected Health Information
Attachment 5	Authorization to Disclose Protected Health Information Form

ADULT HEALTH CARE CONSENT ACT (AHCCA)
S.C. CODE ANN. § 44-66-10 (Supp. 2010)



INSTRUCTIONS FOR HEALTH CARE CONSENT FORM

GENERAL INFORMATION

This form is designed to follow the requirements of S.C. Ann. § 44-66-10 (Supp.2010), known as the Adult Health Care Consent Act (AHCCA). The Adult Health Care Consent Act spells out a process in which two physicians perform independent evaluations of an adult and certify whether the person is able to consent to his/her health care. This establishes allows a mechanism in which surrogate health care decision-makers are subsequently identified according to a specific priority set out in the Adult Health Care Consent Act.

A specific issue raised is the concept of "unable to consent" which means that an adult is either:

1. unable to appreciate the nature and implications of his/her condition in proposed health care,

2. unable to make a reasoned decision concerning the proposed health care, or

3. unable to communicate that decision in an unambiguous manner.

"Health care" is defined in the Adult Health Care Consent Act as procedures to diagnose or treat a human disease ailment, defect, abnormality, or complaint whether of physical or mental origin. It specifically states that it also includes provision of intermediate or skilled nursing care as well as services for the rehabilitation of injured, disabled, or sick persons in the placement in or removal from a facility that provides these forms of care. If independent evaluations by two physicians result in a patient being certified as displaying an inability to consent, this sets the stage for selecting a surrogate decision maker to act on behalf of the patient. The certification is a major decision with significant and profound implications for the adult who is being certified as unable to consent and therefore, the examination as well as the documentation should thoroughly and specifically demonstrate evidence of the inability to consent. The Adult Health Care Consent Act specifically does not apply to minors unless they are legally married or have been determined to be emancipated. There are also specific steps that can be taken in an emergency that will be dealt with separately.

Note: The ability to consent must take into consideration each person's capability to understand each procedure, therefore blanket consents for all persons receiving services and/or "all or none" consents are strongly discouraged.

SECTIONS I and II:

PROPOSED HEALTH CARE and CERTIFICATION OF INABILITY TO CONSENT

Starting at the beginning of the document, the full legal name of the person should be entered on the line as well as the date of the certification process.

Section I: Enter the proposed health care procedure, medical or other event that is "triggering" the need to evaluate the person's ability to give informed consent.

Section II: First Part - The physician certifies that he/she has examined the person and that the person is:

a. Unable to appreciate the nature and implications of his/her condition and the proposed health care,

b. Unable to make a reasoned decision concerning the proposed health care and/or,

c. Unable to communicate a decision concerning the proposed healthcare in an unambiguous manner.

The physicians are to check the boxes that apply.

Section II: Second Part - The physicians state the specific bases for their medical opinions and conclusions.

1. The **cause** is defined as the injury, insult, disease or condition that is thought to be responsible for the inability to consent. Some examples of cause would include prematurity, birth trauma/hypoxia, severe closed head injury with persistent neurological deficits, Trisomy 21, or other known or suspected disease. Obviously, the cause of the insult leading to the cognitive and developmental deficits in many service users is not known and therefore "unknown" is an appropriate response.

2. The **nature** of the person's inability to consent is generally defined as the degree of intellectual or related disability, i.e., scale IQ of 10, etc. It is important in this section that the physicians give specific examples of the degree of impairment. An example of this would be "non-verbal and unable to communicate using assistive technology," "patient is unable to follow a three-step command," "patient is unable to recall examiner's name," etc. Demonstration of an inability to perform simple tasks would be consistent with significant cognitive impairment and an inability to appreciate the various health care choices and make a reasoned decision concerning alternatives. If use of any evaluation in the person's file/record is made, then the physician should reference that evaluation in the comments for this section.

3. The **extent** of the person's inability addresses specific areas where the individual cannot make informed decisions. This would be areas where the individual's cognitive limitations prevent him/her from adequately evaluating the different options for making decisions. This section of the document is designed to draw parameters around the inability to consent and still leave other areas in which the individual may be able to consent unaffected. For example, a person maybe unable to make informed decisions about psychotropic medications; however, he/she may be able to understand a simple two step option such as a restrictive Behavior Support Plan that used time loss of a home visit as a consequence for inappropriate behavior. In this situation, the restrictive Behavior

Support Plan would be a simple matter of understanding cause and effect and someone with limited cognitive abilities may very well be able to understand this option. Therefore, in the extent area, list only the areas where the person is unable to give full informed consent.

The Explanation of Exceptions section would address areas where the person can give informed consent.

4. The **probable duration** of the person's inability to consent is an estimate of how long the disabling condition will last. For many individuals this will be lifelong due to the chronic nature of their disability. However, even if lifelong, the inability to consent must be reviewed on a yearly basis.

5. A **delay in application** refers to situations where the inability to consent is believed to be a temporary condition. However, with a majority of persons the inability to consent is going to be a chronic condition, such as an intellectual or related disability. If this is the case, check the "yes" box indicating that it is not feasible to wait an extended period for the person's cognitive ability to improve to give consent. Clearly, for many of persons checking "yes" indicates that the proposed health care cannot be deferred for months or even years.

6. Each physician will read and sign the statement at the bottom of the page indicating his/her agreement and the date of the evaluation. There are lines below the signature that are intended to give the physician room to apply observations that were noted during their examination. For instance, if the first physician filled out the majority of the information on the consent form, then the second physician may add additional observations during their independent evaluation. An issue that might be discussed here would be whether special programming could improve the person's ability to give consent in certain areas in the future.

Section III:

SURROGATE SELECTION

The Adult Health Care Consent Act specifically defines a priority for surrogates, which is listed there.

1. Court Appointed Guardian: This is a person who has been appointed by a court to make decisions on behalf of a person who has been adjudicated incompetent. This is usually done through the probate court system and it is important to verify that the guardian actually has the authority to make health care decisions and not just conservator or financial decisions. If a guardian has been appointed, his/her name should be written here and a copy of the court order should be attached to this form.

2. Durable Power of Attorney: This is a person named in the durable power of attorney as a decision-maker. It must be determined if the attorney in fact has authority to make health care decisions. Again, copies of the legal document should be attached to this form.

3. Other Statutory Provision: This applies when another person or agency has been identified as having the legal authority to make health care decisions. A specific example might be if a person has been placed in Adult Protective Services under the Department of Social Services (DSS); that agency would have the legal responsibility for health care decisions.

4. A Spouse: A legally married spouse would be the fourth priority. It is important to make sure that the person is legally married. If they are divorced or legally separated, the spouse cannot be selected.

5. Parent or Adult Child of the Patient

6. Adult Sibling, Grandchild, or Grandparent

7. Relative by Blood or Marriage: This applies to a relative who is reasonably believed to have a close personal relationship with the person unable to consent. This could be an aunt, uncle, cousin, or other persons who have shown a consistent involvement and interest in the person.

8. Person Given Authority by Other Statutory Provision: This would refer to Facility Administrators, Executive Directors of DSN Boards or CEOs of contracted service providers. This is the last priority and would only come into play if all of the above were not applicable.

When going down the surrogate selection list, write in N/A (for not applicable) in each category until you come to the first one where a surrogate is available, and then write in the full name of that person. Then go down to the primary surrogate designation and again write in this person's full name, address, and phone number. It is important that the treatment team/key staff specifically follow the surrogate priority exactly and make every effort to contact the primary surrogate in order to obtain consent for the proposed health care. If an emergency occurred and one needed to obtain consent quickly, all reasonable efforts should be exhausted with the primary surrogate before one should proceed to the next surrogate to obtain consent. It is important that if there is family discord at the same priority level then the surrogate selection process would not apply and it would be necessary to proceed to the probate judge for an official court appointed guardian.

Other Points to Remember About This Document

1. This form refers only health care for persons unable to consent.

2. This form applies only to adults unless a minor child has been married legally or is emancipated.

3. Specific examples of the person's inability to consent must be stated, such as, "non-verbal," "unable to follow a two-step command," and "unable to remember the two health care options." **Just writing intellectually disabled or related disability under the nature is insufficient documentation of their inability to consent**.

4. It is important to note whether the disability is a chronic condition and to give suggestions for possible areas of programming that may improve the person's ability to give an informed consent at a future date.

5. Surrogate selection: Must follow the list according to the priority. This is specified in the state's statue. If persons of equal priority disagree on whether certain health care should be provided, the health care provider or any person interested in the welfare of the person may petition the probate court for an order to determine what care should be provided or for the appointment of a temporary or permanent guardian. Priority should not be given to a person who the health care provider determines is not reasonably available, unwilling, or unable to make health care decisions for the person. If, prior to becoming unable to consent, the person expressed a desire that certain person(s) not be involved in his/her health care decisions, those desires must be respected, and the next available person on the priority list with the highest priority may act as a surrogate.

   The Adult Health Care Consent Act does not authorize surrogate health care decisions if the person is only temporarily unable to consent and the health care provider or attending physician determines that a delay occasioned by postponing the health care/treatment will not result in significant determent to the person. A person authorized to make health care decisions as a surrogate must base those decisions on the person's wishes when he/she was able to consent to the extent that those wishes can be determined. If those wishes cannot be determined, the surrogate must base the decision on the person's best interest.

   A person selected as a surrogate under the Adult Health Care Consent Act may consent or withhold consent to health care for the person. The Adult Health Care Consent Act does not authorize the provision of health care when the physician or health care provider has actual knowledge that the health care is contrary to the religious beliefs of the person or contrary to the person's unambiguous and uncontradicted instructions expressed at a time when he/she was able to consent. The next surrogate can be used if the health care professional is of the opinion that a delay due to attempts to locate the primary surrogate may be detrimental to the health and the well-being of the person. If the health care provider and treatment team responsible for the care of the person who is unable to consent feels that the surrogate is not acting in the person's best interest, the treatment team/key staff may elect to petition the Probate or Family Court for appointment of a guardian. This will help to resolve differences of opinion, especially if the family is unable to resolve the conflicts on their own. If concerns or doubts arise, contact the Legal Department of DDSN for guidance.

HEALTH CARE FOR ADULTS UNABLE TO CONSENT

This form is designed to conform to the requirements for obtaining surrogate consent for adults unable to consent to health care in accordance with Adult Healthcare Consent Act (hereinafter the "AHCCA"), S. C. Code Ann § 44-66-10, et seq. (Supp.2010) and DDSN Directive 535-07-DD: Obtaining Consent for Minors and Adults.

(USE BLACK INK AND WRITE LEGIBLY)

Name of Person: _____

Date: _____

I. Proposed Health Care: ☐Non-Emergency ☐Emergency

_____

_____

_____

II. Certification of Inability to Consent

The undersigned two licensed physicians certify that he/she has examined the person and, based on independent examination, it is their professional opinion and judgment that: (Check all that apply).

☐The person is unable to appreciate the nature and implications of his/her conditions and the proposed health care.
☐The person is unable to make a reasoned decision concerning the proposed health care.
☐The person is unable to communicate a decision concerning the proposed health care in an unambiguous manner.

The basis for this medical opinion and conclusion is supported by the following facts and observations:

1) The **Cause** of the person's inability to consent is: _____

2) The **Nature** of the person's inability to consent is: _____
_____
_____

3) The **Extent** of the individual's inability to consent is: _____

4) The **Probable Duration** of the individual's inability to consent is: _____
_____

5) A **Delay In Application** of the proposed health care beyond the above stated time presents a substantial risk of death, impairment of functioning of a bodily organ, or other serious threat to the health and safety of the patient.
☐Yes ☐No

I, the undersigned, hereby state that I am a licensed physician and have personally examined the above named person and, based on my observations and conclusions as stated above, believe that the person is unable to consent to the proposed health care and is in need of a surrogate that can make health decisions in the best interest of this person.

First Physician: _____ Second Physician: _____

Date of Exam: _____ Date of Exam: _____

Additional Observations/Impressions: _____

_____

_____

III. Surrogate Selection

1) Court Appointed Guardian:_____
(Attach court papers)

2) Durable Power of Attorney:_____
(Attach legal papers)

3) Other Statutory Provision:_____
(Attach documents verifying authority)

4) Spouse:_____

5) Parent or Adult Child:_____

6) Adult sibling, Grandchild, or Grandparent:_____

7) Relative by blood or marriage who reasonably is believed to have a close personal relationship with person unable to consent::_____

8) Person given authority by other statutory provision:_____

Surrogate Information

Full Name:_____

Address:_____

Phone Number:_____

Instructions for Authorization to Disclose Protected Health Information Form

S.C. Ann. § 44-66-10 et seq. (Supp. 2016), known as the Adult Health Care Consent Act (AHCCA) was revised in January 2014 to require that a health care provider or the provider's agent provide on the patient information form or by electronic health records, the opportunity for the patient to designate a family member or other individual they choose as a person with whom the provider may discuss the patient's medical condition and treatment plan. This form was created to fulfill this requirement of S.C. Code Ann. § 44-66-75 (Supp. 2016) and 42 CFR part 2.

The form must be signed by the person, guardian or surrogate. It must be completed upon the determination of DDSN eligibility and when enrolling in a new service.

The question," DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? If YES, WHOM? must be provided in bold print or by electronic means.

Provider will check yes or no, according to the person's wishes. When disclosure is desired, complete the name person to whom the information may be disclosed and their contact information.

Check the areas in which the person wishes information to be disclosed (medical condition, treatment plan, other). If the person wishes to disclose limited portions of those areas, detail on the form what may or may not be disclosed. For example, the person may want to disclose medical condition but not disclose prognosis.

The provider must specify that the patient may revoke or modify the authorization and that the revocation or modification must be in writing.

The revocation/modification portion of the form is to be completed if/when the person wishes to revoke authorization to disclose or change the information they wish to disclose.

This form must be maintained in the person's file.

Revised 02/08/17

AUTHORIZATION FOR RELEASE OF INFORMATION
From the SC Department of Disabilities and Special Needs
3440 Harden Street Ext., Columbia, SC 29203

Print/type in Black Ink

Requestor Last Name: _____
Suffix: _____
First Name: _____

SECTION I **To be completed by SC Department of Disabilities and Special Needs**

Name and address of consumer at time services were provided (include zip code)

Relationship to consumer: _____

Consumer
Date of Birth: _____

SECTION II **To be completed by requestor or person authorized to act on his/her behalf**

I voluntarily authorize and request disclosure (including paper and secure electronic interchange):

OF WHAT: All my medical records; also education records and other information from the SC Department of Disabilities and Special Needs

This includes specific permission to release:

1. All records and other information regarding my services from the SC Department of Disabilities and Special Needs which may include:
   - Psychological, psychiatric, or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases
   - Gene-related impairments (including genetic test results)
2. Copies of educational tests or evaluations, including individualized Educational Programs, triennial assessments, psychological and speech evaluations, and teachers' observations and evaluations in SC Department of Disabilities and Special Needs records.
3. Specific Records Only: *(Please list)*

   _____ _____ _____

   _____ _____ _____

4. This request is for records from DATE: _____ to DATE: _____

TO WHOM – The SC Department of Disabilities and Special Needs is authorized to release my records (usually called SCDDSN), to the following named entities:

_____ _____ _____

_____ _____ _____

PURPOSE: Authorizing the SC Department of Disabilities and Special Needs the ability to release personal and confidential information to myself or my legal representative or other entities as listed above.

EXPIRES WHEN: This authorization is good for 12 months from the date signed.

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
I may write to the SC Department of Disabilities and Special Needs to revoke this authorization at any time.
The SC Department of Disabilities and Special Needs will give me a copy of this form when requested.

I HAVE READ THIS FORM AND AGREE TO THE DISCLOSURES OF MY RECORDS

Date: _____

_____
Signature of Requestor or Legal Guardian

Street
Address:

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; S.C. Code Ann. § 44-66-10 et seq. (Supp. 2016); and S.C. Code Ann. §44-66-75 (Supp. 2016).

Return completed form to the SC Department of Disabilities and Special Needs (see above address)
Please contact SCDDSN with any questions at (803) 898-9706; 1-888-376-4636 (within SC only) or by email at dalston@ddsn.sc.gov