**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS**
**CERTIFICATION AND LICENSING STANDARDS**
**REQUEST FOR EXCEPTION**

Provider Requesting Exception:_____ Date:_____

Facility/Program:_____ _____
Signature of Provider Executive

Participant or Staff for whom Exception is Requested:_____

| Policy/Standard from which Exception is requested (e.g., 000-00- DD, DDSN Residential Habilitation Standards, etc.) | Nature and Reason for Exception Request | Explain how the health, safety, and welfare of participants will be maintained and the Quality and Quantity of Services will continue: |
|---|---|---|
| | | |

DDSN Comments:

Time Limited Approval: ☐Yes ☐No Effective Dates:_____
*Unless otherwise stated, the exception is in effect for as long as the conditions noted in the justification remain current*

_____ ☐Approved ☐Denied Date:_____
Signature – Director-Quality Management

_____ ☐Approved ☐Denied Date:_____
Signature – State Director/Designee