SOUTH CAROLINA
DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

PERMISSION TO EVALUATE

_____ _____
(Name of Applicant) (Date of Birth)

As the applicant or the parent or legal guardian of the applicant named above, I am requesting that he/she be evaluated to determine his/her eligibility for services through the South Carolina Department of Disabilities and Special Needs (DDSN).

I understand that in order to determine if the applicant is eligible for services through DDSN, DDSN may need to review medical, psychological, social, school and/or other existing records. If assistance is needed to obtain these records, assistance will be provided. Additionally, it may be necessary for psychological testing or other evaluations to be completed in order to determine if the applicant is eligible. If additional, evaluations are needed, DDSN will arrange for the evaluations. Neither the applicant nor his/her legal guardian will be held responsible for the cost of psychological testing when the testing is required by DDSN and arranged by DDSN

I understand that being determined eligible for services through DDSN does not guarantee that the applicant will receive any specific services.

_____ _____
Printed Name of Signatory Relationship to Service Recipient

_____ Date:_____
Signature

_____ Date:_____
Witness

SAMPLE