

**South Carolina Department of Disabilities and Special Needs (DDSN)
State Funded Community Supports**

Authorization for Other Services (DDSN Billed)

To (*Service Provider*): _____

From (*Case Manager*): _____

Participant's Name: _____

Address (*include zip code*): _____

Date of Birth: _____ Effective Date: _____

Participant's Legal Guardian/Representative: _____

Legal Guardian/Representative's Phone Number (*include area code*): _____

Legal Guardian/Representative's Email Address: _____

Beginning on the effective date noted above, you are hereby authorized to provide the service indicated below. Only the number of units authorized and rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s). Complete one authorization per service.

Personal Care Services - Number of Units per Week: _____ [one unit = 15 minutes]

PERS Installation - Number of Units: _____ [one unit = installation at the address above]

PERS Monitoring – Number of Units: _____ [one unit = one month of service]

Adult Day Health Care Services - Number of Units per Week: _____ [one unit = 1 (4 hour) day]

Adult Day Health Care Nursing - Number of Units per Week: _____ [one unit = 1 day of ADHC]

Behavior Support Services

Number of Units for Assessment and Plan Development (one-time): _____ [one unit = 30 minutes]

Number of Units for Training, Monitoring, Revisions per month: _____ [one unit = 30 minutes]

The person noted above participates in DDSN's State Funded Community Supports program. Through this program, when authorized services are provided, payment for services, up to the amount authorized above will be made by DDSN. See attached billing procedures.

Case Management Board/Provider: _____

Case Manager's Name: _____

Phone Number (*include area code*): _____ Email Address: _____

Signature of Case Manager Authorizing Services

Date: _____

**South Carolina Department of Disabilities and Special Needs
State Funded Community Supports Billing Procedures**

The following services are available to State Funded Community Supports participants and must be billed to DDSN:

Adult Day Health	Adult Day Health – Nursing	
Behavior Support Services	Personal Care Services	Personal Emergency Response System
Private Vehicle Modifications	Environmental Modifications	Emod/PVM Consultation

- 1) Providers must receive a paper authorization from the Case Manager before services begin. The effective date of the service authorization must be on or prior to the begin date of service. Services provided outside of the authorization date range will not be paid.
- 2) To receive reimbursement, the provider must submit an invoice to DDSN for services provided during that month. Invoices must include the following information:
 - a) Provider name and address
 - b) Individual’s name
 - c) Type of billable service
 - d) Number of billable units if applicable
 - e) Service billable rate
 - f) Total for each individual and grand total of invoice.
- 3) Invoices must have copies of all applicable authorizations attached and may be submitted:
 - a) By upload through the Reporting and Billing Center (RBC) in the DDSN Application Portal. RBC is a secure system on DDSN’s application portal for uploading confidential billing documents that goes to the SURB area. Contact SURB to obtain access to the RBC. Please note: Uploaded documents should not also be mailed. **This option is only available to DDSN contracted providers listed in Service Provider Management on the DDSN Application Portal.**

OR

 - b) By mail no later than the subsequent month of service delivery to:
DDSN Finance Division, Attn: SURB, 3440 Harden Street Ext., Columbia, SC 29203.