South Carolina Department of Disabilities and Special Needs

REQUEST FOR DETERMINATION

IDENTIFYING INFORMATION:

Name: _____ Date of Birth: _____

Sex: ☐Male ☐Female County of Residence: _____

Date of Home Visit: _____

DDSN Eligibility Category: ☐ID ☐RD ☐AUTISM ☐TBI ☐SCI ☐SD

This request is for a determination of need for:

☐Critical ☐Priority I ☐Residential Habilitation

RESIDENTIAL SERVICES:

Recommended setting for Residential Services:

☐SLP-I ☐SLP-II ☐CTH-I ☐CTH-II ☐ICF/IID ☐CRCF ☐ECTH-1 ☐Alternative Placement

County(ies) preferred:

_____

If preferred county is not available, will interim placement in another county be accepted if offered?

☐Yes ☐No

CASE MANAGEMENT/EARLY INTERVENTION:

CM/EI Name: _____

CM/EI Agency: _____

CM/EI Phone Number/Ext.: _____

CM/EI e-mail address: _____

I hereby certify that the information submitted reflects an accurate and complete summary of the situation. **I also certify that all efforts at the local level to resolve the situation without resorting to out of home placement have been explored and implemented.**

Case Manager: _____ Date: _____
Signature

Case Manager Supervisor: _____ Date: _____
Signature

Executive Director: _____ Date: _____
Signature