

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

Provider Requesting Exception: _____		Date: _____	
Facility Type: _____	Signature of Provider Executive Director: _____		
Name of Facility: _____	Signature of Governing Board Chairperson: _____		
Policy or Standard from which Exception is requested (e.g., 000-00-DD, DDSN Respite Standards, etc.)	Nature and reason for Exception Request (specify if for one individual (give name), one Facility (give name), for all residential programs, day, etc., or for the entire Organization along with the reason)	Explain how the safety of program participant(s), the staff or the public will not be endangered, if this Exception is Granted	
_____	_____	_____	
Explain how this Exception, if granted, the Quality and Quantity of Services will be maintained	_____		
Comments: _____	_____		
Signature: _____ _____ Director Quality Management	Recommendation: <input type="checkbox"/> Approved _____ <input type="checkbox"/> Deny _____ Date: _____		
Signature: _____ _____ State Director/Designee	Recommendation: <input type="checkbox"/> Approved _____ <input type="checkbox"/> Deny _____ Date: _____		

Provider Requesting Exception:

Date:

Facility/Program:

Signature of Provider Executive

Participant or Staff for whom Exception is Requested:

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

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