South Carolina
Department of Disabilities
and Special Needs

3440 Harden Street Extension
Columbia, South Carolina 29203
(803) 898-9600
Toll Free: 888/DSN-INFO
Home Page: ddsn.sc.gov

Hello,

We want to make sure you understand what is happening with the SC Department of Disabilities and Special Needs (DDSN). We are starting the process to see if you're eligible for help because of Autism Spectrum Disorder. Here's what you need to do:

1. Fill out the four forms we sent you (Autism Intake Questionnaire, Service Agreement, Permission to Evaluate, and Authorization to Release or Obtain Records). Make sure you sign and date each one. Send them back as soon as you can.

2. If you have any records that show you have Autism Spectrum Disorder, send them too. These could be things like school papers (evaluations or assessments), reports from doctors, or mental health records.

3. If you're younger than 21 years old, you need to send school records too.

Put everything in the envelope we gave you and send it back. You can mail it to DDSN Eligibility Division at 8301 Farrow Road, Columbia, SC 29203. Or you can email it to autismeligibility@ddsn.sc.gov. If you prefer, you can fax it to 803-545-4476.

You can find more information in English and Spanish on the DDSN website: https://ddsn.sc.gov/services/applying-services.

Para aprender mas sobre DDSN en espanol, ve a nuestra pagina web. Si necesitas ayuda para entender esta carta o el proceso de Admisi6n y Elegibilidad de DDSN, nuestro equipo que habla espanol esta listo para ayudarte. Por favor, comunicate con lxis Vazquez al 803-898-9811 o IVazquez@ddsn.sc.gov.

Remember, some DDSN services are only for people with waivers. If you get approved for DDSN services, two waivers can help you. But there's a waitlist for both of them right now. They are called the Intellectual Disability/Related Disabilities (ID/RD) Waiver and the Community Supports (CS) Waiver.

If you have questions, you can call DDSN Eligibility Division toll-free at 1-800-289-7012. They're open from 8:30 AM to 5:00 PM, Monday to Friday, except holidays.

Thank you for your interest in DDSN.

Sincerely,
Brian K. Hawkins, MA

Director, Eligibility Division

South Carolina Department of Disabilities and Special Needs

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

South Carolina Department of Disabilities and Special Needs has become a member of the South Carolina Health Information Exchange ("SCHIEx"). Your privacy and your personal health information are protected by federal and state law. Those federal and state laws also govern the way your personal and electronic health information is used or shared through SCHIEx. Your doctors and other health care providers will use and share your electronic health information with other doctors and health care providers, involved in your care, through SCHIEx EXCHANGE to provide, coordinate, or manage your health care and any related services.

SCHIEx EXCHANGE members may include health care providers licensed in the State of South Carolina, including medical doctors, dentists, chiropractors, optometrists, podiatrists, pharmacists, physician assistants, and nurse practitioners. Members also may include organizations such as hospitals, ambulatory surgical facilities, home health agencies, pharmacies, case management providers, tele-monitoring providers, health information exchanges and organizations within which eligible individuals practice. We may also share your personal health information through SCHIEx EXCHANGE with agencies that audit, investigate, and inspect health programs for the health and safety of the public. We may submit information as required by law, including but not limited to: immunization data, quality reporting data, and communicable disease data to a state or federal agency.

You may 'Opt Out' of SCHIEx EXCHANGE. By opting out, your personal health information will not be shared through SCHIEx EXCHANGE.

If you wish to opt out of SCHIEx EXCHANGE, you must ask for, complete, and sign an Opt Out form that tells us in writing that you do not want your personal health information included in or shared through SCHIEx EXCHANGE

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

South Carolina Department of Disabilities and Special Needs
3440 Harden Street Ext., Columbia, SC 29203
http://www.ddsn.sc.gov/
DDSN Privacy Officer, dalston@ddsn.sc.gov, 803-898-9706

South Carolina Department of Disabilities and Special Needs

SERVICE AGREEMENT

Service Recipient:_____ Date of Birth:_____

The person mentioned in this document is either being checked to see if they qualify for help from the South Carolina Department of Disabilities and Special Needs (DDSN), or they have already been found eligible for DDSN services. We will call this person the "service recipient" in this document.

If you are the service recipient or caregiver of the service recipient mentioned above, you need to know that any DDSN services given before determining eligibility will stop if the person is found not eligible for DDSN services.

Even if the person is found eligible for DDSN services, it doesn't guarantee they will receive specific services. Whether they get services depends on the professionals recognized by DDSN assessing their needs and DDSN accepting those results. Availability of a service or program is also important, and if there's no opening, the person may have to wait.

If the person is eligible for DDSN services and their needs match, they will receive services according to their requirements and based on DDSN, Medicaid, or other rules.

If the best way to meet the person's needs is by placing them in a residential setting sponsored by DDSN, it will depend on whether there's an opening in the most suitable and least restrictive setting for them.

DDSN may bill the person's private insurance, Medicare, Medicaid, or any other third-party payer for covered services provided. The person or their caregiver won't be responsible for costs not covered by Medicare, Medicaid, or any third-party payer.

_____ Date:_____
Signature of Person/Caregiver/Legal Representative

_____ Date:_____
Witness Signature

Send records to:

Mailing Address
DDSN Eligibility Division
ATTN: Autism
8301 Farrow Road
Columbia, SC 29203

or

Email
autismeligibility@ddsn.sc.gov

or

Fax
(803) 545-4476

South Carolina Department of Disabilities and Special Needs

PERMISSION TO EVALUATE

Name of Person Applying:_____ Date of Birth:_____

As the person applying or the parent/legal guardian of the person applying, I am asking for an evaluation to see if they are eligible for services through the South Carolina Department of Disabilities and Special Needs (DDSN).

I understand that to figure out if the person can get DDSN services, DDSN might need to look at medical, psychological, school, or other records. If help is needed to get these records, they will assist. They might also need to do psychological testing or other evaluations. If more evaluations are needed, DDSN will set them up. The applicant or their caregiver will not have to pay for the psychological testing when DDSN arranges it.

I understand that even if the person is found eligible for DDSN services, it does not mean they will get any specific help.

_____ Date:_____
Signature of Person/Caregiver/Legal Representative

_____ Date:_____
Witness Signature

Send records to:

Mailing Address
DDSN Eligibility Division
ATTN: Autism
8301 Farrow Road
Columbia, SC 29203

or

Email
autismeligibility@ddsn.sc.gov

or

Fax
(803) 545-4476

South Carolina Department of Disabilities and Special Needs

AUTHORIZATION TO RELEASE OR OBTAIN RECORDS

This paper gives permission to the South Carolina Department of Disabilities and Special Needs (DDSN) Eligibility Division to GET or SHARE the following records:

Name:_____ SS#:_____

Date of Birth:_____ Date of Service(s):_____

To/From:_____

DDSN will use this information to help with evaluation, creating a service plan, treatment, or other services. DDSN will get the most recent records **if they are available at no cost**. These records may include:

- ☐ Admission/Discharge Summaries
- ☐ Emergency Department Records
- ☐ Medical History and Physical
- ☐ PT/OT/ST/Initial Evaluations
- ☐ Records Relating to Functional Capacity
- ☐ CT/MRI Reports of the Head/Brain/Spine
- ☐ IEP
- ☐ Neurology Consults
- ☐ Psychological Evaluation
- ☐ Other (*specify*):_____

By signing this form, I agree to release information that will help determine if I am eligible for services from DDSN.

I understand that the records being released may have details about psychiatric care, sexual assault, drug or alcohol issues, and infectious diseases, including HIV and AIDS.

I know that I can take back this permission in writing at any time before the information is released. If I don't withdraw it, this permission will be valid for one year from the date I signed it.

I understand that not signing this form won't stop me from getting services. But if I do not provide the necessary information, it might affect my eligibility for services.

I know that the information shared through this authorization might be shared again by the recipient, and it may not be protected by the law anymore.

I understand that the information could be released in different ways, like fax, email, direct mail, wireless communication, or over the phone.

_____ Date:_____
Signature of Person/Caregiver/Legal Representative

_____ Date:_____
Witness Signature

Send records to:

Mailing Address
DDSN Eligibility Division
ATTN: Autism
8301 Farrow Road
Columbia SC 29203

or

Email
autismeligibility@ddsn.sc.gov

or

Fax
(803) 545-4476

South Carolina Department of Disabilities and Special Needs

Autism Eligibility Intake Questionnaire

At the South Carolina Department of Disabilities and Special Needs (DDSN), we aim to offer the best services to help people with disabilities and their families in our state. To make sure we can assist you effectively, please fill out this questionnaire completely and include any extra papers we've asked for. You can send back the questionnaire and documents to DDSN through email or postal mail. If you do not complete the whole questionnaire, it will delay getting the referral information processed and reviewed in a timely manner. If you have any questions, you can reach the Autism Eligibility department at (803) 898-3201 or email them at autismeligibility@ddsn.sc.gov.

Section I

Applicant's Full Name:				
Date of Birth:	Age:	Sex:	Race:	
Medicaid Number:		Social Security Number:		
Street Address:		City:	State:	Zip Code:
Phone Number:		Email Address:		
How would you like us to get in touch with you? ☐ Phone Call ☐ Email				
Does the person applying live on their own or with their parent(s) or guardian(s)? ☐ Independently ☐ With Parent(s) ☐ With Guardian(s)				
What language does the person applying speak the best or most often?		Does the person applying need someone to help translate or interpret languages for them? ☐Yes ☐No		

Section II

If the person applying is 18 years old or older, are they considered legally responsible for themselves?
☐ Yes ☐ No ☐ Unknown

**If "Yes," please proceed to the next question.*
**If "No," please attach the Power of Attorney or Guardianship documentation and list the requested information below.*

Name of the Applicant's Guardian:		Relationship to the Applicant:		
Street Address:		City:	State:	Zip Code:
Phone Number:		Email Address:		
Date of Birth:	Marital Status:	Highest Level of Education Completed:		
Name of Employer:				
Employer Phone Number:		Occupation:		
Employer Street Address:		City:	State:	Zip Code:

Section III

Has the person applying chosen someone to receive and/or talk about information on their behalf and go to possible appointments? ☐ Yes ☐ No ☐ Unknown

**If "Yes," please list the name, phone number, email address, and the relationship of that person, in the space below.*

Name:	Relationship to the Applicant:
Phone Number:	Email Address:

Section IV

Is the applicant adopted or currently in foster care? ☐ Yes ☐ No ☐ Unknown **If "Yes," please specify the applicable status.* ☐ Adopted ☐ Currently in foster care	
Is the applicant aware of their adoption or foster care status? ☐ Yes ☐ No ☐ Unknown	
How many foster homes or temporary places has the person applying lived in throughout their life?	
Applicant's Place of Birth *(city & state)*:	Applicant's age when adopted or placed in foster care?

Section V

Are there any other people living in the applicant's home? ☐ Yes ☐ No ☐ Unknown

**If "Yes," in the chart below, please list the name(s), age, and the relationship of that individual to the applicant.*

Name	Age	Relationship to the Applicant

Section VI

Does the person applying have any family members with a similar disability or disorder?
☐ Yes ☐ No ☐ Unknown

**If "Yes," in the chart below, please specify by including the relationship of the family member on the appropriate line.*

Disability/Disorder	Relationship to the Applicant *(father, mother, brother, sister, grandfather, grandmother, uncle, aunt)*
Autism Spectrum Disorder	
Intellectual Disability/Intellectual Related Disability	
Attention Deficit Hyperactivity Disorder (ADHD)/ attention deficit disorder (ADD)	
Language/Communication Disorder	
Anxiety/Depression	
Oppositional Defiant Disorder (ODD)/Conduct Disorder	
Schizophrenia/Psychosis	
Bipolar Disorder	
Other *(please specify)*:	

Section VII

Does the person applying have a Case Manager or an Early Interventionist or Intervention Specialist?
☐Yes ☐ No ☐Unknown

**If "Yes," in the space below, please specify and provide their name, contact information and their employing agency.*

Name:	
Title/Position: ☐ Case Manager ☐ Early Interventionist/Intervention Specialist	
Agency:	
Phone Number:	Email Address:

Section VIII

Does the person applying receive help or support from any other programs or agencies in the state?
☐ Yes ☐ No ☐ Unknown
**If "Yes," in the spaces below, please provide the service providers contact information.*

Provider Name (#1):	Phone Number:
Provider Contact/Representative Name:	
Provider Name (#2):	Phone Number:
Provider Contact/Representative Name:	
Provider Name (#3):	Phone Number:
Provider Contact/Representative Name:	

Section IX

Has the person applying currently or in the past received any kinds of therapy? ☐ Yes ☐ No ☐ Unknown
** If "Yes," please complete the chart below*
*** Therapy includes things like Early Intervention, Applied Behavioral Analysis, Speech-Language, Occupational, Physical, Cognitive Behavioral, Psychotherapy, and more.*

Therapy Type	Provider/Agency	Most Recent Date of Service

Section X

Has the person applying ever been diagnosed with autism spectrum disorder (ASD)? ☐ Yes ☐ No ☐ Unknown
** If "Yes," please write the name and contact information of the doctor, evaluator, or clinic and the diagnosis in the space provided below.*
*** Remember to attach a copy of the diagnosis report and any other important documents with this questionnaire.*

Name of the Doctor/Evaluator/Clinic:			
Date of the Assessment/Diagnosis:	Phone Number:		
Street Address:	City:	State:	Zip Code:

Section XI

Has the person applying ever had a developmental, psychological, neuropsychological, educational, or psychiatric evaluation? ☐ Yes ☐ No ☐ Unknown ** If "Yes," please complete the chart below.*
*** Remember to attach a copy of the diagnosis report and any other important documents with this questionnaire.*

Doctor/Evaluator/Clinic Name	Phone Number	Diagnosis	Were you satisfied with the outcome?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Section XII

Is the person applying **currently** seeing a developmental pediatrician, mental health provider, psychologist, psychiatrist, or counselor? ☐ Yes ☐ No ☐ Unknown ** If "Yes," please complete the chart below*

Doctor/Evaluator/Clinic Name	Phone Number	Most Recent Date of Service

Section XIII

Does the person applying go to a daycare? ☐ Yes ☐ No ☐ Unknown
** If "Yes," please write the name, address, and phone number of the daycare in the space provided below.*

Name of Daycare:	Phone Number:		
Street Address:	City:	State:	Zip Code:

Section XIV

Does the person applying go to school? ☐ Yes ☐ No ☐ Unknown
**If "Yes," in the space below, please specify the school type, school's name, address, phone number, name of their teacher(s), and the classroom type.*

Name of School:			
School Type: ☐ Public ☐ Private ☐ Homeschool			
Classroom Type: ☐ General Education ☐ Special Education ☐ Combination			
Street Address:	City:	State:	Zip Code:
Phone Number:	Grade Level:	Teacher Name(s):	

Section XV

Has the person applying finished high school? ☐ Yes ☐ No ☐ Unknown
**If "Yes," please check the appropriate box to indicate which diploma or certificate they received.*

☐ High School Diploma ☐ High School Equivalency Diploma *(certificate)*
☐ General Education Diploma (GED) ☐ Test Assessing Secondary Completion Diploma (TASC)

Section XVI

Does the person applying have an Individualized Education Program (IEP) or a 504 Plan?
☐ Yes ☐ No ☐ Unknown
**If "Yes," please submit a copy of the IEP, 504 Plan and/or any evaluations along with this questionnaire.*
*** Important: If the person is under 21 years of age, make sure to submit all school records.*

*If the applicant is over 18 years of age and legally responsible for themselves, their signature is required on all forms.

Name of the person completing this form *(print)*: _____

Relationship to Applicant: _____

Signature of Parent/Guardian: _____ **Date:** _____

Signature of Applicant: _____ **Date:** _____

After you have completed the questionnaire, you can send it back in two ways: via email or postal mail.

<u>If you want to use email, send the filled form and any reports or documents to this email address:</u>

autismeligibility@ddsn.sc.gov

<u>If you prefer to use postal mail, address the envelope like this:</u>

DDSN Eligibility Division
ATTN: Autism
8301 Farrow Road
Columbia, SC 29203