



STATE FUNDED COMMUNITY SUPPORTS

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Program Description:

The South Carolina Department of Disabilities and Special Needs (DDSN) is the agency established by state law that plans, develops, coordinates and funds services for South Carolinians with severe lifelong disabilities of:

- Intellectual disabilities/related disabilities
- Autism
- Traumatic brain injury
- Spinal cord injury/similar disabilities.

When possible, those who are eligible for DDSN services are assisted to maximize the programs, resources, and benefits available to them in order to secure needed services. However, when other programs, resources or benefits are not available to provide needed services, DDSN offers some services and programs exclusively.

State Funded Community Supports is an array of services offered by DDSN to those who are eligible for DDSN services, but are not eligible for a DDSN-operated Home and Community Based Waiver.

To be eligible for a DDSN-operated Home and Community Based Waiver, one must qualify for Medicaid and meet the Level of Care specified by the waiver. When someone who is eligible for DDSN services has been offered the opportunity to enroll in a DDSN-operated Home and Community Based Waiver, but was unable to do so perhaps because they were determined to not qualify for Medicaid or determined to not meet Level of Care for the waiver in which they are trying to enroll, State Funded Community Supports may be offered.

When assessed by a DDSN contracted Case Manager to be needed, the following State Funded Community Supports services are available:

- Adult Day Health
- Adult Day Health - Transportation
- Adult Day Health- Nursing
- Personal Care Services (PC-I and PC-II)
- Respite and Home Support
- Incontinence Supplies
- Assistive Technology and Appliances
- Behavior Supports Services
- Career Preparation Services
- Community Services
- Day Activity
- Employment Services
- Environmental Modifications
- Personal Emergency Response System
- Private Vehicle Modifications
- Support Center Services

Participants may receive service(s) that cost no more than the annual cost limit per state fiscal year (July 1- June 30). The annual cost cap will be prorated for those who begin participating

during any month other than July. Funding not used during the state fiscal year cannot be carried forward to the next year. The annual cost limit for State Fiscal Year 2016 is \$13,047. The annual cost limit is subject to change each State Fiscal Year.

Those participating in this program may also receive Individual and Family Support as described in DDSN Directive 734-01-DD: Individual and Family Support and Respite - State Funding, if the needed service or product is not available through State Funded Community Supports. Because Respite is available through State Funded Community Supports, participants cannot also receive state funded (family arranged) Respite as described in DDSN Directive 734-01-DD: Individual and Family Support and Respite - State Funding.

Program Eligibility/Entrance:

DDSN may offer State Funded Community Supports to:

- Those who were awarded an ID/RD or Community Supports waiver slot on or after July 1, 2014 or HASCI waiver slot on or after October 1, 2013, but were not enrolled or those who are dis-enrolled from the ID/RD or Community Supports waiver after July 1, 2014 or HASCI waiver after October 1, 2013.

Inability to enroll is limited to those who are determined to not meet Level of Care criteria or those determined not eligible for Medicaid. Failure to apply for or complete the application/application process for Medicaid does not meet this criterion.

Dis-enrollment from the waiver is limited to those who fail to continue to meet Level of Care criteria.

- Those who are not currently receiving any in-home supports (e.g., Community Choices Waiver, Rehabilitative Behavioral Health Services, etc.) and for whom one or more of the following conditions apply:
 - ✓ The individual lives with a primary caregiver who is 80 years of age or older; or
 - ✓ The individual’s situation has been determined to meet criteria for “Critical Needs” as defined in DDSN Directive 502-05-DD: DDSN Waiting Lists, but residential services are not anticipated to be provided for at least 30 days; or
 - ✓ The provision of services offered through the State Funded Community Supports program will address needs which, if not provided, will likely result in the individual’s situation being deemed a “Critical Need” in accordance with DDSN policy.
 - In the event that a State Funded Community Supports are needed to divert a possible Critical Circumstance situation, the procedure outlined in DDSN Directive 502-05-DD: DDSN Waiting Lists for “Determination of Critical Needs” must be followed. Upon submission and review, each District Office will vet the situation and route the request for State Funded Community Supports to DDSN Central Office for possible assignment of a State Funded Community Supports slot.

Waiting List Procedures:

When someone meets criteria for participation in State Funded Community Supports, but no slots are available, the individual's name will be placed on the State Funded Community Supports Waiting List based on their qualifying category. When a slot becomes available, those waiting will be offered State Funded Community Supports based on the following prioritization:

- First Priority:** Inability to enroll or dis-enrollment from ID/RD, CS or HASCI due to failure to continue to meet level of care criteria.
- Second Priority:** Not receiving in-home services; on Critical Needs list and not anticipated to receive residential services for at least 30 days.
- Third Priority:** Not receiving in-home services; will be placed on Critical Needs list if State Funded Community Supports are not provided.
- Fourth Priority:** Not receiving in-home services; living with primary caregiver who is 80 years or older.

Anyone in the higher priority categories will be offered State Funded Supports prior to anyone from a lower priority category, regardless of the date the name was added to the list. Within each priority category, individuals will be served in the order in which their names were added to the waiting list.

DDSN reserves the right to restrict enrollment, adjust or impose additional limits to this program or its services as DDSN determines necessary.

Those receiving State Funded Community Supports will also be eligible for and will receive Case Management. If the individual is being served by a DDSN-contracted Case Management provider, the current Case Management provider will be notified of the individual's eligibility for the program. If the individual is Medicaid eligible, he/she may be eligible for and/or may be receiving Medicaid Targeted Case Management (MTCM); if so, State Funded Case Management would not also be provided unless the Medicaid Targeted Case Management provider is not a DDSN-contracted provider of Case Management.

Enrollment Process:

The Case Manager will be expected to discuss the program with the individual, his/her representative or legal guardian, including a discussion of the:

- ✓ Services potentially available through the program;
- ✓ Requirement that services only be provided when the need for the service is established by assessment; and
- ✓ Annual cost limit.

If enrollment is desired, the Case Manager will be expected to provide the individual, his/her representative or legal guardian with the document entitled "**Statement of Understandings, Rights, and Responsibilities**" complete with legible Case Management Provider contact information. The signature of the individual, his/her representative or legal guardian acknowledging receipt the "Statement of Understandings, Rights, and Responsibilities" must be secured on the form entitled "**Acknowledgement of Understandings, Rights, and**

Responsibilities” (SFCS Form 1).

The individual will be considered “ENROLLED” in the State Funded Community Supports program when the “Acknowledgement of Understandings, Rights, and Responsibilities” (SFCS Form 1) is signed. This form must be submitted to DDSN and can be submitted to DDSN by:

Scanning the signed SFCS Form 1, attaching to an email message with “SFCS Enrollment” noted in the subject line, sending the email message to ygoodwin@ddsn.sc.gov. An email acknowledging receipt will be sent.

Or

Faxing the completed SFCS Form 1 to the attention of Yolanda Goodwin at (803) 898-9653. The fax cover sheet should indicate the means by which an acknowledgement of receipt should be sent (e.g., “please confirm receipt via email to c.manager@CMP.org”; “please confirm receipt via fax to (803) 555-1212,” etc.).

If enrollment is **not** desired, the “**Statement of Individual Declining Services**” form may be used. When possible, the signature of the individual or his/her representative should be obtained. If the signature of the individual or his/her representative cannot be obtained after multiple attempts, that should be noted on the form. All attempts to contact the person should be noted in service notes. Upon completion, the form must be submitted to DDSN and can be submitted to DDSN by:

Scanning the “**Statement of Individual Declining Services**” form, attaching to an email message with “SFCS Declination” noted in the subject line, sending the email message to ygoodwin@ddsn.sc.gov. An email acknowledging receipt will be sent.

Or

Faxing the “**Statement of Individual Declining Services**” form to the attention of Yolanda Goodwin at (803) 898-9653. The fax cover sheet should indicate the means by which an acknowledgement of receipt should be sent (e.g., “please confirm receipt via email to c.manager@CMP.org”; “please confirm receipt via fax to (803) 555-1212,” etc.).

Program Exit/Disenrollment:

Participation in this program will end if/when the participant:

- ✓ Enrolls in a Medicaid Home and Community Based Waiver;
- ✓ Is admitted to an ICF/IID or Nursing Facility, Assisted Living Facility or Community Residential Care Facility/Boarding Home;
- ✓ Begins receiving Rehabilitative Behavior Health Services or Autism Spectrum Disorder

Services;

- ✓ Voluntarily withdraws or no longer wishes to receive State Funded Community Supports;
- ✓ Moves out of state, into a PRTF or a Correctional Facility;
- ✓ Is admitted to a DDSN-sponsored Residential setting (e.g., CTH, CRCF, SLP);
- ✓ Refuses to cooperate with the terms listed in the Statement of Understandings, Rights, and Responsibilities.

When the individual's participation in the program cannot continue, the **State Funded Community Supports – Notice of Disenrollment** form must be completed and the effective date of the disenrollment noted. The completed form must be sent to the participant/representative, the Financial Management Provider and to DDSN. Completed forms sent to DDSN may be sent by:

Scanning the completed **Notice of Disenrollment** form, attaching to an email message with "SFCS Disenrollment" noted in the subject line, sending the email message to ygoodwin@ddsn.sc.gov. An email acknowledging receipt will be sent.

Or

Faxing completed **Notice of Disenrollment** form to the attention of Yolanda Goodwin at (803) 898-9653. The fax cover sheet, should indicate the means by which an acknowledgement of receipt should be sent (e.g., "please confirm receipt via email to c.manager@CMP.org"; "please confirm receipt via fax to (803) 555-1212." etc.).

Additional Case Management Responsibilities:

Once enrolled, the Case Manager will be expected to complete a new or update an existing **Case Management Assessment and Plan (CMAP)**. The completed or updated assessment portion of the CMAP must reflect all of the participant's need(s), including those need(s) that can be met through the provision of State Funded Community Support services. The plan portion of the CMAP must include the actions to be taken (e.g., services to which the individual will be referred, products to be received, etc.) to address the need(s). The plan must include the name of each State Funded Community Support service to be provided and the amount and frequency of the service to be delivered.

Once the CMAP is completed, the State Funded Community Support Budget must be calculated. Using the **State Funded Community Supports Budget Calculator** (Calculator), which can be found on DDSN's Application Portal under *Business Tools>State Funded Community Supports*, enter participant's name, and the State Funded Community Support Enrollment Date (*which is date the SFCS Form 1 was signed*). By entering the Enrollment Date, the calculator will adjust/prorate the total amount available for the State Fiscal Year to reflect the amount remaining in the fiscal year. This amount will be shown on the Calculator as "Available Funding."

Enter the number of units or price/cost of each service to be provided for the remainder of the

state fiscal year in the “Budgeted Units” column. If explanatory notes are needed, enter notes in the “Note” column. The Calculator will calculate the cost of each service based on the units/price entered. The Calculator will add together the “total cost” of each service to determine the “*Total Budgeted Cost*” for all services entered and “*Total Budgeted Cost*” will appear on the line titled “*Amount Budgeted Below.*” The calculator will subtract “*Total Budgeted Cost*” from the “*Available Funding*” leaving any “*Balance Remaining.*” Any “*Balance Remaining*” can be used for additional services to address assessed needs. The “*Total Budgeted Cost*” cannot exceed the “*Available Funding.*”

Once State Funded Community Support services are assessed, planned and budgeted, then services must be arranged and authorized. When a *service* (e.g., Personal Care, Adult day Health, etc.) is to be delivered, the Case Manager will be responsible for offering the participant or his/her representative a choice among available providers of the service. The list of qualified providers from DDSN’s web site:

<http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx> can be used. This choice should be documented in the service notes.

When a *product* (e.g., Incontinence Supplies, Assistive Technology & Appliances, etc.) is to be delivered, the participant or his/her representative will choose the method through which the products will be secured (i.e., Reimbursement or Financial Management Agency Purchase).

The Reimbursement method can be used if the participant/representative is willing and able to purchase the needed item and follow the specific instructions from the Financial Management Provider in order to be reimbursed, a needed item can be secured using this “reimbursement” method.

Financial Management Provider Purchase method can be used if the participant/representative is not willing or able to be reimbursed for a purchased item, the needed item can be purchased by the Financial Management Provider and delivered to the participant.

The Reimbursement method should be offered first. If Reimbursement is not the preferred option for the participant, then the Financial Management Provider Purchase method should be used.

If the “Financial Management Provider Purchase” method will be used, the specifications of the product (e.g., *brand and size of diapers; dimensions of microwave oven, etc.*) must be determined and shared with the Financial Management Provider.

When a *service* is to be delivered and a provider is chosen, the Case Manager will refer the individual to the chosen provider. This referral may be by phone or in writing, but must be sufficient for the provider to decide if they will serve the participant, and if so, when the service will begin.

All State Funded Community Support services (*services and products*) will be secured by the Case Manager. All delivered services and products will be paid for by the participant’s Financial Management Provider. This may be a new or unique situation for some service providers and may require additional explanation by the Case Manager. For that reason, the Financial Management Provider must make available the name of staff who will answer the provider’s questions about billing, payment, etc., of State Funded Community Supports services.

NOTE: Copies of all authorization/request forms must be provided to the Financial Management Provider at the time of issuance.

In order for a DDSN Employment or Day Service (i.e., Adult Activity, Career Preparation, Community Supports, and Support Center) to be received, the Service Tracking System (STS) “Services Menu” must be updated to reflect the participant is receiving the employment or day service. As appropriate, other State Funded Community Support services should also be reflected on STS/CDSS.

The participant or his/her representative has the right to be notified of any decision/action that may adversely affect him/her. If adversely affected, the participant/representative may choose to appeal the decision/action. Therefore, when a service is reduced or ended (terminated), the participant/representative has the right to be notified prior to the action being taken.

Ten (10) calendar days waiting period (from the date the participant or responsible party is notified) should be given before proceeding with the adverse action unless the action is one noted below. For these actions, no waiting period is required:

- Participant requested reduction
- Voluntary withdrawal
- Death
- Participant moves out of state or into a Nursing Facility, ICF/IID, PRTF or Correctional Facility
- Participant enrolls in a HCB Waiver
- Cost limit has been reached

A **Notice of Reduction or Termination** form should be used to notify the participant/representative and/or the service provider and the Financial Management Provider of the action.

A reduction means that fewer units of the same service will be authorized to the provider who currently provides the services. When services are to be reduced, the **Notice of Reduction or Termination** is issued to the participant/representative and the Financial Management Provider and a new Authorization/Referral with the reduced number of units or price is issued.

A termination means that the service will no longer be provided. Either the provider can no longer be paid for rendering the service or the noted price will no longer be paid for the service. When a service is to be terminated, the **Notice of Reduction or Termination (Form 1, 2 or 3)** is issued to the participant/representative and/or the provider and the Financial Management Agency.

State Funded Community Support services should be monitored in accordance with DDSN Case Management Standards. Additionally, there is no requirement for participants to receive a service every 30 days. It is understood that some participants/families may utilize a non-standard schedule of services and may not receive a service every 30 days. The case manager should monitor for situations in which the State Funded Community Supports program is being underutilized (i.e. exceeding 60 – 90 days with no services and no expectation that services will begin in the near future). When this occurs, contact DDSN Central Office for guidance and possible disenrollment.



**STATE FUNDED COMMUNITY SUPPORTS
STATEMENT OF UNDERSTANDINGS, RIGHTS, AND RESPONSIBILITIES**

Participant's Name: _____

DOB: _____

I acknowledge that this information is to help me understand the State Funded Community Supports program and the rights and responsibilities of program participants. I understand the participant will work with a Case Manager from the Case Management Agency. The Case Manager will determine the services needed, will assist in arranging for them, and will monitor them. He/she will be available is available to answer questions about the program.

Case Management Provider: _____

Case Manager: _____

Contact: _____
(Phone Number) (Email Address)

I. Understandings:

As a State Funded Community Supports participant or his/her representative, I understand that:

- ✓ The State Funded Community Supports program will not provide for all of the participant's service needs.
- ✓ If non-responsive to requests from DDSN, the Case Manager or the Financial Management Provider, services could be delayed, suspended, or terminated.
- ✓ Not abiding by the rights and responsibilities indicated in this document may lead to the termination of certain State Funded Community Supports funded services or from the State Funded Community Supports program.

II. Rights:

As a State Funded Community Supports participant or his/her representative, I have the right to:

- ✓ Be treated with dignity and respect by the Case Manager and the providers of State Funded Community Supports services;
- ✓ Receive a full explanation of all the forms I am asked to sign;
- ✓ Be told about all services available from DDSN;
- ✓ Participate in the development of a plan for the participant's services, have the plan explained to me and have a copy provided to me;
- ✓ Choose the provider that will deliver services directly from the available qualified providers (a list for most State Funded Community Supports services is available online at www.ddsn.sc.gov);

- ✓ Contact potential direct service providers to evaluate service quality and gather information to assist in making an informed choice;
- ✓ Change my direct service provider and can do so by notifying the Case Manager;
- ✓ Appeal to DDSN if I disagree with any decision or action concerning services or participation in the State Funded Community Supports program ([http://ddsn.sc.gov/about/directives-standards/Documents/currentdirectives/535-11-DD%20-%20Revised%20\(051712\).pdf](http://ddsn.sc.gov/about/directives-standards/Documents/currentdirectives/535-11-DD%20-%20Revised%20(051712).pdf));
- ✓ Complain about services/providers by contacting the Case Manager;
- ✓ Discontinue participation in the State Funded Community Supports program by contacting the Case Manager;
- ✓ Refuse to participate in/receive a service or the State Funded Community Supports program.

III. **Responsibilities:**

As a State Funded Community Supports participant or his/her representative, I will:

- ✓ Treat the Case Manager and service providers/caregivers in a considerate, respectful and courteous manner and will expect the same treatment in return.
- ✓ Be present at the time of the provider's scheduled visits or inform them in advance when the participant will not be available on dates of scheduled services/visits.
- ✓ Allow the Case Manager and chosen service providers to enter my home.
- ✓ Not ask the service provider to perform tasks that are against the law or that are not a part of my Plan.
- ✓ Follow the agreed upon Plan for service provision.
- ✓ Provide accurate and complete information about:
 - Family members or others who can provide supports;
 - Other services being received;
 - Changes in my condition or situation, (i.e., hospitalization, additional caregiver(s), and other events impacting my care);
 - Changes of important addresses, phone number(s); and
 - Time keeping records that I may be required to sign in regards to Personal Care, Respite or In-Home Support.

State Funded Community Supports – SFCS Form1 (12/1/14)



**STATE FUNDED COMMUNITY SUPPORTS
STATEMENT OF UNDERSTANDINGS, RIGHTS, AND RESPONSIBILITIES**

Participant's Name: _____

Date of Birth: _____

Case Management Provider: _____

The DDSN, State Funded Community Supports, "Statement of Understandings, Rights and Responsibilities" document has been provided to me as the State Funded Community Supports program participant or his/her representative. This document included legible contact information about the Case Management Provider. I have been offered the opportunity to ask questions about the understandings, rights and responsibilities included within the document and know that I may contact the Case Management Provider should I have any additional questions.

Signature of Participant or Representative

Date: _____

Printed Name of Signatory

Relationship to Participant

Signature of Witness

Date: _____

Original – Participant's file

Copy – DDSN Central Office

State Funded Community Supports – SFCS Form1 (12/1/14)



STATE FUNDED COMMUNITY SUPPORTS STATEMENT OF INDIVIDUAL DECLINING SERVICES

Participant's Name: _____

Date of Birth: _____

I, _____, as recipient/legal guardian of recipient, have decided at this time to not pursue enrollment in the State Funded Community Supports program. I understand that declining participation now does not prohibit me from reapplying for the State Funded Community Supports program in the future.

I understand that this decision may affect my eligibility for other services available through the South Carolina Department of Disabilities and Special Needs.

Reason services are being declined: _____

Individual/Legal Guardian

Date: _____

Case Manager/Early Interventionist

Date: _____

I am unable to obtain a signature from either the individual or legal guardian, therefore, the procedure for a Non-Signature Declination was followed and is documented in the individual's file.

Case Manager/Early Interventionist

Date: _____

Original: File
Copy: Individual/Legal Guardian and DDSN Central Office



STATE FUNDED COMMUNITY SUPPORTS PARTICIPANT INFORMATION

DDSN is pleased to offer to those who are eligible for DDSN services, but do not qualify for enrollment in a DDSN-operated Home and Community Based Waiver an array of services and/or products. This array of services and/or products is called State Funded Community Supports. As part of State Funded Community Supports, each participant will work with a Case Manager to determine which services/products are needed the plan for and arrange for those needed services/products to be provided/delivered.

Services and/or Products: The services/products available, when needed, are:

Adult Day Health Care (ADHC): Care furnished to someone 18 or older, four (4) or more hours per day for one or more days per week encompassing both health and social services.	Day Activity: Supports and services provided in therapeutic settings to enable participant's to achieve, maintain, improve, or decelerate the loss of personal care, social or adaptive skills.
Adult Day Health Care-Nursing Services: Nursing services in the ADHC center for ostomy care, urinary catheter care, decubitus/wound care, tracheostomy care, tube feedings and nebulizer treatment.	Career Preparation: Services aimed at preparing participants for paid and unpaid employment and careers through exposure to and experience careers and through teaching career concepts.
Adult Day Health Care-Transportation: Transportation to and/or from the ADHC service for who will be transported within 15 miles of the center.	Community Services: Services aimed at developing one's awareness of, interaction with and/or participation in their community through exposure to and experience in the community and through teaching such concepts as self-determination, self-advocacy, socialization and the accrual of social capital.
Behavior Support Services: Services to assist those who care for a participant who exhibits problem behaviors to learn why the behavior occurs, strategies to prevent and respond to behaviors, and how to teach the participant appropriate behaviors to replace the problem behaviors.	Employment Services: Intensive, on-going supports that enable participants for whom competitive employment at or above minimum wage is unlikely absent the provision of supports and who, because of their disabilities, need supports to perform in a regular work setting.
Incontinence Supplies: Diapers, under-pads, wipes, liners and disposable gloves provided to participants who are incontinent of bowel and/or bladder.	Support Center Services: Non-medical care, supervision and assistance provided in a non-institutional, group setting outside of the participant's home to individuals who because of their disability are unable to care for and supervise themselves.
Respite and Home Support: Care, supervision, teaching and/or assistance provided directly to or in support of the participant. This includes care and supervision provided on a short-term basis due to the absence or need of relief of the primary caregiver.	Environmental Modification: Physical adaptations to the participant's home which are necessary to ensure the health, welfare and safety of the participant (e.g., installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, etc.)
Private Vehicle Modification: Modifications to a privately owned vehicle used to transport the participant (e.g., installation of a lift, tie downs, raising the roof, etc.).	Personal Care Services (I and II): Assistance with personal care and activities of daily provided by a company or provider.
Assistive Technology and Appliances: A device, item, or product that is used to increase or improve functional capabilities of the participant.	Personal Emergency Response System: An electronic device which enables a participant who is alone for a portion of the day to secure help in an emergency.

Program Limitations:

Enrollment in State Funded Community Supports is limited to those who are eligible for DDSN services, but are do not qualify for enrollment in a DDSN-operated Home and Community Based Waiver perhaps because they do not meet the Level of Care required for enrollment or because they do not qualify for Medicaid.

Through State Funded Community Supports, services/products, costing up to an amount determined by DDSN can be provided each year. DDSN will determine the annual amount or cost limit per state fiscal year (July 1 – June 30). The amount available will be prorated or adjusted during the first year of participation based on the month in which participation begins. For example, if the participant begins receiving services in January, one-half of the total annual amount will be available for services/products delivered between January and June 30th. On July 1, the total annual amount will be available for services/products to be delivered between July 1st and June 30th. Amounts not used during the fiscal year will not roll over and cannot be used to increase the cost limit for the next year.

DDSN reserves the right to adjust or impose additional limits to this program or its services as needed.

Program Exit/Disenrollment:

Participation in this program will end if/when the participant:

- Enrolls in a DDSN operated Medicaid Home and Community Based Waiver;
- Is admitted to an ICF/IID or Nursing Facility;
- Voluntarily withdraws or no longer wishes to receive State Funded Community Supports;
- Moves out of state, into a PRTF or a Correctional Facility;
- Is admitted to a DDSN-sponsored Residential setting (e.g., CTH, CRCF, SLP)
- Refuses to cooperate with the terms listed in the Statement of Understandings, Rights, and Responsibilities.

Rights:

Decisions that adversely affect State Funded Community Supports participants may be appealed in accordance with DDSN Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures.



**STATE FUNDED COMMUNITY SUPPORTS
NOTICE OF DISENROLLMENT**

Participant's Name: _____

Date of Birth: _____ Effective Date of Disenrollment: _____

Effective on the date noted above, this individual's participation in DDSN's State Funded Community Supports program will end. His/her participation is ending because he/she:

- Enrolled in a DDSN operated Medicaid Home and Community Based Waiver;
- Was admitted to an ICF/IID or Nursing Facility;
- Voluntarily withdrew or no longer wishes to receive;
- Moved out of state, into a Psychiatric Residential Treatment Facility (PRTF) or a Correctional Facility;
- Was admitted to a DDSN-sponsored Residential setting (e.g., CTH, CRCF, SLP);
- Did not comply with the terms listed in the Statement of Understandings, Rights, and Responsibilities.

Because his/her participation is ending, the following service(s), which have been received through this program, will not continue: *(Check all services provided to the participant through State Funded Community Supports)*

- | | |
|---|--|
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Day Activity |
| <input type="checkbox"/> Adult Day Health Care-Nursing Services | <input type="checkbox"/> Career Preparation |
| <input type="checkbox"/> Adult Day Health Care-Transportation | <input type="checkbox"/> Community Services |
| <input type="checkbox"/> Behavior Support Services | <input type="checkbox"/> Employment Services |
| <input type="checkbox"/> Incontinence Supplies | <input type="checkbox"/> Support Center Services |
| <input type="checkbox"/> Respite and Home Support | <input type="checkbox"/> Environmental Modification |
| <input type="checkbox"/> Private Vehicle Modification | <input type="checkbox"/> Personal Care Services (I and II) |
| <input type="checkbox"/> Assistive Technology and Appliances | <input type="checkbox"/> Personal Emergency Response |

Please direct any questions regarding this notice to the Case Manager noted below.

(Case Management Provider)

(Case Manager's Name)

(Phone Number)

(Email Address)

Date: _____

Signature of Person Completing Form

In accordance with DDSN Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Adult Day Health Care:

Definition: Adult Day Health Care services are furnished four (4) or more hours per day on a regularly scheduled basis for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the participant.

Authorization of services will be based on the participant's need for the service as identified and documented in the participant's plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three (3) meals per day). Physical, occupational and speech therapies indicated in the participant's plan are not furnished as component parts of this service.

Providers: Providers of Adult Day Health Care on the Qualified Provider Listing can be found on DDSN's website at <http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx>.

Arranging For The Service: When Adult Day Health Care services are needed and documented on the plan, a list of qualified service providers should be given to person/representative from which a provider can be chosen. Choosing a provider may include the person/representative visiting several providers before choosing one. The offering of choice should be documented in service notes.

The Adult Day Health Care Center is required to secure a physical examination within 60 days prior to the enrollment of any participant. The physician's report must include recommendations regarding limitations of activities, special diet, medications (name, type, dosage and whether the individual is capable of self-administering), and other considerations to determine whether appropriate services are available. The **State Funded Community Supports (ADHC 2)** form can be used to document the physician's report, but this form is not required.

When a start date is determined, the authorization can be completed. For Adult Day Health Care, one unit equals one program day, which is a minimum of hours four (4) hours per day excluding transportation time. The **State Funded Community Supports (ADHC 1)** must be used to authorize the service. The **State Funded Community Supports (ADHC 1)** instructs the provider to bill the participant's Financial Management Provider for services rendered. The **State Funded Community Supports (ADHC 1)** will remain in effect until a new authorization is issued or a Notice of Reduction or Termination is issued.

The cost Adult Day Health Care must be added to the **State Funded Community Supports Budget Calculator**. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

Monitoring the Services: The plan, which includes ADHC services, should be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When ADHC services are being reduced or terminated the *State Funded Community Supports Notice of Reduction or Termination Form 1* must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
AUTHORIZATION/REQUEST FOR ADULT DAY HEALTH CARE**

TO: _____
(Adult Day Health Care Services Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide the following to the individual named above. Only the number of units rendered may be billed. **NOTE: This nullifies any previous authorization to this provider for this service(s).***

Adult Day Health Care Services:

Number of Units per Week: _____ [one unit = 1 (4 hour) day]

The individual 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 the Financial Management Agency serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____
(Name of Person to Contact)

(Phone Number)

(Email Address)

(Case Management Provider Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Date: _____

Copy to Financial Manager



**STATE FUNDED COMMUNITY SUPPORTS
ADULT DAY HEALTH CARE
PHYSICIAN'S RECOMMENDATION**

Patient's Name: _____

DOB: _____

Should this person's activities be limited: Yes No

If yes, explain: _____

Should this person be provided a special diet? Yes No

If yes, explain: _____

What medications does this person take (name, type and dosage)?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Is this person capable of self-administering their medications? Yes No

Other considerations? _____

Signature

Date: _____

State Funded Community Supports (ADHC 2) 12/1/2014



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization will end)

The authorization for service (s) issued to: _____
(Name of provider authorized to provide the service)

For service (s) to be provided to: _____
(Name of the individual receiving the service and his/her date of birth)

Is/are being (check one): Reduced Terminated

Payment will not be made units of service (s) rendered after the effective date of this Notice of Reduction or Termination for the following service(s):

- | | |
|---|---|
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Personal Care (I & II) |
| <input type="checkbox"/> Adult Day Health Care-Transportation | <input type="checkbox"/> Behavior Support |
| <input type="checkbox"/> Adult Day Health Care-Nursing | <input type="checkbox"/> PERS |

Direct any questions regarding this notice to: _____

(Case Manager's Name)

(Phone Number)

(Email Address)

Case Manager's Signature

Dated: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Adult Day Health Care Nursing:

Definition: Adult Day Health Care (ADHC) Nursing services are provided in and by a nurse at an Adult Day Health Care Center and are limited to the skilled procedures listed below and as ordered by a physician:

- Ostomy Care
- Urinary Catheter Care
- Decubitus/Wound Care
- Tracheostomy Care
- Tube Feedings
- Nebulizer Treatment

This service is provided to participants who are 18 or older. One (1) unit of Adult Day Health Care Nursing includes any one or combination of the listed skilled procedures provided to a State Funded Community Supports Adult Day Health Care service participant during one day's attendance at an Adult Day Health Care Center. Authorization for Adult Day Health Care Nursing will be separate from the Adult Day Health Care authorization and will not be day specific unless so ordered by a physician.

Providers: Providers of Adult Day Health on the Qualified Provider Listing can be found on DDSN's website at <http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx>. All Adult Day Health Care Nursing services must be provided in the Adult Day Health Care Center by a licensed nurse, as ordered by a physician and within the scope of the South Carolina Nurse Practice Act.

Arranging for the Service: Adult Day Health Care Nursing is available for those participants who require specific specialized nursing care, which is beyond the care typically provided in the Adult Day Health Care. In order for Adult Day Health Care Nursing services to be authorized, a Physicians Order must be obtained clearly stating the required skilled procedure (ostomy care, urinary catheter care, etc.) and the frequency the skilled procedure is to be performed at the ADHC Center. The **State Funded Community Supports (ADHC N1)** can be used for that purpose.

The **State Funded Community Supports (ADHC N)** must be used to authorize the service. The **State Funded Community Supports (ADHC N)** instructs the provider to bill the participant's Financial Management Provider for services rendered.

The cost Adult Day Health Care-Nursing must be added to the **State Funded Community Supports Budget Calculator**. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

The **State Funded Community Supports (ADHC N)** will remain in effect until a new authorization is issued or a Notice of Reduction or Termination Form 1 is issued.

Monitoring the Services: The plan, which includes Adult Day Health Care Nursing services, must be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When Adult Day Health Care services are being reduced or terminated the **Notice of Reduction or Termination (Form 1)** must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Adult Day Health Care Nursing**

TO: _____
(Adult Day Health Care Nursing Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide the following service to the individual named above. Only the number of units rendered may be billed. **Note: This nullifies any previous authorization to this provider for this service(s).***

Adult Day Health Care Nursing:

Number of Units per Week: _____ [one unit = 1 day of ADHC]

The individual 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 the Financial Management Agency serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____
(Name of Person to Contact)

(Phone Number)

(Email Address)

(Case Management Provider Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Adult Day Health Care Nursing Statement of Need**

Re: _____
(Individual's Name)

Date of Birth: _____

Provide the following skilled task at the frequency noted to the person noted above. These tasks must be performed by a Licensed Practical Nurse or a Registered Nurse and may be performed at the Adult Day Health Care Center.

Check if Required	Skilled Task	Frequency
<input type="checkbox"/>	Ostomy Care	
<input type="checkbox"/>	Urinary Catheter Care	
<input type="checkbox"/>	Decubitus/Wound Care	
<input type="checkbox"/>	Tracheostomy Care	
<input type="checkbox"/>	Tube Feedings	
<input type="checkbox"/>	Nebulizer Treatment	

Physician's Signature

Date: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization will end)

The authorization for service (s) issued to: _____
(Name of provider authorized to provide the service)

For service (s) to be provided to: _____
(Name of the individual receiving the service and his/her date of birth)

Is/are being (check one): Reduced Terminated

Payment will not be made units of service (s) rendered after the effective date of this Notice of Reduction or Termination for the following service(s):

- | | |
|---|---|
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Personal Care (I & II) |
| <input type="checkbox"/> Adult Day Health Care-Transportation | <input type="checkbox"/> Behavior Support |
| <input type="checkbox"/> Adult Day Health Care-Nursing | <input type="checkbox"/> PERS |

Direct any questions regarding this notice to: _____

(Case Manager's Name)

(Phone Number)

(Email Address)

Case Manager's Signature

Dated: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Adult Day Health Care Transportation:

Definition: This service is for those authorized to receive Adult Day Health Care (ADHC) who reside within 15 miles of the ADHC Center. Transportation will be provided using the most direct route, door to door from between the individual's residence or other location and the ADHC Center. The pick-up and drop off location should be noted on the form authorizing the service.

Providers: Providers of Adult Day Health on the Qualified Provider Listing can be found on DDSN's website at <http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx>.

Arranging for the Service: If transportation is determined to be needed and it has been determined that the participant who is authorized to receive ADHC lives within 15 miles of the ADHC Center, the service can be authorized.

The **State Funded Community Supports (ADHC T)** must be used to authorize the service. The **State Funded Community Supports (ADHC T)** instructs the provider to bill the participant's Financial Management Provider for services rendered.

The cost for ADHC Transportation must be added to the **State Funded Community Supports Budget Calculator**. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

The **State Funded Community Supports (ADHC T)** will remain in effect until a new authorization is issued or until a Notice of Reduction or Termination (Form 1) is issued.

Monitoring the Services: The plan must include ADHC Transportation. The plan must be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When ADHC services are being reduced or terminated the **Notice of Reduction or Termination (Form 1)** must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Adult Day Health Care Transportation

TO: _____
(Adult Day Health Care Transportation Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide the following service to the individual named above. Only the number of units rendered may be billed. **Note: This nullifies any previous authorization to this provider for this service(s).***

Adult Day Health Care Transportation:

Number of Units Per Week: _____ [1 unit = one way] [2 units = Round trip]

Drop off/Pick Up Location: _____

The individual 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 the Financial Management Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____
(Name of Individual to Contact)

(Phone Number)

(Email Address)

(Case Management Provider Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization will end)

The authorization for service (s) issued to: _____
(Name of provider authorized to provide the service)

For service (s) to be provided to: _____
(Name of the individual receiving the service and his/her date of birth)

Is/are being (*check one*): Reduced Terminated

Payment will not be made units of service (s) rendered after the effective date of this Notice of Reduction or Termination for the following service(s):

- | | |
|---|---|
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Personal Care (I & II) |
| <input type="checkbox"/> Adult Day Health Care-Transportation | <input type="checkbox"/> Behavior Support |
| <input type="checkbox"/> Adult Day Health Care-Nursing | <input type="checkbox"/> PERS |

Direct any questions regarding this notice to: _____

(Case Manager's Name)

(Phone Number)

(Email Address)

Case Manager's Signature

Dated: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Assistive Technology and Appliances:

Definition: Assistive Technology and/or Appliances means a device, an item, piece of equipment, or product system, that is used to increase or improve functional capacities of participants thereby resulting in a decrease or avoidance of need for other services (e.g., personal care, respite, etc.). This service may include the evaluation of the assistive technology/appliance needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; and training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant. Appliances intended for general household utility that do not result in a decrease in need for other services are not covered. This service is not intended to replace traditional household appliances for the convenience of family/household members or caregivers. Additionally, devices, items, equipment and/or product systems not proven effective, or those considered experimental or trial are not covered. Repairs not covered by warranty are covered, and replacement of parts/equipment is covered, if these repairs or parts/equipment are not related to abuse, mistreatment or carelessness.

Arranging for the Service:

The need for Assistive Technology and Appliances must be identified and the specific item, piece of equipment, device, or appliance (the item) must be documented on the Plan. Once the need is determined and the item to meet the need documented, the method to be used to secure the item must be determined.

Reimbursement Method: If the participant/representative is willing and able to purchase the needed item and follow the specific instructions from the Financial Management Provider in order to be reimbursed, a needed item can be secured using this “reimbursement” method. When this method will be used, the **Authorization/Request for Assistive Technology and Appliances [State Funded Community Supports (ATA 1)]** will be used. The participant/representative must be given the specific instructions for requesting reimbursement from the Financial Management Provider. These instructions will be provided by the Financial Management Provider. The **Authorization/Request for Assistive Technology and Appliances [State Funded Community Supports (ATA 1)]** should reflect the needed item and the maximum amount allowed for the purchase of the item including any taxes or shipping that will be charged.

The participant/representative will not be reimbursed for more than the “maximum amount” noted on the form. When the Authorization/Request is completed, copies of the form should be shared with the participant/representative and with the Financial Management Provider. The State Funded Community Supports (ATA 1) will remain in effect until a new authorization is issued or a Notice of Reduction or Termination is issued.

Financial Management Provider Purchase Method: If the participant/representative is not willing or able to be reimbursed for a purchased item, the needed item can be purchased by the Financial Management Provider and delivered to the participant.

When this option is used, the **Authorization/Request for Assistive Technology and Appliances [State Funded Community Supports (ATA 2)]** will be used. A description including any specifications for the item must be determined along with the maximum allowable

cost. The maximum allowable cost should be determined by estimating the cost of the item plus tax and any potential shipping and handling charges. Very specific information must be provided to the Financial Management Provider so that needed items can be purchased. If needed, attach additional pages (e.g., printed manufacturer's or supplier's website that includes the specifications of the product to be purchased).

The maximum amount per month for the item must be noted. The Financial Management Provider will not purchase an item that costs in excess of the maximum amount noted on the **Authorization/Request for Assistive Technology and Appliances [State Funded Community Supports (ATA 2)]**.

Whether or not the participant/representative is willing to pick up the item from the Financial Management Provider's offices or other Provider location rather than having the item shipped/delivered to the home should be noted. If the participant/representative is not willing to pick up item, the maximum monthly amount must include costs for shipping/handling/delivery.

The form must also indicate a shipping address for the item if the address is different than the participants address noted at the top of the Authorization/Request for Assistive Technology and Appliances [State Funded Community Supports (ATA 2)].

The maximum amount per month of the item must be added to the State Funded Community Supports Budget Calculator. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

When the Financial Management Provider determines the means by which items will be supplied, the Financial Management Provider will notify the Case Manager of the method and the cost of the item. The actual amount per month of the item must be added to the State Funded Community Supports Budget Calculator, to update the cost from the maximum to the actual.

The Authorization/Request for Assistive Technology and Appliances [State Funded Community Supports (ATA 2)] will remain in effect until a new authorization is issued or a Notice of Reduction or Termination is issued.

Consultations: Consultations can be used to assess and determine the specific needs related to the participant's disability for which appliances and assistive technology will assist the participant to function more independently. Consultations must occur **prior to** the issuance of the authorization for the item. A consultation may be authorized by completing the Authorization/Request for Assistive Technology and Appliances (**State Funded Community Supports (ATA 3)**). The amount for a consultation for the **initial** placement of an item should not typically exceed \$300.00.

Monitoring the Services: "Assistive Technology and/or Appliances" must be included on the Plan; the Plan must be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When ADHC services are being reduced or terminated the **Notice of Reduction or Termination (Form 2)** must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Assistive Technology and Appliances

TO: _____
(Participant/Representative)

Re: Name: _____

Address: _____

Date of Birth: _____

The individual noted above participates in DDSN's State Funded Community Supports program. The individual referenced above has been determined to need the following item(s) which is considered:

Assistive Technology and Appliances:

Name of Item: _____

Description/Specifications: _____

Maximum Allowable Cost: _____

The participant or his/her representative has agreed to purchase this item and be reimbursed for the cost of the item purchased. He/she agrees to provide itemized, dated receipt to the Financial Management Provider in order to be reimbursed. Receipts dated prior to the date of this Authorization/Request or not itemized will not be reimbursed. Written instructions for how to request reimbursement from the Financial Management Provider have been given to the individual noted below:

(Name and relationship of individual willing to purchase)

(Case Management Provider's Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Dated: _____



STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Assistive Technology and Appliances

TO: _____
(Financial Management Agency)

Re: Name: _____

Address: _____

Date of Birth: _____

The individual noted above participates in DDSN's State Funded Community Supports program. The individual referenced above has been determined to need the following item(s) which is considered:

Assistive Technology and Appliances:

Name of Item: _____

*Description/Specifications: _____

Maximum Allowable Cost: _____

**Include sufficient information/specifications such as printed material from manufacturer's website or other supplier (e.g., Amazon, etc.) for the Financial Management Provider to purchase appropriate products. Attach pages if needed.*

The individual noted above/representative can arrange for item to be picked up from one of the Financial Management Provider's locations: Yes No

Contact number for item pick-up: _____

Address to which item should be shipped if different than participant address noted above:

Shipping address: _____

(Case Management Provider's Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Assistive Technology and Appliances**

TO: _____
(Consultant)

Re: Name: _____

Address: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide the following service to the individual named above. Only the cost for services rendered may be billed. **Note: This nullifies any previous authorization to this provider for this service(s).***

Assistive Technology and Appliances – Consultation:

Description: _____

Maximum Allowable Cost: _____

The individual 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 the Financial Management Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____
(Name of Individual to Contact)

(Phone Number)

(Email Address)

(Case Management Provider Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization for the service will end)

The following service *(check one)*:

- | | |
|---|---|
| <input type="checkbox"/> Assistive Technology/Appliances-Consultation | <input type="checkbox"/> Assistive Technology/Appliances: _____ |
| <input type="checkbox"/> Environmental Modification/Consultation | <input type="checkbox"/> Environmental Modification |
| <input type="checkbox"/> Private Vehicle Modification/Consultation | <input type="checkbox"/> Private Vehicle Modification |
| <input type="checkbox"/> Respite and Support | |

Incontinence Supplies:

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Diapers or briefs | <input type="checkbox"/> Under pads | <input type="checkbox"/> Incontinence pads/liners |
| <input type="checkbox"/> Gloves | <input type="checkbox"/> Wipes | |

Which is authorized through the State Funded Community Supports program to be provided to:

(Name of the State Funded Community Supports participant and his/her date of birth)

Is being *(check one)*: Reduced Terminated

Payment for the service indicated above will not continue and will not be made for services rendered after the effective date of this Notice.

Comments: _____

Direct any questions regarding this notice to:

Case Manager's Name: _____

(Phone numbers)

(Email Address)

Case Manager's Signature

Dated: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Behavior Support Services:

Definition: Behavior Support Services are those services which use current empirically validated practices to identify causes of, intervene to prevent, and appropriately react to problematic behavior. These services include initial assessment for determining the need for and appropriateness of behavior support services; behavioral assessment (i.e., functional assessment and/or analysis) that includes direct observation, interview of key individuals, collection of objective data; analysis of behavioral/functional assessment data to determine the function of the behaviors (and later to assess success of intervention and any needed modifications) and behavioral intervention based on the functional assessment that is primarily focused on prevention of the problem behavior(s) based on their function.

Providers: Those listed as providers of Behavior Support Services on the Qualified Provider Listing can be found on DDSN's website at <http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx>. These providers must be used.

Arranging for the Service: If it is determined that those who support the participant need support in order to know how to respond to the problem behavior(s) engaged in/displayed by the participant, Behavior Support should be authorized. The participant or his/her family or guardian should be provided with a listing of available Behavior Support Service providers. The offering of the choice of providers must be clearly documented. The initial authorization should be sufficient to cover the functional assessment and development of the Behavior Support Plan (*while every individual is unique, typically around 16 hours/32 units of service would be sufficient for assessment and plan development*). Once the assessment is completed and the plan developed, an authorization can be issued so that those who will implement the plan can be trained and the effectiveness of the Behavior Support Plan can be monitored (*while everyone is unique, typically two (2) hours/four (4) units per month would be sufficient for typical monitoring and three (3) hours/six (6) units per month would be sufficient for when fidelity checks are required; approximately 56 units per year*).

One unit of Behavior Support Services equals 30 minutes of professional time. The **State Funded Community Supports (BSS 1)** must be used to authorize the service. The **State Funded Community Supports (BSS 1)** instructs the provider to bill the participant's Financial Management Provider for services rendered. The **State Funded Community Supports (BSS 1)** will remain in effect until a new authorization is issued or until a Notice of Reduction or Termination (Form1) is issued.

The cost of Behavior Support Services must be added to the State Funded Community Supports Budget Calculator. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

Monitoring: The CMAP, which will include the Behavior Support Services, must be monitored in accordance with DDSN Case Management Standards. When monitoring, it will be important to know if the assessment and plan are completed with a reasonable amount of resources used and once the plan is completed, it will be important to know whether or not those who support the individual understand the strategies they are to use and whether or not they find the strategies to be effective.

Reduction or Termination of Services: When Behavior Support Services are being reduced or terminated the Notice of Reduction or Termination (Form 1) must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Behavior Support Services**

TO: _____
(Behavior Support Services Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide the following service to the individual named above. Only the number of units rendered may be billed. **Note: This nullifies any previous authorization to this provider for this service(s).***

Behavior Support Services:

Number of Units for Assessment & Plan Development: _____ [one unit =30 minutes]

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

Frequency of Units (e.g., monthly or yearly): _____

The individual 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 the Financial Management Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____

Name of Individual to Contact: _____

(Phone Number)

(Email Address)

(Case Management Provider Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Date: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization will end)

The authorization(s) for service (s) issued to: _____
(Name of provider authorized to provide the service)

For service (s) to be provided to: _____
(Name of the individual receiving the service and his/her date of birth)

Is/are being *(check one)*: Reduced Terminated

Payment will not be made units of service (s) rendered after the effective date of this Notice for the following service(s):

- | | |
|---|--|
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Personal Care (I &II) |
| <input type="checkbox"/> Adult Day Health Care – Transportation | <input type="checkbox"/> Behavior Support |
| <input type="checkbox"/> Adult Day Health Care – Nursing | <input type="checkbox"/> PERS |

Comments: _____

Direct any questions regarding this notice to:

(Case Manager's Name)

(Phone numbers)

(Email Address)

(Case Manager's signature) Date: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Career Preparation Services:

Definition: Services aimed at preparing participants for paid or unpaid employment and careers through exposure to and experience with various careers and through teaching such concepts as compliance, attendance, task completion, problem solving, safety, self-determination, and self-advocacy. Services are not job-task oriented, but instead aimed at a generalized result. Services are reflected in the participant's service plan and are directed to habilitative rather than explicit employment objectives. On-site attendance at the licensed facility is not required to receive services that originate from the facility.

Transportation will be provided from the participant's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participant's habilitation site back to their residence when the service start time is after 12:00 Noon. The cost for transportation is included in the rate paid to the provider.

Providers: Services will be provided in facilities licensed by DDSN. A list of Career Preparation Services providers can be found on the Qualified Provider Listing found on DDSN's website at <http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx>. In some locations across the state, only one provider is available.

Arranging for Services:

Once the participant has been determined to need services aimed at preparing him/her for employment, a choice of providers of this service should be offered and the offering of choice documented. If there is only one provider available, this must be explained to the participant/representative and documented.

One unit of Career Preparation equals one-half day as indicated on the Monthly Data Recording Sheet maintained by the Day Services provider. The **State Funded Community Supports (CP 1)** must be used to authorize the service. The **State Funded Community Supports (CP1)** instructs the provider to bill the participant's Financial Management Provider for services rendered. The **State Funded Community Supports (CP 1)** will remain in effect until a new authorization is issued or a Notice of Reduction or Termination is issued.

The "Services Menu" of Service Tracking System (STS) must be updated to indicate the participant is receiving Career Preparation.

The cost of Career Preparation must be added to the State Funded Community Supports Budget Calculator. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

Monitoring: The CMAP, which will include the Career Preparation services, must be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When Career Preparation services are being reduced or terminated the **Notice of Reduction or Termination** (Form 3) must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Career Preparation**

TO: _____
(Career Preparation Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide the following service to the individual named above. Only the number of units rendered may be billed. **Note: This nullifies any previous authorization to this provider for this service(s).***

Career Preparation:

Number of Units per Week: _____ [one unit = 1/2 day or 2-3 hours]

The individual 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 the Financial Management Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____
(Name of Individual to Contact)

(Phone Number)

(Email Address)

(Case Management Provider's Name)

(Case Manager's Name)

(Phone number)

(Email Address)

Signature of Case Manager Authorizing Services

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization will end)

The authorization(s) for service (s) issued to: _____
(Name of provider authorized to provide the service)

For service (s) to be provided to: _____
(Name of the individual receiving the service and his/her date of birth)

Is/are being *(check one)*: Reduced Terminated

Payment will not be made for units of service (s) rendered after the effective date of this Notice for the following service(s):

- | | |
|--|--|
| <input type="checkbox"/> Employment Services: Individual | <input type="checkbox"/> Career Preparation |
| <input type="checkbox"/> Employment Services: Group | <input type="checkbox"/> Community Services - Group |
| <input type="checkbox"/> Day Activity | <input type="checkbox"/> Community Services - Individual |
| <input type="checkbox"/> Support Center | |

Comments: _____

Direct any questions regarding this notice to: _____
(Case Manager's Name)

(Phone Number)

(Email Address)

Case Manager's Signature

Date: _____

In accordance with DDSN's policy 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Community Services:

Definition: Services aimed at developing one's awareness of, interaction with and/or participation in their community through exposure to and experience in the community and through teaching such concepts as self-determination, self-advocacy, socialization and the accrual of social capital. On site attendance at the licensed facility is not required to receive services that originate from the facility.

Transportation will be provided from the participant's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participant's habilitation site to their residence when the service start time is after 12:00 Noon. The cost for transportation is included in the rate paid to the provider.

Community Services can be provided in two different ways:

1. **Community Group Services -Group** - is available to those participants who can benefit from services provided in a group setting. (One unit = ½ day or 2- 3 hours).
2. **Community Services - Individual** - is available to those who require that services be provided on a one-to-one basis. **Community Services - Individual must always be provided with a one to one participant to staff ratio.** (One unit = 1 to 3 hours)

In determining which way Community Services is most appropriately provided, you must carefully consider the participant's assessed abilities/strengths, interests/preferences and needs to determine which way would be most conducive in achieving his/her goals must be carefully considered.

Providers: Services will be provided in facilities licensed by DDSN. A list of Community Services providers can be found on the Qualified Provider Listing found on DDSN's website at <http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx>. In some locations across the state, only one provider is available.

Arranging for Services: Once the participant has been determined to need services aimed at developing his/her awareness of, interaction with and/or participation in their community and the method of service delivery is determined, a choice of providers of this service should be offered and the offering of choice documented. If there is only one provider available, this must be explained to the participant and/or his/her legal guardian and documented.

The "Services Menu" of Service Tracking System (STS) must be updated to indicate the participant is receiving Community Services.

One unit of Community Service – Group equals one-half day as indicated on the Monthly Data Recording Sheet which is maintained by the Day Service provider.

One unit of Community Services – Individual equals one-to-three hours of one-on-one service provision as indicated on the Monthly Data Recording Sheet which is maintained by the Day Service provider.

The **State Funded Community Supports (CS 1)** must be used to authorize the service. The **State Funded Community Supports (CS 1)** instructs the provider to bill the participant's Financial Management Provider for services rendered. The **State Funded Community Supports (CS 1)** will remain in effect until a new form changing the authorization is issued or until a Notice of Reduction or Termination is issued.

The cost of Community Supports must be added to the State Funded Community Supports Budget Calculator. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

Monitoring: The CMAP, which must include Community Services, must be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When Community Services is being reduced or terminated, the **Notice of Reduction or Termination** (Form 3) must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Community Services**

TO: _____
(Community Services Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide the following service to the individual named above. Only the number of units rendered may be billed. **Note: This nullifies any previous authorization to this provider for this service(s).***

Community Services (CS):

CS – Group - Number of Units per Week: _____ [one unit =1/2 day or 2-3 hours]

CS – Individual - Number of Units per Week: _____ [one unit =1-3 hours]

The individual 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 the Financial Management Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____
(Name of Individual to Contact)

(Phone Number)

(Email Address)

(Case Management Provider Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Date: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization will end)

The authorization(s) for service (s) issued to: _____
(Name of provider authorized to provide the service)

For service (s) to be provided to: _____
(Name of the individual receiving the service and his/her date of birth)

Is/are being *(check one)*: Reduced Terminated

Payment will not be made for units of service (s) rendered after the effective date of this Notice for the following service(s):

- | | |
|--|--|
| <input type="checkbox"/> Employment Services: Individual | <input type="checkbox"/> Career Preparation |
| <input type="checkbox"/> Employment Services: Group | <input type="checkbox"/> Community Services - Group |
| <input type="checkbox"/> Day Activity | <input type="checkbox"/> Community Services - Individual |
| <input type="checkbox"/> Support Center | |

Comments: _____

Direct any questions regarding this notice to: _____
(Case Manager's Name)

(Phone Number)

(Email Address)

Case Manager's Signature

Dated: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Day Activity:

Definition: Supports and services provided in therapeutic settings to enable participants to achieve, maintain, improve, or decelerate the loss of personal care, social or adaptive skills. Services are provided in non-residential settings that are licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Day Activity. On site attendance at the licensed facility is not required to receive services that originate from the facility.

Transportation will be provided from the participant's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participant's habilitation site to their residence when the service start time is after 12:00 Noon. The cost for transportation is included in the rate paid to the provider.

Providers: Services will be provided in facilities licensed by DDSN. A list of Day Activity providers can be found on the Qualified Provider Listing found on DDSN's website at <http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx>. In some locations across the state, only one provider is available.

Arranging for Services: Once the participant has been determined to need services provided in therapeutic settings to enable him/her to achieve, maintain, improve, or decelerate the loss of personal care, social or adaptive skills, a choice of providers of this service should be offered and the offering of choice documented. If there is only one provider available, this must be explained to the participant and/or his/her legal guardian and documented.

One unit of Day Activity equals one-half day as indicated on the Monthly Data Recording Sheet maintained by the Day Service provider. The **State Funded Community Supports (DA 1)** must be used to authorize the service. The **State Funded Community Supports (DA 1)** instructs the provider to bill the participant's Financial Management Provider for services rendered. The **State Funded Community Supports (DA 1)** will remain in effect until a new authorization is issued or a Notice of Reduction or Termination (Form 3) is issued.

The "Services Menu" of Service Tracking System (STS) must be updated to indicate the participant is receiving Day Activity.

The cost of Day Activity must be added to the State Funded Community Supports Budget Calculator. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

Monitoring: The CMAP, which must include Day Activity, must be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When Day Activity is being reduced or terminated the **Notice of Reduction or Termination** (Form 3) must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Day Activity**

TO: _____
(Day Activity Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide the following service the individual named above. Only the number of units rendered may be billed. **Note: This nullifies any previous authorization to this provider for this service(s).***

Day Activity:

Number of Units per Week: _____ [one unit = 1/2 day or 2-3 hours]

The individual 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 the Financial Management Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____
(Name of Individual to Contact)

(Phone Number)

(Email Address)

(Case Management Provider's Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Date: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization will end)

The authorization(s) for service (s) issued to: _____
(Name of provider authorized to provide the service)

For service (s) to be provided to: _____
(Name of the individual receiving the service and his/her date of birth)

Is/are being *(check one)*: Reduced Terminated

Payment will not be made for units of service (s) rendered after the effective date of this Notice for the following service(s):

- | | |
|--|---|
| <input type="checkbox"/> Employment Services: Individual | <input type="checkbox"/> Career Preparation |
| <input type="checkbox"/> Employment Services: Group | <input type="checkbox"/> Community Services - Group |
| <input type="checkbox"/> Day Activity | <input type="checkbox"/> Community Services -Individual |
| <input type="checkbox"/> Support Center | |

Comments: _____

Direct any questions regarding this notice to: _____
(Case Manager's Name)

(Phone number)

(Email Address)

Case Manager's Signature

Date: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Employment Services:

Definition: Employment Services consist of intensive, on-going supports that enable those for whom competitive employment at or above minimum wage is unlikely absent the provision of supports, need supports to perform in regular work settings. Employment Services may include services to assist the participant to locate a job or develop a job on behalf of the participant. Employment Services are conducted in a variety of settings, particularly work sites where individuals without disabilities are employed and include activities needed to sustain paid work. Employment Services may be provided in group settings, such as mobile work crews on enclaves, or individually at the participant's place of employment.

Models:

Employment Services consist of three distinct models: Individual Community Placement; Enclave; and Mobile Work Crew:

1. **Individual Community Placement** - Assessment, job development, placement, and training involve direct facilitation and instruction by DDSN job coach staff. Individual community placement provides support in community based instruction, career awareness, skill acquisition, strategic on the job training, long term support and follow-along. Ongoing supports and identification of long term natural supports are imperative for the individual with significant disabilities to participate in competitive employment and to ensure job stabilization without support throughout the tenure of the placement.

Note: One unit = 1 hour

2. **Enclave** - A small group of individuals (usually eight or less) with developmental disabilities, who work under the supervision of an employee of the provider organization, in a community business/industry alongside non-disabled employees to produce goods or services controlled by the community business/industry (e.g., janitorial services at a specific business/industry, etc.). The contractual relationship is between the business/industry and the provider organization, whereby the provider organization then pays the participant. **Note:** One unit = ½ day
3. **Mobile Work Crew** - A small group of people (usually eight or less) with developmental disabilities, who work under the supervision of an employee of the provider organization as a self-contained business, who typically move to different work sites, by selling a service (e.g., landscaping, janitorial) to purchasers within the community excluding provider organizations. The contractual relationship is between the business/industry and the provider organization, whereby the provider organization then pays the participant. **Note:** One unit = ½ day

NOTE: Services provided through the Enclave and Mobile Work Crew models will be referred to as "Employment Services – Group."

Providers: A list of Employment Services providers can be found on the Qualified Provider Listing found on DDSN's website at <http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx>. In some locations across the state, only one provider is available.

Arranging for the Service: For those determined to need the kind of assistance described in the Employment Services definition, the plan must clearly reflect the need for the service. Additionally, consideration must be given to the best model through which Employment Services should be provided given the strengths/abilities, needs and goals of the participant. The specific model through which Employment Services should be provided must be noted in the plan. A choice of providers should be offered and the offering of choice must be documented. If there is only one available choice, then this must be explained to the participant/representative and documented.

For Employment Services - Individual Community Placement, one unit equals one hour of service.

Employment Services - Individual Community Placement can be authorized using the **State Funded Community Supports (ES-individual)**. The table below shows the major activities provided as part of Employment Services when the Individual Community Placement model is used.

Major Activity	# of Units based on Typical Placements
45 Day Referral Process	15
Skills Acquisition / Placement	40
Job Training to Stabilization (60 days)	75
Six Months Follow-Along	12
TOTAL UNITS	142

Employment Services - Individual Community Placement should be authorized by separating the “45 Day Referral Process” from the other Major Activities which are Skills Acquisition/Placement, Job Training to Stabilization, and Six Months Follow-Along.

For Employment Services- Group, one unit of services equals ½ day or 2-3 hours of service. **State Funded Community Supports (ES-GRP)** must be used to authorize the service.

The “Services Menu” of Service Tracking System (STS) must be updated to indicate the participant is receiving Employment Services.

The cost of Employment Services must be added to the State Funded Community Supports Budget Calculator. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

Monitoring: The CMAP, which will include the Employment Services and the specific model through which the services will be provided, must be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When Employment Services is being reduced or terminated the **Notice of Reduction or Termination** (Form 3) must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
AUTHORIZATION/REQUEST FOR EMPLOYMENT SERVICES - GROUP**

TO: _____

RE: NAME: _____

ADDRESS: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide the following service to the individual named above. Only the number of units rendered may be billed. **NOTE: This nullifies any previous authorization to this provider for this service(s).***

Employment Services - Group
(Enclave or Mobile Work Crew Model)

Number of Units per Week: _____ [one unit = ½ day or 2-3 hours]

The individual 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 the Financial Management Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____
(Name of Individual to Contact)

(Phone Number)

(Email Address)

(Case Management Provider Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Date: _____



**STATE FUNDED COMMUNITY SUPPORTS
AUTHORIZATION/REQUEST FOR EMPLOYMENT SERVICES - INDIVIDUAL**

TO: _____

RE: NAME: _____

ADDRESS: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide the following service to the individual named above. Only the number of units rendered may be billed. **NOTE: This nullifies any previous authorization to this provider for this service(s).***

Employment Services: Start Date: _____

Assessment of Need for Services:

Assessment _____ (number of units)

Authorization for Implementation of Services

Individual Placement Number of Units per Year: _____ (1 unit = 1 hour)

The individual 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 the Financial Management Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____

(Name of Individual to Contact)

(Phone Number)

(Email Address)

(Case Management Provider Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Date: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization will end)

The authorization(s) for service (s) issued to: _____
(Name of provider authorized to provide the service)

For service (s) to be provided to: _____
(Name of the individual receiving the service and his/her date of birth)

Is/are being *(check one)*: Reduced Terminated

Payment will not be made for units of service (s) rendered after the effective date of this Notice for the following service(s):

- Employment Services: Individual Career Preparation
- Employment Services: Group Community Services - Group
- Day Activity Community Services - Individual
- Support Center

Comments: _____

Direct any questions regarding this notice to: _____
(Case Manager's Name)

(Phone Number)

(Email Address)

Case Manager's Signature

Date: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Environmental Modifications:

Definition: Physical adaptations to the participant's primary residence which are necessary to ensure his/her health, welfare and safety, or which enable the participant to function with greater independence. Home is defined as non-government subsidized living quarters; modifications to any government subsidized housing (i.e., group homes or community residential care facilities) are not permitted. Adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, etc., which are necessary for the welfare of the participant. Environmental Modifications may also include consultation and assessment to determine the appropriate specifications of the anticipated modifications and follow-up inspections of the completed modification.

The following are examples of possible adaptations that may be done as a part of Environmental Modifications include, but are not limited to:

- Installation of a ramp to facilitate safe and easy entering and exiting of the home.
- Installation of grab-bars.
- Porch-lift to facilitate safe egress (in certain situations a porch lift can be more feasible and cost effective than extensive ramping).
- Widening of interior doorways to allow use of all areas of the home, etc.
- Flooring modifications to facilitate propelling of a manual wheelchair (e.g., carpet is replaced with vinyl floor covering).
- Modification of a bathroom for independent or easier accessibility and or safety, (e.g., a roll-in shower with grab bars, roll-under sink, etc.).

Please note the following exclusions:

- Adaptations or improvements which are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, painting, roof repair, central air conditioning, etc. are not covered.
- Routine and one-time home maintenance (e.g., siding, repairs/replacement, gutter work, foundation repair, electrical wiring problems, etc.) is not covered.
- Modifications that add square footage to the home are not covered.
- Financial assistance for any phase of new home construction or major home renovation projects is not allowed.

All services shall be provided in accordance with applicable State and local building codes.

Providers:

Environmental Modification - Consultations can be provided by licensed Occupational or Physical Therapists, Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/Contractors certified by Professional Resource in Management (PRIME).

Environmental Modification - Installation will be determined by the Financial Management Provider.

Arranging for the Service:

When modifications are thought to be needed, but before proceeding with bid requests, the **Environmental Modifications Fact Sheet for Those Who Live in Privately Owned or Rented Homes** must be given to the participant and/or representative and signature acknowledging receipt obtained used the **State Funded Community Supports (EM 1)**.

Once the participant's specific need has been identified and documented in the Plan and it is determined that Environmental Modification is the appropriate service to meet the need, the scope of the work/specifications must be determined. This should be done in consultation with the participant/representative and home owner and should define the expected modification as clearly as possible. There are two (2) ways to accomplish this task:

1. You can define the expected modifications by meeting with the participant/representative/home owner in the home, reviewing the modifications that are needed, and developing some parameters in writing to provide to the contractors submitting bids. This is a crucial step to ensure that all requested contractor bids are based on similar expectations (e.g., for someone who cannot access their bathroom, the contractor would need to take into account the dimensions of the participant's wheelchair).

OR

2. The expected modifications can also be defined by obtaining an Environmental Modification Consultation by using part of the annual cost limit. An Environmental Modification Consultation is highly recommended when multiple modifications are needed and the participant/representative/homeowner is unsure how to proceed or unable to clearly articulate the specifications. (The cost for the consultation will count against the annual cost limit).

The written specifications must be provided to Financial Management Provider when the Authorization/Request for Environmental Modifications form is completed.

If a the project specifications will be determined using a professional, Environmental Modifications - Consultation should be secured by offering the participant/representatives choice of providers and issuing the **State Funded Community Supports (EM-C)** form which instructs the provider to bill the Financial Management Provider for services provided. The cost of a consultation will vary, but would not be expected to exceed \$600.00 per consultation.

When Environmental Modifications - Installation is needed, the **State Funded Community Supports (EM-I)** form should be used. This form instructs the Financial Management Provider that modifications are needed. The specifications for the project must be noted. If a consultation has been secured, the specification from the consultant should be attached. The MAXIMUM amount allowed for the Environmental Modification must be included. This will instruct the Financial Management Provider as they seek bids for the project. The Financial Management Provider with assistance from the Case Manager and the participant/representative will secure bids if needed.

The maximum amount allowed for the modification must be added to the State Funded Community Supports Budget Calculator. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded. Once the project has been awarded to a contractor, the Financial Management Provider will notify the Case Manager of the actual cost of the project. The maximum amount previously entered into the Budget Calculator should be updated to reflect the actual cost of the modification.

The **Environmental Modification Project Agreement (EM 2)** must be provided to the home owner and signature agreeing to its terms obtained. This form must be sent to the Financial Management Provider.

Please note: If the participant/representative or home owner desires Environmental Modifications above the SFCS maximum amount allowed, they can **privately** contract with and pay the same professional/contractor who is completing the SFCS project. Any additional work funded by the family or other outside resources cannot be a part of the Authorization/Request for Environmental Modifications. It must be a separate contract between the family and their chosen provider.

Monitoring: The plan, which includes Environmental Modifications, should be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When the Environmental Modification service is being reduced or terminated the **Notice of Reduction or Termination** (Form 2) must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



STATE FUNDED COMMUNITY SUPPORTS
Environmental Modifications
Fact Sheet for Those Who Live in Privately Owned or Rented Homes

- Environmental modifications for individuals served through the DDSN's State Funded Community Supports program are available when there is an assessed need and when the cost of the modification and other services do not exceed the State Fiscal Year cost limit of the State Funded Community Supports program.
- DDSN's Directive 250-08-DD: Procurement Requirements for Local DSN Boards, must be followed.
- To be eligible for modifications, a privately owned or rented house or apartment must be sanitary, safe, adequately maintained, and architecturally feasible for cost-effective modification methods.
- Routine home maintenance such as cleaning, painting, roof repair/replacement, gutter clearing, pest control, plumbing repairs, water damage repairs, floor repairs, appliance repairs, and yard work are not provided as environmental modifications. These issues are the responsibility of the homeowner or landlord/tenant.
- Modifications are provided only to improve the participant's safety and functional independence in his/her home. Requests will only be considered for essential modifications, such as an entrance/exit ramp, widening of selected exterior/interior doorways, flooring to facilitate wheelchair movement, alterations to make a bathroom accessible, etc. Environmental modifications may also include consultation and assessment to determine the specific needs and follow-up inspections upon completion of the project.
- Home additions (addition of square footage) are not allowed.
- Should modifications to a bathroom be required, due to significant differences in the framework and flooring support structures used in mobile homes and manufactured housing, conventional ceramic tile showers/floors cannot be provided. The most appropriate and cost-effective solution is a prefabricated accessible shower unit.
- Upgraded and expensive materials and fixtures, such as decorative marble or tile flooring/walls, brass faucets, wallpaper, etc. are not permitted.
- When modifications are not feasible because of architectural, sanitary, or other basic habitability considerations, alternatives such as assistance in securing accessible public housing or another rental dwelling may be offered. After relocating, if there remains a need for modifications, three (3) new written bids must be obtained.

- All (participant, family, others) who live in the home or would otherwise be affected by the completed modification must be in full agreement on what work will be done before the request can be approved. Therefore, the participant (or his/her representative) and other homeowner/landlord must sign an agreement about the modifications before modifications will begin.
- Environmental modifications must be completed by a licensed contractor and comply with all local building ordinances. Three or more written bids must be obtained and the lowest used.
- If unforeseen structural problems or damage are discovered after a modification project has started that resulted from preexisting maintenance neglect, plumbing leaks, improper drainage, or termites, it will be the responsibility of the homeowner/landlord to correct the structural problems or damage before the modifications will continue.
- If any of the outlined specifications cannot be met due to architectural designs, you must notify the Case Manager or Financial Management Provider's representative immediately.
- The Financial Management Provider's Name and Contact information:



**STATE FUNDED COMMUNITY SUPPORTS
ENVIRONMENTAL MODIFICATIONS**

ACKNOWLEDGEMENT

Participant's Name: _____

DOB: _____

The DDSN State Funded Community Supports, "Environmental Modifications Fact Sheet for Those Who Live in Privately Owned or Rented Homes" document has been provided to me as the State Funded Community Supports program participant or his/her representative. I have been offered the opportunity to ask questions about the information provided and know that I may contact the Case Management Provider should I have any additional questions.

Signature of Participant or Representative

Dated: _____

(Printed name of signatory)

(Relationship to Participant)

Signature of Witness

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Environmental Modification - Consultation**

TO: _____
(Environmental Modification - Consultation Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

Beginning on the date noted below, you are hereby authorized to provide an Environmental Modification for the individual named above. Only the amount noted below will be paid.

NOTE: This nullifies any previous authorization to this provider for this service(s).

Environmental Modification - Consultation: \$ _____ (Price)

The individual 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 the Financial Management Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____
(Name of Individual to Contact)

(Phone Number)

(Email Address)

(Case Management Provider Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Environmental Modification - Installation**

TO: _____
(Financial Management Agency)

Re: Name: _____

Address: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide an Environmental Modification for the individual named above. No more than the amount noted below will be paid. **NOTE: This nullifies any previous authorization to this provider for this service(s).***

Environmental Modification:

Address to be modified if different than the address noted above: _____

Specifications/description of the modifications to be complete (*attach drawings or pages if needed*): _____

MAXIMUM PRICE FOR MODIFICATION: \$ _____

(Case Management Provider Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Environmental Modifications
Project Agreement**

Participant's Name: _____

Date of Birth: _____

Terms:

I understand that the requested environmental modification(s) is/are being funded with public money.

I have seen and agreed to the specifications for the environmental modification(s).

I understand that only the listed specifications will be provided and funded as part of this project.

I understand that under South Carolina State Procurement Law, if the requested environmental modification project costs more than \$2,500.00, the project must be awarded to the lowest qualified bidder.

I agree that I will not request or instruct the provider to change any of the approved specifications after the project is awarded.

I understand that any additional work performed by the provider and/or any work separately negotiated with the provider will solely be my financial responsibility as the home owner.

I agree to work cooperatively with the provider to insure a positive working relationship during the course of the project.

I agree to make the location available during the project should the provider need to take measurements or ask questions to insure modifications will be correct and beneficial.

I understand that I must notify the participant's Case Manager immediately if any problems occur during the project.

I, _____, as owner of the home/location to be modified, have read, understand, and agree to each of the above terms. I also understand that the requested environmental modification project cannot proceed without my signature below.

Signature of Home Owner

Dated: _____

Signature of Witness

Dated: _____

Printed Name of Witness

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization for the service will end)

The following service (check one):

- | | |
|---|---|
| <input type="checkbox"/> Assistive Technology/Appliances - Consultation | <input type="checkbox"/> Assistive Technology/Appliances: |
| <input type="checkbox"/> Environmental Modification/Consultation | <input type="checkbox"/> Environmental Modification |
| <input type="checkbox"/> Private Vehicle Modification/Consultation | <input type="checkbox"/> Private Vehicle Modification |
| <input type="checkbox"/> Respite and Support | |

Incontinence Supplies:

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Diapers or briefs | <input type="checkbox"/> Under Pads | <input type="checkbox"/> Incontinence pads/liners |
| <input type="checkbox"/> Gloves | <input type="checkbox"/> Wipes | |

Which is authorized through the State Funded Community Supports program to be provided to:

(Name of the State Funded Community Supports participant and his/her date of birth)

Is being (check one): Reduced Terminated

Payment for the service indicated above will not continue will not be made for services rendered after the effective date of this Notice.

Comments: _____

Direct any questions regarding this notice to: _____
(Case Manager's Name)

(Phone Number)

(Email Address)

Case Manager's Signature

Dated: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Respite and Support:

Definition: Care, supervision, teaching and/or assistance provided directly to or in support of the participant. This includes care and supervision provided on a short-term basis due to the absence or need of relief of the primary caregiver. Services may be provided in locations determined by participant/representative.

Respite and Support may be chosen in lieu of provider-managed services such as Personal Care although the use of both services is not prohibited.

Respite and Support is a participant and/or representative arranged and directed. That means that the participant and/or representative is responsible for hiring, training, supervising and paying the worker(s) who performs the service.

Providers: Funding for Respite and Support is awarded to the participant and/or representative as a monthly stipend. Workers who perform the service are chosen, trained, supervised and paid by the participant or his/her representative.

Arranging for the Service: When it is determined that Respite and Support is needed, the participant/representative must understand that he/she is completely responsible for recruiting, determining the wage to be paid, choosing/hiring, training, supervising, and paying the worker(s). The Case Manager should have a sense of how and when the services will be provided. The Case Manager will authorize a monthly amount to be paid to the participant/representative each month for the services. Case Managers can authorize up to \$300.00 per month for these services. Because the rate paid to the worker (the unit rate) will be determined by the participant/representative, the exact units of service that can be purchased with \$300.00 per month cannot be determined. However, generally speaking, \$300.00 per month would likely purchase 30 to 40 hours of service.

If more than \$300.00 per month of services is needed, approval must be obtained from the DDSN District Office. This approval should be based on the needs of the participant. For example, more than \$300.00 per month for Respite and Support is needed during the summer months when a 15 year old is not in school.

The **Authorization for Respite and Support (State Funded Community Supports RS 1)** should be used to authorize the amount of the stipend. Under no circumstances will an amount in excess of the amount on the form be paid to the participant/representative.

The **Authorization for Respite and Support (State Funded Community Supports RS 1)** will remain in effect until a new/revised authorization form is issued or until a Notice of Reduction or Termination is issued.

The cost of Respite and Support must be added to the **State Funded Community Supports Budget Calculator**. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

The Financial Management Provider serving this participant must receive verification that the money paid was spent for Respite and Home Support services. The Financial Management Provider will provide written instructions for what types of documentation are acceptable and how verification should be submitted.

Monitoring the Services:

The plan, which Respite and Support, should be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When the Respite and Support service is being reduced or terminated the **Notice of Reduction or Termination** (Form 2) must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
Authorization for Respite and Support**

TO: _____
(Name of Participant/Representative to whom stipend will be sent)

Mailing Address: _____

Re: Participant Name: _____

Date of Birth: _____

Beginning on the date noted below, the participant is hereby authorized to receive Respite and Support. The amount noted below will be provided in order to cover the cost for the service.

You are responsible for recruiting, hiring, training, supervising and paying any workers.

NOTE: This nullifies any previous authorization for this service(s).

Respite and Support:

Amount per Month: \$ _____ *(Maximum = \$300.00 unless approved by DDSN)*

The individual noted above participates in DDSN's State Funded Community Supports program.

Through this program, payment for needed services, up to the amount authorized above, will be made by the Financial Management Provider serving the participant. The Financial Management Provider serving this participant must receive verification that the money paid was spent for Respite and Home Support services. The Financial Management Provider will provide written instructions for verification. For the individual noted above, direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____
(Name of Individual to Contact)

(Phone Number)

(Email Address)

(Case Management Provider's Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Service

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization for the service will end)

The following service *(check one)*:

- Assistive Technology/Appliances - Consultation
- Assistive Technology/Appliances: _____
- Environmental Modification/Consultation Environmental Modification
- Private Vehicle Modification/Consultation Private Vehicle Modification

Respite and Support (Incontinence Supplies):

- Diapers/briefs Under pads Incontinence pads/liners Gloves Wipes

Which is authorized through the State Funded Community Supports program to be provided to:

(Name of the State Funded Community Supports participant and his/her date of birth)

Is being (check one): Reduced Terminated

Payment for the service indicated above will not continue will not be made for services rendered after the effective date of this Notice.

Comments: _____

Direct any questions regarding this notice to:

(Case Manager's Name)

(Phone Number)

(Email Address)

Case Manager's Signature

Dated: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Incontinence Supplies:

Definition: Diapers, under pads, wipes, liners, and disposable gloves provided to participants who are incontinent of bowel and/or bladder.

PLEASE NOTE

Some State Funded Community Supports participants may be Medicaid Eligible (e.g., did not meet Level of Care (LOC) for Waiver, but Medicaid eligible). If the participant is Medicaid eligible, he/she may be eligible for the some supplies if deemed by Medicaid to be medically necessary. Medicaid could provide:

One (1) case of diapers or briefs [1 case = 96 diapers or 80 briefs]

One (1) case of incontinence pads/liners [1 case = 130 pads]

One (1) case of under pads

One (1) box of wipes

One (1) box of gloves

Providers: The Financial Management Provider will determine the provider of the service.

Arranging for the Service: Once the participant's has been determined to be incontinent and the need for supplies has been identified and documented on the CMAP, the method to be used for securing supplies must be determined.

Reimbursement method: If the participant/representative is willing and able to purchase the needed supplies and follow the specific instructions from the Financial Management Provider in order to be reimbursed, needed supplies can be secured using this method. When this method will be used, the **Authorization/Request for Incontinence Supplies [State Funded Community Supports (IS 1)]** will be used. The participant/representative must be given the specific instructions for requesting reimbursement from the Financial Management Provider. These instructions will be provided by the Financial Management Provider. The **Authorization/Request for Incontinence Supplies [State Funded Community Supports (IS 1)]** should reflect the needed products and quantity along with the maximum amount per month for all needed incontinence supplies. The participant/representative will not be reimbursed for more than the "maximum amount per month" noted on the form. When completed, copies of the form should be shared with the participant/representative and with the Financial Management Provider. The State Funded Community Supports (IS 1) will remain in effect until a new authorization is issued or a Notice of Reduction or Termination is issued.

Financial Management Provider Purchase method: If the participant/representative is not willing or able to be reimbursed for purchased products, needed products can be purchased by the Financial Management Provider and delivered to the participant.

When this option is used, the **Authorization/Request for Incontinence Supplies [State Funded Community Supports (IS 2)]** will be used. Very specific information must be provided to the Financial Management Provider so that needed items can be purchased (e.g., size needed, preferred brand, other specifications like "latex free," etc.). If needed, attach additional pages (e.g., printed manufacturer's or supplier's website of specific product to be purchased).

The maximum amount per month for all needed incontinence supplies must be noted. The Financial Management Provider will not purchase supplies that cost in excess of the maximum monthly amount noted on the **Authorization/Request for Incontinence Supplies [State Funded Community Supports (IS 2)]**.

Whether or not the participant/representative is willing to pick supplies up from the Financial Management Provider's offices or other provider location rather than having the supplies shipped/delivered to the home should be noted. If the participant/representative is not willing to pick up supplies, the maximum monthly amount must include costs for shipping/handling/delivery. **Note:** The Financial Management Provider shall not charge the participant for delivering supplies from a provider location to the participant.

The form must also indicate a shipping address for the Incontinence Supplies if the address is different than the participants address noted at the top of the Authorization/Request for Incontinence Supplies [State Funded Community Supports (IS 2)].

The maximum amount per month of the item must be added to the **State Funded Community Supports Budget Calculator**. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

When the Financial Management Provider determines the means by which products will be supplied, the Financial Management Provider will notify the Case Manager of the method and the cost of the item. The actual amount per month of the products must be added to the State Funded Community Supports Budget Calculator, to update the cost from the maximum to the actual.

The State Funded Community Supports (IS 2) will remain in effect until a new authorization is issued or a Notice of Reduction or Termination is issued.

Monitoring: "Incontinence Supplies" must be included on the Plan; the Plan must be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When Incontinence Supplies are being reduced or terminated the **Notice of Reduction or Termination (Form 2)** must be used to notify the participant/representative and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Incontinence Supplies Purchase**

TO: _____
(Financial Management Agency)

Re: Name: _____

Address: _____

Date of Birth: _____

The individual noted above participates in DDSN's State Funded Community Supports program and has been determined to need the following product(s):

Incontinence Supply/Quantity Size/Other *Specifications:

- Diapers/briefs Incontinence pads/liners Under pads Box of Wipes
- Box of Gloves

**Include sufficient information/specifications for the Financial Management Agency to purchase appropriate products. If a specific brand is preferred, please note and attach pages if needed.*

Maximum allowed per calendar month for Incontinence Supplies: \$ _____

The individual noted above/representative can arrange for supplies to be picked up from one of the Financial Management Provider's locations: Yes No

Contact number for supply pick-up: _____

Address to which products are to be shipped if different than participant address noted above:

Shipping address: _____

(Case Management Provider's Name)

(Case Manager's Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization for the service will end)

The following service (check one):

- | | |
|---|---|
| <input type="checkbox"/> Assistive Technology/Appliances - Consultation | <input type="checkbox"/> Assistive Technology/Appliances: |
| <input type="checkbox"/> Environmental Modification/Consultation | <input type="checkbox"/> Environmental Modification |
| <input type="checkbox"/> Private Vehicle Modification/Consultation | <input type="checkbox"/> Private Vehicle Modification |

Respite and Support (Incontinence Supplies):

- Diapers or briefs Under pads Incontinence pads/liners Gloves Wipes

Which is authorized through the State Funded Community Supports program to be provided to:

(Name of the State Funded Community Supports participant and his/her date of birth)

Is being (check one): Reduced Terminated

Payment for the service indicated above will not continue will not be made for services rendered after the effective date of this Notice.

Comments: _____

Direct any questions regarding this notice to: _____

(Case Manager Name)

(Phone Number)

(Email Address)

Case Manager's Signature

Dated: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Personal Emergency Response System (PERS):

Definition: A Personal Emergency Response System (PERS) is an electronic device that enables someone to secure help in an emergency. The participant may wear a portable “help” button. The system is connected to the individual’s telephone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals. PERS services are limited to those who live alone, or those who are alone in their own home for three (3) or more hours of the day/night, and who could be alone with a PERS, but otherwise require supervision.

Providers: Companies listed as providers of Personal Emergency Response Systems (PERS) can be found on the Qualified Provider Listing found on DDSN’s website at <http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx>.

Arranging for and Authorizing Services: To receive this service the participant must have a working telephone. The cost covered by this service is limited to the cost for the PERS; it does not include costs for the telephone service. A participant will be assessed to need a PERS when he/she will be alone for three (3) or more hours per day, three (3) or more days per week and otherwise require direct supervision. The participant must also be determined to be capable of using the system if installed. Once it is determined that PERS is needed, the need must be documented in the participant’s plan. A choice of providers must be offered and the offering of the choice documented.

Once a provider is chosen, the budget information can be entered in the State Funded Community Supports Budget Calculator and the service authorized using the **State Funded Community Supports (PERS)**. The **installation** of PERS will be authorized as a one-time service. The ongoing availability of the PERS called “**monitoring**” will be authorized as a monthly service. The **State Funded Community Supports (PERS)** instructs the provider to bill the participant’s Financial Management Provider for services rendered. The **State Funded Community Supports (PERS)** will remain in effect until a new authorization is issued or until a **Notice of Reduction or Termination (Form 1)** is issued.

The cost of PERS must be added to the **State Funded Community Supports Budget Calculator**. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

Monitoring: The plan, which includes PERS, should be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When PERS is being terminated the Notice of Reduction or Termination (Form 1) must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Personal Emergency Response System**

TO: _____
(Personal Emergency Response System (PERS) Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide the following to the individual named above. Only the number of units rendered may be billed. **NOTE: This nullifies any previous authorization to this provider for this service(s).***

Personal Emergency Response System:

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

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

The individual 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 the **Financial Management Provider** serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:*

(Financial Management Provider’s Name)

Address: _____

Representative: _____
(Name of Individual to Contact)

(Phone Numbers)

(Email Address)

(Case Management Provider Name)

(Case Manager’s Name)

(Phone Number)

(Email Address)

Signature of Case Manager Authorizing Services

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization will end)

The authorization for service (s) issued to: _____
(Name of provider authorized to provide the service)

For service (s) to be provided to: _____
(Name of the individual receiving the service and his/her date of birth)

Is/are being *(check one)*: Reduced Terminated

Payment will not be made units of service (s) rendered after the effective date of this Notice of Reduction or Termination for the following service(s):

- | | |
|---|--|
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Personal Care (I &II) |
| <input type="checkbox"/> Adult Day Health Care – Transportation | <input type="checkbox"/> Behavior Support |
| <input type="checkbox"/> Adult Day Health Care – Nursing | <input type="checkbox"/> PERS |

Comments: _____

Direct any questions regarding this notice to: _____

(Case Manager's Name)

(Phone Number)

(Email Address)

Case Manager's Signature

Dated: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Personal Care Services:

Definition: Personal Care Services are defined as assistance, either hands-on (actually performing a personal care task for an individual) or cueing so the individual performs the task by him/herself, in the performance of Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs). ADLs include eating, bathing, dressing, toileting, transferring, personal hygiene, and maintaining continence. IADLs capture more complex life activities and include light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, to include informing a client that it is time to take medication as prescribed by his/her physician or handing a client a medication container, and money management to consist of delivery of payment to a designated recipient on behalf of the client. Personal Care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

Authorizations to providers will be made at two (2) different payment levels. The higher level will be called Personal Care II and will be used, based on assessed need, when the majority of care is related to activities of daily living (e.g., hands-on care to include bathing, dressing, toileting, etc.). This service may also include monitoring temperature, checking pulse rate, observing respiratory rate, and checking blood pressure. The lower level, Personal Care I, will be authorized when, based on assessed need, all of the care is for instrumental activities of daily living (e.g., hands off tasks such as laundry, meal preparation, shopping, etc.). Personal Care I services do not include hands-on care. Both services allow the provider to accompany the participant on visits in the community when the visits are related to the needs of the participant, specified in the plan of care, and related to needs for food, personal hygiene, household supplies, pharmacy or durable medical equipment. You have the responsibility to identify the necessity of the trip, document the plan of care, authorize this component of the service, and monitor the provision of the services.

The unit of service is 15 minutes, provided by one Personal Care Aide (PCA).

***NOTE:** If the SFCS participant is Medicaid eligible and under age 21, he/she may be eligible for Children's Personal Care (CPCA) as a Medicaid State Plan service. If the State Funded Community Support participant may be eligible for CPCA, call (855) 278-1637 to refer to the South Carolina Department of Health and Human Services for services.*

Providers: Centers/organizations listed as providers of Personal Care on the Qualified Provider.

Listing found on DDSN's website at

<http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx>.

Arranging For The Service:

The Personal Care Needs Assessment (*Community Supports Form PC-34*) may be used to assess the need for Personal Care, but is not required. This assessment can be found on DDSN's Application Portal under "*Business Tools*" > "*Forms*" > "*CSW Waiver*" > "*CSW Manual Forms*" > "*Personal Care Assessment*." If not used, the assessment portion of the CMAP must reflect the tasks with which the assistance of a Personal Care Aide is needed. When Personal

Care services are needed and documented on the plan, a list of qualified service providers should be given to the person/representative, from which a provider can be chosen. The offering of choice should be documented.

When a start date is determined, the services can be budgeted using the State Funded Community Supports Budget Calculator and authorized. For Personal Care, one unit equals fifteen minutes of service. The **State Funded Community Supports (PC)** must be used to authorize the service. The **State Funded Community Supports (PC)** instructs the provider to bill the participant's Financial Management Provider for services rendered. The **State Funded Community Supports (PC)** will remain in effect until a new authorization is issued or until A Notice of Reduction or Termination is issued.

The completed **State Funded Community Supports (PC)** must be forwarded to the chosen Personal Care Provider. This form indicates whether Personal Care Services I (PC-I) or Personal Care Services II (PC-II) are to be provided and includes the tasks to be completed. These activities must correspond to the assessment.

The **State Funded Community Supports (PC)** authorization remains in effect until a new/revised **State Funded Community Supports (PC)** is sent or until a Notice of Reduction or Termination is issued.

The cost of Personal Care must be added to the **State Funded Community Supports Budget Calculator**. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

Monitoring the Services: The CMAP, which includes Personal Care services, should be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When Personal Care services are being reduced or terminated, the **Notice of Reduction or Termination (Form 1)** must be used to notify the participant/representative, the provider, and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Personal Care**

TO: _____
(Personal Care Services Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

Beginning on the date noted below, you are hereby authorized to provide the following service to the individual named above. Only the number of units rendered may be billed. NOTE: This nullifies any previous authorization to this provider for this service(s).

Personal Care Services:

PERSONAL CARE I - Number of Units per Week: _____ [one unit =15 minutes]

PERSONAL CARE II - Number of Units per Week: _____ [one unit =15 minutes]

Service Tasks Requested:

- Assistance with personal care activities (e.g., bathing, dressing, toileting, brushing teeth, grooming, shampooing, etc.)
- Assistance with meals (e.g., feeding, shopping for food, preparing/cooking meals, cleanup, etc.)
- Assistance with home care/light housekeeping tasks (e.g., sweeping, light laundry, bed making, bed linens, etc.)
- Monitoring conditions (e.g., temperature, pulse rate, respiratory rate, blood pressure, monitoring medications, etc.)
- Assistance with exercise, positioning, etc.

The individual 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 the Financial Management Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

(Financial Management Provider Name)

(Address)

Representative (Name of Individual to Contact)

(Phone Number)

(Email Address)

(Case Management Provider Name)

(Case Manager's Name)

Signature of Case Manager Authorizing Services

Dated: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization will end)

The authorization for service (s) issued to: _____
(Name of provider authorized to provide the service)

For service (s) to be provided to: _____
(Name of the individual receiving the service and his/her date of birth)

Is/are being *(check one)*: Reduced Terminated

Payment will not be made units of service (s) rendered after the effective date of this Notice of Reduction or Termination for the following service(s):

- | | |
|---|---|
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Personal Care (I and II) |
| <input type="checkbox"/> Adult Day Health Care – Transportation | <input type="checkbox"/> Behavior Support |
| <input type="checkbox"/> Adult Day Health Care – Nursing | <input type="checkbox"/> PERS |

Comments: _____

Direct any questions regarding this notice to: _____
(Case Manager's Name)

Phone Number: _____ Email Address: _____

Case Manager's Signature Date: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Support Center Services:

Definition: Non-medical care, supervision and assistance provided in a non-institutional, group setting outside of the individual's home to people who because of their disability are unable to care for and supervise themselves. Services provided are necessary to prevent institutionalization and maintain the individuals' health and safety. The care, supervision and assistance will be provided in accordance with a plan of care. An array of non-habilitative activities and opportunities for socialization will be offered throughout the day but not as therapeutic goals.

Transportation will be provided from the individual's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the individual's habilitation site to their residence when the service start time is after 12:00 Noon. The cost for transportation is included in the rate paid to the provider.

Providers: Services will be provided in facilities licensed by DDSN. A list of Support Center Services providers can be found on the Qualified Provider Listing found on DDSN's website at <http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx>. Providers may not be available in every county in the state and, in some locations across the state, only one provider may available.

Arranging for Services:

Once the participant has been determined to need non-medical care, supervision and assistance provided in a non-institutional, group setting outside of the individual's home, a choice of providers of this service should be offered and the offering of choice documented. If there is only one provider available, this must be explained to the participant and/or his/her legal guardian and documented.

One unit of Support Center equals one-half day as indicated on the Monthly Data Recording Sheet maintained by the Day Service provider. The **State Funded Community Supports (SC 1)** must be used to authorize the service. The **State Funded Community Supports (SC 1)** instructs the provider to bill the participant's Financial Management Provider for services rendered. The **State Funded Community Supports (SC 1)** will remain in effect until a new authorization is issued or a Notice of Reduction or Termination (Form 3) is issued.

The "Services Menu" of Service Tracking System (STS) must be updated to indicate the participant is receiving Support Center.

The cost of Support Center must be added to the **State Funded Community Supports Budget Calculator**. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded.

Monitoring: The CMAP, which must include Support Center Services, must be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When Day Activity is being reduced or terminated the **Notice of Reduction or Termination (Form 3)** must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Support Center**

TO: _____
(Support Center Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide the following service the individual named above. Only the number of units rendered may be billed. **NOTE: This nullifies any previous authorization to this provider for this service(s).***

Support Center

Number of Units per Week: _____ [one unit = 1/2 day or 2-3 hours]

The individual 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 the Financial Management Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider Name: _____

Address: _____

Representative: _____
(Name of Individual to Contact)

Phone Number: _____ Email Address: _____

Case Management Provider's Name: _____

Case Manager's Name: _____

Phone Number: _____ Email Address: _____

Signature of Case Manager Authorizing Services

Date: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization will end)

The authorization(s) for service (s) issued to: _____
(Name of provider authorized to provide the service)

For service (s) to be provided to: _____
(Name of the individual receiving the service and his/her date of birth)

Is/are being (*check one*): Reduced Terminated

Payment will not be made for units of service (s) rendered after the effective date of this Notice for the following service(s):

- | | |
|---|--|
| <input type="checkbox"/> Employment Services – Individual | <input type="checkbox"/> Career Preparation |
| <input type="checkbox"/> Employment Services – Group | <input type="checkbox"/> Community Services – Group |
| <input type="checkbox"/> Day Activity | <input type="checkbox"/> Community Services - Individual |
| <input type="checkbox"/> Support Center | |

Comments: _____

Direct any questions regarding this notice to: _____
(Case Manager's Name)

Phone Number: _____ Email Address: _____

Case Manager's Signature Date: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DDSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.

Private Vehicle Modifications:

Definition: Private Vehicle Modifications are modifications to a privately owned vehicle used to transport the participant and any equipment which are necessary to make the vehicle accessible to the participant. Modifications to government subsidized vehicles are not permitted. Private Vehicle Modifications may include:

- Consultation and assessment to determine the specific modifications/equipment;
- Follow-up inspection after modifications are completed;
- Training in use of equipment;
- Repairs to previously installed equipment not covered by warranty, and
- Replacement of parts or equipment.

This service may not be used to make general repairs to a vehicle used by the participant.

Providers:

Consultations/Assessments may be completed Licensed Occupational or Physical Therapists, Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/Contractors certified by Professional Resource in Management (PRIME) or by vendors whose qualification have been verified by the Case Manager.

The Financial Management Provider will determine who will install the modification.

Arranging for the Service:

Once the participant's need for a Private Vehicle Modification has been identified and documented in the Plan, the scope of the modification/specifications must be determined. This should be done in consultation with the participant/representative and vehicle owner and should define the expected modification as clearly as possible. There are two (2) ways to accomplish this task:

1. The expected modification can be defined by meeting with the participant/representative/vehicle owner, reviewing the modifications that are needed, and developing parameters/specifications. This is a crucial step to ensure that all requested bids are based on similar expectations;

OR

2. The expected modifications can be defined by obtaining a Private Vehicle Modification Consultation. A Consultation is highly recommended when multiple modifications are needed and the participant/representative/vehicle owner is unsure how to proceed or unable to clearly articulate the specifications. (The cost for the consultation will be deducted from the annual cost limit). If the project specifications will be defined using a professional, Private Vehicle Modifications - Consultation should be secured by

offering the participant/representative s choice of providers and issuing the **State Funded Community Supports (PVM-C)** form which instructs the provider to bill the Financial Management Provider for services provided. The cost of a consultation will vary but would not be expected to exceed \$600.00 per consultation.

When Private Vehicle Modifications - Installation is needed, the **State Funded Community Supports (PVM -I)** form should be used. This form instructs the Financial Management Provider that modifications are needed. The specifications for the project must be noted. If a consultation has been secured, the specification from the consultant should be attached. The MAXIMUM amount allowed for the Private Vehicle Modification must be included. This will instruct the Financial Management Provider as they seek a contractor/provider for the project. The Financial Management Provider with assistance from the Case Manager and the participant/representative/vehicle owner will secure bids if needed.

The **Private Vehicle Modification Project Agreement (PVM 2)** must be provided to the vehicle owner and signature agreeing to its terms obtained. This form must be sent to the Financial Management Provider.

The maximum amount allowed for the modification must be added to the State Funded Community Supports Budget Calculator. Under no circumstances may the annual cost limit of the State Funded Community Supports be exceeded. Once the project has been awarded to a contractor, the Financial Management Provider will notify the Case Manager of the actual cost of the project. The maximum amount previously entered into the Budget Calculator should be updated to reflect the actual cost of the modification.

NOTE: If the participant/representative or vehicle owner desires Private Vehicle Modifications above the SFCS maximum amount allowed, they can **privately** contract with and pay the same professional/contractor who is completing the SFCS project. However, any additional work funded by the family or other outside resources cannot be a part of the Authorization/Request for Private Vehicle Modifications and will not be the responsibility of the Case Manager, Financial Management Provider or DDSN.

Monitoring: The plan, which includes Private Vehicle Modifications, should be monitored in accordance with DDSN Case Management Standards.

Reduction or Termination of Services: When the Private Vehicle Modification service is being reduced or terminated the **Notice of Reduction or Termination (Form 2)** must be used to notify the participant/representative, the provider and the Financial Management Provider. See the Case Management section for more information.



**STATE FUNDED COMMUNITY SUPPORTS
Private Vehicle Modifications
Project Agreement**

Participant's Name: _____

DOB: _____

Terms:

I understand that the requested private vehicle modification(s) is/are being funded with public money.

I have seen and agreed to the specifications for the private vehicle modification(s).

I understand that only the listed specifications will be provided and funded as part of this project.

I understand that under South Carolina State Procurement Law, if the requested private vehicle modification project costs more than \$2,500.00, the project must be awarded to the lowest qualified bidder.

I agree that I will not request or instruct the provider to change any of the approved specifications after the project is awarded.

I understand that any additional work performed by the provider and/or any work separately negotiated with the provider will solely be my financial responsibility as the vehicle owner.

I agree to work cooperatively with the provider to insure a positive working relationship during the course of the project.

I agree to be available during the project should the provider need to take measurements or ask questions to insure modifications will be correct and beneficial.

I understand that I must notify the Case Manager immediately if any problems occur during the project.

I, _____, as owner of the vehicle to be modified, have read, understand, and agree to each of the above terms. I also understand that the requested private vehicle modification project cannot proceed without my signature below.

Signature of Vehicle Owner

Date: _____

Signature of Witness

Date: _____

Printed Name of Witness:



STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Private Vehicle Modification - Consultation

TO: _____
(Private Vehicle Modification - Consultation Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

Beginning on the date noted below, you are hereby authorized to provide a Private Vehicle Modification for the individual named above. Only the number of units rendered may be billed.

NOTE: This nullifies any previous authorization to this provider for this service(s).

Private Vehicle Modification – Consultation: \$ _____ (Price)

The individual 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 the Financial Management Provider serving the participant. For the individual noted above, please request payment from and direct questions regarding payment to:

Financial Management Provider's Name: _____

Address: _____

Representative: _____
(Name of Individual to Contact)

Phone Number: _____ Email Address: _____

Case Management Provider's Name: _____

Case Manager's Name: _____

Phone Number: _____ Email Address: _____

Signature of Case Manager Authorizing Services

Date: _____



**STATE FUNDED COMMUNITY SUPPORTS
Authorization/Request for Private Vehicle Modification -Installation**

TO: _____
(Financial Management Provider)

Re: Name: _____

Address: _____

Date of Birth: _____

*Beginning on the date noted below, you are hereby authorized to provide a Private Vehicle Modification for the individual named above. No more than the amount noted below will be paid. **NOTE: This nullifies any previous authorization to this provider for this service(s).***

Private Vehicle Modification

Make, model and year of vehicle to be modified: _____

Specifications/description of the modifications to be complete (attach drawings or pages if needed):

MAXIMUM PRICE FOR MODIFICATION: \$ _____

Case Management Provider's Name: _____

Case Manager's Name: _____

Phone Number: _____ Email Address: _____

Signature of Case Manager Authorizing Services

Date: _____



**STATE FUNDED COMMUNITY SUPPORTS
Notice of Reduction or Termination**

Effective: _____
(Date the authorization for the service will end)

The following service *(check one)*:

- Assistive Technology/Appliances - Consultation
- Assistive Technology/Appliances: _____
- Environmental Modification/Consultation Environmental Modification
- Private Vehicle Modification/Consultation Private Vehicle Modification
- Respite and Support

Incontinence Supplies:

- Diapers/briefs Under pads Incontinence pads/liners Gloves Wipes

Which is authorized through the State Funded Community Supports program to be provided to:

(Name of the State Funded Community Supports participant and his/her date of birth)

Is being *(check one)*: Reduced Terminated

Payment for the service indicated above will not continue will not be made for services rendered after the effective date of this Notice.

Comments: _____

Direct any questions regarding this notice to: _____
(Case Manager's Name)

Phone Number: _____ Email Address: _____

Case Manager's Signature Date: _____

In accordance with DDSN's Directive 535-11-DD: Appeal and Reconsideration Policy and Procedures, State Funded Community Supports participants have the right to appeal any decisions with which he/she disagrees. Appeals should be in writing and mailed to DSN, Attn: State Director, P.O. Box 4706, Columbia, SC 29240.



STATE FUNDED COMMUNITY SUPPORTS Required Specifications for Ramps:

Ramps funded by the DDSN must meet the following minimum requirements or comply with ANSI A117.1-1998:

Materials: The use of treated lumber (rated for ground contact) is required throughout the ramp (local building codes may be more specific as to the level of treatment in the lumber). Earth berming, used in conjunction with ramping is permissible due to uneven terrain.

Width: The usable platform width of all ramps must be a minimum of 36 inches.

Slope: The slope or grade of the ramp must be no less than one foot of linear ramp for every 1 inch of height that is to be ascended.

Designs: Fold-back (180 degree or 90 degree) turn designs are permissible. At each point where the ramp's direction changes there must be a functional turning platform with adequate space for the participant's mobility device to safely brake and/or change directions.

Wheelchair Turning Platforms/Landings: All turning platforms or "landings" (usually at the top end of the ramp or where the ramp changes directions) that lead directly into the home must be a minimum of five feet by five feet (5' x 5') for a safe functional space to turn and enter the home. At any exterior entry/exit door, the turning platform should start at the hinged side of the door and extend beyond the latch side of the door to best utilize the available space to turn and maneuver a wheelchair.

Decking Material: All decking boards must be of sufficient thickness to maximize strength, provide stability, and maximize the life of the ramp.

Railings: All ramps should include handrails with pickets or other designs that will prevent wheelchairs from accidentally rolling off the sloped surface of the ramp.

Support Structures: Where it is necessary such as soft grass, soil, sand, loose gravel or muddy areas, or as local building codes dictate, all the ramp support posts and turning platform support posts shall be set in concrete for long-term stability.

Landing Pads: At the lower or ground end of the ramp, and where necessary such as soft grass, soil, sand, loose gravel or muddy areas, ramps shall include a concrete minimum four feet by four feet (4' x 4') landing pad, for function and safety. Ramps that end, for example, onto a hardened surface or a concrete driveway usually do not require a concrete landing pad.

Repairs to Existing Ramps:

If the project is to simply repair an existing ramp that is in unsatisfactory condition, the repairs must not in any way bring a ramp out of accessibility compliance regulations or exceed the cost of replacing the ramp with a new one.



STATE FUNDED COMMUNITY SUPPORTS
Required Specifications for Widening Doorways/Installing Door Hardware:

Modifications to widen doorways or install door hardware funded by DDSN must meet the following minimum requirements or comply with ANSI A117.1-1998:

Width: Whenever possible, a doorway must always be expanded to three (3) feet (or a 3'0" doorway). The three (3) foot door allows better function for a wider variety of mobility devices and can usually accommodate upgraded wheelchair prescriptions. In some cases existing architectural designs may circumvent widening the door to a full three (3) feet. This should be brought to the attention of the Case Manager at any time prior to authorization of the project.

Lever door hardware: Lever-type door hardware must always be used when participants have limited hand/finger dexterity. In some cases the custom mounting of large "D" pull-type handles might be necessary to maximize one's independence in opening and closing doors. For participants with limited finger dexterity, locks for bedroom/bathroom doors should be the push-to-lock design.

Thresholds: When doorways are widened, thresholds should be kept to a minimum of ½ inch or less, to prevent a barrier for those participants who use manual wheelchairs and/or shower chairs.



STATE FUNDED COMMUNITY SUPPORTS

Bids for Modifications:

(Environmental or Private Vehicle)

Depending on the anticipated cost of the modification(s) to be made, bids may be required in order to comply with DDSN's Directive 250-08-DD: Procurement Requirements for Local DSN Boards. Any modification costing less than \$2,500.00 will not require competitive written bids. However, any modification costing \$2,500.00 up to \$10,000 requires the solicitation of three (3) different written bids. A "no-bid" response is accepted as part of the solicitation process. Any purchase over \$10,000 requires the written solicitation of bids, from various providers, and the project must be advertised following the procurement policy.

When bids are needed, the clearly written specifications must be available to be provided to those contractors/companies from whom a bid is requested. The participant/representative/home owner should be assisted as needed to obtain the bids and should be advised that the home may need to be available to potential bidders for assessment. Three (3) written bids must be obtained and submitted to the Financial Management Provider.



**STATE FUNDED COMMUNITY SUPPORTS
Acknowledgement of Receipt of Bid**

To: _____
(Name of Bidder)

From: _____
(Name of Case Manager and Name of Provider)

Date: _____

Re: _____
(Name of SFCM Participant) (Name of Home Owner)

Address of Home to be modified: _____

A bid in the amount of \$_____ for the completion of modifications to a home owned by the individual noted above on behalf of the participant noted above has been received. Your bid will be reviewed along with others submitted.

If you are awarded this project, you will be notified in writing. Please be advised that neither DDSN nor its contracted providers will be responsible for any work performed prior to the project award. Additionally, neither DDSN nor its contracted providers will be responsible for work provided in the absence of written notification/authorization to perform the work.

Thank you for your submission.

State Funded Community Supports (EM - Bid) 12/1/2014



**STATE FUNDED COMMUNITY SUPPORTS
Acknowledgement of Receipt of Bid**

To: _____
(Name of Bidder)

From: _____
(Name of Case Manager and Name of Provider)

Date: _____

Re: _____ (Name of SFCM Participant) _____ (Name of Vehicle Owner)

Make, Model and Year of Vehicle to be modified: _____

A bid in the amount of \$_____ for the completion of modifications to a vehicle owned by the individual noted above on behalf of the participant noted above has been received. Your bid will be reviewed along with others submitted.

If you are awarded this project, you will be notified in writing. Please be advised that neither DDSN nor its contracted providers will be responsible for any work performed prior to the project award. Additionally, neither DDSN nor its contracted providers will be responsible for work provided in the absence of written notification/authorization to perform the work.

Thank you for your submission.

State Funded Community Supports (PVM - Bid) 12/1/2014