South Carolina Department of Disabilities and Special Needs

RESIDENTIAL VACANCY REPORT

DSN Board/Private Provider: ______________________________ Month/Year: ________________

Date of Vacancy: ____________ Name of Residential Program: ____________________________

Name of Individual discharged to create vacancy: ____

Type of Program (e.g., SLP, CTH-II, ICF/IID): ______________

Individuals Considered for Admission into Vacancy During Past Month (name and current setting):

____

Anticipated Date/Individual to be Admitted into Vacancy (if none; explain why):

____

Date of Vacancy: ____________ Name of Residential Program: ____________________________

Name of Individual discharged to create vacancy: ____

Type of Program (e.g., SLP, CTH-II, ICF/IID): ______________

Individuals Considered for Admission into Vacancy During Past Month:

____

Anticipated Date/Individual to be Admitted into Vacancy (if none; explain why):

____

Date of Vacancy: ____________ Name of Residential Program: ____________________________

Name of Individual discharged to create vacancy: ____

Type of Program (e.g., SLP, CTH-II, ICF/IID): ______________

Individuals Considered For Admission into Vacancy During Past Month:

____

Anticipated Date/Individual to be Admitted into Vacancy (if none; explain why):

____

DSN Board/Private Provider Certification

I hereby certify that the information contained in this report is accurate.

____ Date: ______________________

Executive Director Signature

(Send to DDSN District Office Assistant District Director)

SAMPLE