SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Request for PDD Waiver Slot Allocation

Section 1: Participant Information **Date:**

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Name of Participant:	Social Security Number:
Address:	Medicaid #:
	If no Medicaid, has application been made? ☐ Yes ☐ No
Date of Birth:	☐ Male ☐ Female
Parent / Legal Guardian Name:	
Is this participant covered under a Ryan's Law insurance provider? ☐ Yes ☐ No	
☐ Autism ☐ Asperger's Syndrome ☐ Other PDD (specify)	
☐ Eligible ☐ Eligibility Pending	
Section 2: Provider Information:	
Case Manager:	Provider:
Address:	
Case Manager Supervisor:	County:
Section 3: Other Waiver Information:	
Is the participant in any other Medicaid Waiver? ☐ Yes ☐ No	
If yes: Name of Waiver: My signature here indicates my understanding that I can participate in no more than one waiver at any given time. Therefore, I wish to participate in the: ID/RD Waiver ☐ PDD Waiver ☐ Community Supports Waiver ☐ **Parent/Legal Guardian Signature:** **Date:**	
Type and amount of services received:	
Section 4: Family Support Information:	
Is the participant receiving ongoing family support funds through DDSN? ☐ Yes ☐ No	
If yes: What is the amount of funding and type of service received per month?	

Section 5: Indicate specifically how Early Intensive Behavioral Intervention will assist the consumer and prevent the need for institutional placement. Include specific information regarding the consumer's behaviors.

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_____ **The following information/documents must be attached to this application:** If the consumer is age 3 or older, there must be documentation that supports the diagnoses checked above.

*Case Manager Supervisor signature confirms all necessary information is attached.

Case Manager Signature / Date Case Manager Supervisor Signature / Date

*Case Manager Supervisor signature confirms all necessary information is attached.

Case Manager Signature / Date

Case Manager Supervisor Signature / Date