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SOUTH CAROLINA DEPARTMENT OF DISABILITIES & SPECIAL NEEDS

Hospice Services Information Sheet

FACILITY INFORMATION

Provider Name:	**Provider Number:**

HOSPICE INFORMATION

Consumer Name:	
Medicaid Number:	**Consumer SSN (Last 4 Digits):**
Hospice Admission Date:	**Patient ID:**
Hospice Provider Name: **Address:**	**Hospice Contact Person:** **Phone #:**
Hospice Medicaid Provider Number:	
Hospice Primary Nurse (if available):	
Hospice Medical Director (if available):	

Form Completed By: _____

Contact Phone #/Email: _____

District Office Only:

Reviewed By: _____
District Office Signature

Title: _____

Date: _____

Forward to: ***DDSN Finance Division, Attn: SURB, PO Box 4706, Columbia SC 29240***

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South Carolina Department of Disabilities and Special Needs
Residential Census Log
FOR NEW RESIDENTIAL FACILITIES

Regional Center:	
Provider:	
Facility Name:	
Month:	

Individual's Name	Soc Sec # (Last 4 only)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total

Notes:
Complete this log for all new individuals entering the above named facility. Enter the name and social security number for each individual. Make sure that all the above named individuals are added to the STS system. This is imperative to insure future generated logs.

Preparer's Signature: _____

Authorized Desiginated Signature: _____

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SOUTH CAROLINA DEPARTMENT OF DISABILITIES
AND SPECIAL NEEDS

SPL/ISR MAILING REQUEST FORM

Provider: _____ **Date of Request:** _____

Document Type, Program/Facility	Name/Address of SPL/ISR Recipient	Requested By: Your Name, Title & Signature
1)		
2)		
3)		
4)		

Mail completed form to:

SC Department of Disabilities and Special Needs
ATTN: SURB
P. O. Box 4706
Columbia, SC 29240

SCDDSN USE ONLY
Address file updated:

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SOUTH CAROLINA DEPARTMENT OF DISABILITIES
& SPECIAL NEEDS

SPL/ISR APPROVAL SIGNATURE DESIGNATION FORM

Provider: _____ **Date of Request:** _____

DOCUMENT TYPE PROGRAM/FACILITY	AUTHORIZED SIGNATURE (Name, Title, Signature)	REQUESTED BY (Your Name, Title, Signature)
1.		
2.		
3.		

Mail completed form to: **SC Department of Disabilities and Special Needs**
ATTN: SURB
P. O. Box 4706,
Columbia, SC 29240

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SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

INDIVIDUAL SUMMARY OF BOARD-BASED HASCI SERVICES

DSN Board:		
Services Provided to:		**SS# (Last 4):**

Service Invoice Code	Unit of Service	Date of Service	No. of Units of Service	Rate	Total
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
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				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$

REQUIREMENT: All services listed above have been provided to the individual named above. Regional documentation of service delivery is available through the DSN Board named above.

Signature ______________________________
HASCI Waiver Case Manager

For Central Office Use Only
SURB Audit Complete:

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SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

MONTHLY PROVIDER SUMMARY OF BOARD-BASED HASCI SERVICES

DSN Board:	
Month & Year Invoiced:	

Services Provided to:

Line #	SS# (Last 4)	Service Recipient	Amount Due
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
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			$
			$
			$
			$
			$
			$
			$
			$
			$

REQUIREMENT: All amounts listed above are for approved HASCI Waiver services and they are supported by the attached signed INDIVIDUAL SUMMARY OF BOARD-BASED HASCI SERVICES form.

Signature _____ Signature _____

Executive Director *Chief Financial Officer*

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SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
REHABILITATION SUPPORTS
REPORT OF SERVICE

PROVIDER: _____

MONTH/YEAR OF SERVICE: _____

CONSUMER: _____ SS#: (Last 4 Digits) _____

STAFF: _____ TITLE: _____

**********REPORT FACE TO FACE SERVICES ONLY**********

DATE OF SERVICE	BEGINNING TIME	ENDING TIME	BEGINNING TIME	ENDING TIME	PROVIDER UNITS	DDSN USE

PAYABLE UNITS _____

COMMENTS: _____

_____ _____ _____ _____
Staff Signature Date Supervisory Approval Date

RS Form 6 (08-10)

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SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
REHABILITATION SUPPORTS

SUMMARY INVOICE FOR REHABILITATION SUPPORTS PROVIDED

DSN Board: _____

Invoice Number: _____

Contract Number: _____

Month and Year Services Delivered: _____

Units of Service Delivered: _____

Contract Rate: $ _____

Total Amount Due (Units x Contract Rate): $ _____

PROVIDER CERTIFICATION: All units of service billed above have been provided in accordance with DDSN's contractual guidelines for Rehabilitation Supports and with my specific authorization. All units billed above are documented on a completed Rehabilitation Supports Report(s) of Services, which are attached.

_____ _____
DSN Board Signature Date

For Central Office Finance use:

The Units billed above are supported by properly completed Rehabilitation Supports Report(s) of Service, and the Units have been received against the applicable contract.

_____ _____
Central Office Signature Date

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SOUTH CAROLINA DEPARTMENT OF DISABILITIES & SPECIAL NEEDS

Community Supports Waiver – Service Documentation

Environmental Modifications/Assistive Technology/Private Vehicle Modifications for Services billed to the DSN Board

Provider Agency:		
Address:		
City:	**State:**	**Zip:**
Contact Person:	**Phone Number:**	
Consumer's Name:	**SSN # (Last 4):**	
Modification Type & Description:		
Cost: $	Date of Completion:	

PROVIDER CERTIFICATION: *The item listed on this form has been provided to the consumer named above as per the attached documentation.*

Signature	***Title***	***Date***

Please attach a copy of the following documentation:

1. **Vendor's Invoice AFTER work is completed.**
2. **Check submitted to Contractor.**
3. **Completed Authorization for Service form.**

This form and the documentation listed above MUST be submitted to SURB either through the RBC System or by U.S. Mail at SCDDSN Attn: SURB, PO Box 4706, Columbia, SC 29240

FOR DDSN/SURB USE ONLY *This service has been billed to Medicaid.*	
Signature:	Date:

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SOUTH CAROLINA DEPARTMENT OF DISABILITIES & SPECIAL NEEDS

ID/RD Waiver Request for Payment of
Assistive Tech, Environmental or Private Vehicle Modifications

Provider Agency:		
Address:		
City:	**State:**	**Zip:**
Contact Person:	**Phone Number:**	

Consumer's Name:	**SSN # (Last 4):**
Type of Modification:	
Cost of Modification (Amount Requested): $	
Date of Completion:	

Please attach a copy of the following documentation:

- ► Vendor's invoice.
- ► Waiver Authorization.
- ► Provider's payment to the Vendor as verification.

Failure to submit all required documentation will delay payment.

PROVIDER CERTIFICATION: *The modification listed on this form has been provided to the individual named above as per the attached documentation.*

Signature	***Title***	***Date***

For SURB Use		**For Accounts Payable Use**	
The appropriate documentation has been received for this environmental modification. This invoice may be released for payment.		*The Accounts Payable audit is complete.*	
Initials:	**Date:**	**Initials:**	**Date:**