SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

REQUEST FOR MR/RD WAIVER SERVICE ADDITIONS IN ALTERNATIVE RESIDENTIAL PLACEMENT

Section 1: Participant Information

Name of Individual:				**Date:**	
Birth Date:	_____/_____/_____		**Social Security Number:**		
Current Residential Placement	☐	Therapeutic Foster Home_____ Location	☐	New Hope_____ Location	
	☐	High Management Group Home _____ Location	☐	LFS Victory House	
	☐	MENTOR _____ Location	☐	Other_____	
Date of Placement:	_____/_____/_____				
SCDDSN Eligibility Category:					
☐	MR/RD	☐	Autism	☐	At-Risk/High Risk	☐	Time Limited MR/RD

Section 2: Provider Information

Service Coordinator/Early Interventionist:	
DSN Board/Provider:	
Address:	

Section 3: Request Information

Service Requested		Anticipated Units Per Month or Needed Items	One-Time or Ongoing/Comments
Adult Companion Services	☐		
Adult Day Health Care	☐		
Behavior Support Services	☐		
Day Activity	☐		
Nursing Services	☐		
Occupational Therapy	☐		
Personal Care Services I or II	☐		
Physical Therapy Services	☐		
Career Preparation	☐		
Psychological Services	☐		
Respite	☐		
Assistive Technology	☐		
Speech Therapy Services	☐		
Employment Services	☐		

Support Center Services	☐		
Community Ser vices	☐		

Section 4: Justification

Section 4: Indicate how the services will assist the consumer and prevent the need for institutional placement. Explain efforts to resolve service need with the Alternative Residential Placements Provider. If the request is for Assistive technology, please include each specific medical supply or equipment along with anticipated schedule of use (e.g. 3 cases of diapers per month), and cost.

_____

_____

_____

_____

_____

_____

_____

I verify that the Support Plan/IFSP/FSP has been reviewed and supports the request for the requested MR/RD Waiver Services. The Support Plan/IFSP/FSP is attached.

_____ _____

Service Coordination/Early Intervention Supervisor **Date**

Section 5: Approval/Denial

☐ **Approved** ☐ **Denied**

_____ _____

SCDDSN MR/RD Waiver Coordinator **Date**

☐ **Approved** ☐ **Denied**

_____ _____

Office of Clinical Services **Date**

☐ **Approved** ☐ **Denied**

_____ _____

Director Cost Analysis **Date**

MR/RD Form 33 (4/09)