State Funded Community Supports
Notice of Reduction or Termination

To:_____

From:_____

Participant's Name:_____

Date of Birth:_____

YOU ARE HEREBY NOTIFIED TO REDUCE OR TERMINATE THE FOLLOWING SERVICE(S) TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE MAY BE BILLED.

Note:** ***If services are reduced, a new authorization must be issued.

Effective Date:_____

☐Reduced ☐Terminated *(check one)*

☐Adult Day Health Care Services
☐Adult Day Health Care Services – Nursing
☐Assistive Technology/Appliances
☐Assistive Technology/Appliances – Consultation
☐Behavior Support
☐Career Preparation
☐Day Activity
☐Incontinence Supplies:
- ☐*Diapers or briefs*
- ☐*Gloves*
- ☐*Pads/liners*
- ☐*Underpads*
- ☐*Wipes*

☐Employment Services - Group
☐Employment Services – Individual
☐Environmental Modification
☐Environmental Modification Consultation
☐PERS
☐Personal Care
☐Private Vehicle Modification
☐Private Vehicle Modification Consultation
☐Community Services
☐Support Center

Case Management Board/Provider:_____

Case Manger's Name:_____

Phone Number *(include area code)*:_____ Email Address:_____

_____ Date:_____
Signature of Case Manager Authorizing Services

In accordance with DDSN's policy 535-11-DD: Appeal and Reconsideration of Decisions, State Funded Community Supports participants have the right to appeal any decisions. Appeals should be in writing and mailed to State Director of DDSN, 3440 Harden Street Extension, Columbia, SC 29203.