

South Carolina Department of Disabilities and Special Needs

COMMUNITY RESIDENTIAL ADMISSION/DISCHARGE/ TRANSFER REPORT

Person's Name: _____ SSN: _____

Residential Provider: _____

Service Coordination Provider: _____

Type of Action (check one)

New Admission Transfer Discharge

If a form is approved and the individual moves to a different unit than that which appears on this A/D/T form, the form will need to be resubmitted by fax to the Quality Management Division 803-898-7450 with a notation indicating the actual address and unit to which the individual moved.

Action Restrictiveness (check one)

More Less Equal N/A (Moving to/from non-DDSN residential setting)

New Admission: (only complete for those who are not currently receiving DDSN funded residential services)

Date Placed on Critical Needs Waiting List: _____ OR Date Placed on Priority I Waiting List: _____ OR Is Living with Aging Caregiver: _____

Date of Proposed Admission: _____ Date Residential Services Desired: _____

Proposed Residential Setting (Name): _____ Type of Residential Setting (e.g., CTH-II): _____

For SLP-I only: Date of Supported Living Assessment: _____ For CTH-I/SLP-I: Date slot allocated from statewide pool: _____

Proposed Residential Address: _____ Apt. #: _____
Street City/State Zip

Is there a current license that would accommodate this admission? Yes No Date of last licensing inspection: _____
(# Total Occupancy Needed: _____ Adult(s) _____ Child(ren))

When requesting a new license, please submit Electrical, HVAC and Fire Marshal Inspections. If a consumer is under 21 years of age and moving into a CTH I or CTH II, also submit DHEC Sanitation Inspection. Send to Central Office Attn: Quality Management/Licensing. Documents should be submitted as a single packet. For CTH-I, please attach page 2 of the Application to Operate.

Current Waiver Participant: _____ Type: _____ Date of Enrollment: _____

Proposed Funding Band/Rate: _____ (Include a justification in Rationale section if a Band different from the standard funding band* is requested).

*Standard funding bands for new admissions: ICF/ID, CRCF and CTH II = Band G; SLP II = Band C; SLP I = Band D; CTH I =Band E and Enhanced CTH I = Band F.

Discharge (only to be completed for those who will no longer receive residential services from any DSN Board or Contracted Provider)

Residential Setting Discharged From (Name): _____ Apt #: _____ County: _____

CLOSE this Residential Address: YES Keep this Residential Address Open: YES

Date of Proposed Discharge: _____ Proposed Service Agency After Discharge: _____

Proposed Post-Discharge Service (e.g., no service, in-home services, Nursing Facility, Private CRCF, etc.):

Proposed Post-Discharge Service Funding Source (e.g., HCB waiver, state-funded day supports, state plan Medicaid, etc.):

Transfer (only complete for those who are currently receiving DDSN funded residential services)

Date of Proposed Transfer: _____ ID/RD Waiver Enrollment Date: _____

Proposed Residential Provider: _____ Proposed Type of Residential Setting (e.g., CTH-II): _____

Proposed Residential Setting (Name): _____ Apt. #: _____ Telephone: _____

Proposed Residential Setting Address: _____
Street City/State Zip

For SLP-I only: Date of Supported Living Assessment: _____ For CTH-I/SLP-I: Date slot allocated from statewide pool: _____

Is there a current license that would accommodate this admission? Yes No Date of last licensing inspection: _____
(# Total Occupancy Needed: _____ Adult(s) _____ Child(ren))

When requesting a new license, please submit Electrical, HVAC and Fire Marshal Inspections. If a consumer is under 21 years of age and moving into a CTH I or CTH II, also submit DHEC Sanitation Inspection. Send to Central Office Attn: Quality Management/Licensing. Documents should be submitted as a single packet.

Current Residential Provider: _____ Current Type of Residential Setting (e.g., CTH II): _____

Current Residential Setting (Name): _____ Apt. #: _____ Telephone: _____

Current Residential Setting Address: _____
Street City/State Zip

CLOSE this Residential Address: YES Keep this Residential Address Open: YES

Current Funding Band: _____ Proposed Funding Band: _____

(Include a justification in rationale section if a Band different from the standard funding band assignment* is requested)

*Standards funding band assignments for transfers: From Regional Center or alternative placement to ICF/ID, CRCF and CTH II = Band H. For all other transfers: ICF/ID, CRCF and CTH II = Band G; SLP II = Band C; SLP I = Band D; CTH I = Band E and Enhanced CTH I = Band F.

Rationale: Explain why the proposed admission/transfer/discharge is recommended – may attach Program Team meeting minutes – must attach documentation of HRC approval for More Restrictive actions – also must include justification for funding at a band higher than standard band assignment as noted above.)

Statements contained in this document are correct. I understand the facility must be in compliance with all applicable Federal, State and local laws and regulations and all applicable DDSN contracts, policies, procedures, and standards, and that noncompliance with these terms may result in enforcement actions as identified in DDSN Directive 104-01-DD: Certification and Licensure of Residential and Day Facilities, and/or DDSN/Provider Contract. I also understand that Residential Habilitation may NOT be billed under any HCB Waiver, unless provided in a licensed CTH-I, CTH-II, SLP-II or unless there is a current, valid SLP-I assessment on file. CDSS and RESLOGS must be updated within 2 business days.

DDSN Board/Contracted Service Provider Certification

Executive Director Date: _____

SCDDSN Approval Pending Final Action

Assistant District Director Date Date Residential Waiver Slot Awarded

District Director Date Date LOC Approved

Director of Cost Analysis Date Medicaid Financial Eligibility Approved