

**Statement of Legal Responsibility**

Medicaid Beneficiary's Name: \_\_\_\_\_

Medicaid ID # or SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

South Carolina Medicaid policy prohibits anyone who is legally responsible for the health care decisions of another to be paid for rendering care/services to that person. If you are legally responsible for the health care decisions of the person noted above you cannot be paid for providing care/services. By signing this statement you acknowledge that you are not legally responsible for the health care decisions of the Medicaid beneficiary noted above.

I am not legally responsible for the person noted above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name