

# CHAPTER 8

## Extension, Reduction, Suspension, Denial or Termination of Waiver Services

Any time a waiver service is denied, reduced, suspended, or terminated, the individual and/or legal guardian must be given written notice of the action and must be given written notice of the right to request reconsideration /appeal. Additionally, there is a ten (10) calendar day waiting period (from the date the form is completed and sent to the individual/legal guardian) before proceeding with the reduction, suspension, or termination. Exceptions that do not require the 10 calendar day waiting period are as follows:

- Denial of Waiver service
- Individual requested reduction
- Loss of Medicaid eligibility
- Voluntary withdrawal
- Death
- Individual moves out of state
- Individual moves to another HCB Waiver
- Individual cost limit has been reached
- Suspension of services due to admission to Hospital, Nursing Home, ICF/MR, or Jail

### Extensions

The Community Supports Waiver is different from many home and community-based waiver programs in that it includes an individual cost limit. This cost limit is the maximum dollar amount allocated to each waiver individual per waiver year (state fiscal year) that can be spent for authorized waiver services as indicated on the Plan. This allocated amount does not include any amount spent on state plan services or targeted case management. Waiver individuals/legal guardians should be instructed that the allocated amount per individual/per year is the total amount available for CS waiver services and must be used to fund assessed needs. To document this information, the **Cost Cap Acknowledgement form (Community Supports Form CCA 1)** must be signed and dated by the individual/legal guardian and Service Coordinator at the time of the annual plan. This will confirm an understanding of the yearly cost cap. You must give one signed copy to the individual/legal guardian and keep one signed copy in the participant record. It is expected that each individual will receive authorized services consistent with his/her Plan. Additionally, it is expected that Service Coordination staff will instruct individuals/legal guardians to consider the benefits of reserving a portion of their cost cap throughout the course of the year for unexpected situations. Service Coordinators will carefully monitor utilization of waiver services to ensure that individuals/legal guardians are aware/remain aware of the individual cost cap and how much funding is available to meet the assessed need.

However, for some individuals, unanticipated situations (i.e. crisis) will occur. When unanticipated changes happen, every effort must be made to respond to the changes within the confines of the cost limit. In the rare

event that the person's needs change due to unanticipated circumstances, and the needs cannot be met within the confines of the cost limit, two options are available.

- 1) If an individual, due to an unanticipated change in his/her condition or situation, has increased needs that will require the long term, ongoing authorization of services that exceed the waiver cost limit, he/she will be referred for enrollment in the ID/RD waiver.
- 2) If an individual, due to an unanticipated, urgent change in his/her condition/situation, has increased needs that can be met by the short-term authorization of Community Supports Waiver services, an extension of the individual cost limit may be allowed. A short-term, unanticipated, urgent need (crisis) is defined as a situation in which the individual:
  - 1) requires, on a short term basis, a service available through the Community Supports Waiver which if not provided will likely result in serious and imminent harm, **and**
  - 2) has an immediate need for direct care or supervision due to a change in his/her condition **or**
  - 3) has recently lost his/her primary caregiver and needs temporary care until further arrangements are made, **or**
  - 4) has a caregiver who is temporarily and unexpectedly hospitalized, **or**
  - 5) is ready for or has recently been discharged from a hospital and immediately needs services, on a short-term basis, to allow discharge or prevent readmission.

Extensions will not be approved for those individuals who exhausted their funding (up to the individual cost limit) prior to the next year's reallocation without a crisis situation identified and validated. Costs exceeding the individual cost cap without approval become the fiscal responsibility of the local Board/qualified provider. The CS waiver is not responsible for any amount or costs that individuals incur over the individual waiver cost cap.

When the crisis situation is identified, a thorough explanation of the situation must be provided to the State Community Supports Waiver Coordinator for validation at the following address:

**SC Department of Disabilities and Special Needs**  
**Attention: Michelle Abney**  
**3440 Harden Street Ext.**  
**P.O. Box 4706**  
**Columbia, South Carolina 29240**

This explanation must include the nature of the unanticipated change; an explanation of why the change is urgent or creates a crisis (must correspond to reasons defined above); the services and amount of service authorized or to be authorized to address the crisis, the length of time anticipated before stabilization, and your email address and the email address of your Supervisor. All efforts to address the crisis within the confines of the cost limit must be explained thoroughly including the reasons why efforts were not successful. Any supporting documentation should be submitted.

Once received, the information will be reviewed to determine/validate that a crisis situation exists. You will be notified via email of the determination. This validation should be printed and placed in the individual's file. At the end of the fiscal/budget year, if services related to the crisis situation resulted in the individual cost limit being exceeded and the crisis situation has been validated, additional state dollar funds to cover the cost of those crisis response services provided can be requested from DDSN State Office. The Community Supports waiver is not permitted to fund waiver costs that exceed the individual cost cap per waiver participant/per waiver year.

## **Denials**

If the individual and/or legal guardian requests a service(s) but it is denied (either at the local or state level) you must complete the **Notice of Denial (Community Supports Form 16-A)** within two (2) business days of notification that the service is denied. The denied services(s) must be indicated on the form along with the reason(s) and any supporting comments. The effective date is the same date the form is completed. The original **Notice of Denial (Community Supports Form 16-A)** must be sent to the individual/legal guardian along with the reconsideration/appeals process. A copy of the denial must also be placed in the individual's file. The individual/legal guardian has thirty (30) calendar days to request reconsideration.

## **Terminations**

If an individual's service(s) will be terminated, you must complete the **Notice of Termination of Service (Community Supports Form 16-B)**. The service(s) must be indicated on the form along with the reason and any supporting comments. The effective date for termination must be at least 10 calendar days from the date the form is completed and mailed to the individual/legal guardian. This gives the individual/legal guardian the opportunity to request a reconsideration of the decision. The original **Notice of Termination of Service (Community Supports Form 16-B)** must be sent to the provider of the service, a copy must be sent to the individual and/or legal guardian along with the reconsideration/appeal process, and a copy must be placed in the individual's file.

**Note:** For exceptions where the ten (10) calendar day waiting period is not required, the effective date of termination is the same day the form is completed.

Although termination of services will be effective ten (10) calendar days from the date the form was completed/mailed to the individual/legal guardian, the individual/legal guardian has thirty (30) calendar days to request reconsideration. If the request is received within ten (10) calendar days of the notification, the individual may choose to have the service(s) uninterrupted while awaiting the outcome of the reconsideration. However, if the reconsideration is upheld, the individual/legal guardian may be liable for payment of those services.

**Note:** If the individual/legal guardian requests reconsideration within ten (10) calendar days and chooses to continue services during the reconsideration process, you must contact the provider of service and ensure that the service is uninterrupted. This contact must be documented in the individual's record.

## **Suspensions**

During an individual's enrollment in the Community Supports Waiver, there may be circumstances when service(s) needs to be suspended. One example is when an individual is admitted to a hospital, nursing home, ICF/MR, or jail, and it is likely he/she may discharge within thirty (30) calendar days. In these instances, all waiver services must be suspended, including incontinence products which might be arranged on automatic delivery. A ten (10) calendar day waiting period is not required in cases when the individual has been hospitalized, admitted to a nursing facility, ICF/MR, or is in jail. The effective date of suspension is the same day the form is completed. **If the service(s) suspended is the only waiver service the individual is receiving and it has been suspended for more than 30 days, please follow the disenrollment policy stated in Chapter 7.**

For other situations when an individual's waiver service(s) is suspended, you must complete the **Notice of Suspension of Service (Community Supports Form 16-C)**. The suspended service(s) must be indicated on

the form along with any supporting comments. The effective date for suspension must be at least ten (10) calendar days from the date the form is completed/mailed to the individual/legal guardian. This gives the individual/legal guardian the opportunity to request a reconsideration of the decision. The original **Notice of Suspension of Service (Community Supports Form 16-C)** must be ~~is~~ sent to the provider of the service, a copy must be sent to the individual and/or legal guardian along with the reconsideration/appeal process, and a copy must be placed in the individual's file.

Although suspension of services will be effective ten (10) calendar days from the date the form was completed and mailed to the individual/legal guardian, the individual/legal guardian has thirty (30) calendar days to request reconsideration. If the reconsideration request is received within ten (10) calendar days of the notification, the individual/legal guardian may choose to have the service(s) uninterrupted while awaiting the outcome of the reconsideration. However, if the reconsideration is upheld, the individual/legal guardian may be liable for payment of those services.

**Note:** If the individual/legal guardian requests reconsideration within ten (10) calendar days and chooses to continue services during the reconsideration process, you must contact the provider of service and ensure that the service is uninterrupted. This contact must be documented in the individual's record.

Once the individual is ready to resume the service(s), you must submit a new authorization form to the designated provider(s). If an individual is not able to resume services after thirty (30) calendar days, please follow the disenrollment policy stated in Chapter 7.

If the Level of Care certification or the Support Plan exceeds three hundred sixty five (365) calendar days, waiver services must be suspended until a current Level of Care certification of Support Plan is completed, at which time a new authorization form must also be completed.

## **Reductions**

If service(s) will be reduced, you must complete the **Notice of Reduction of Service (Community Supports Form 16-D)**. The reduced service(s) must be indicated on the form along with any supporting comments. The effective date for termination must be at least ten (10) calendar days from the date the form is completed and mailed to the individual/legal guardian. This gives the individual/legal guardian the opportunity to request a reconsideration of the decision. The original **Notice of Reduction of Service (Community Supports Form 16-B)** must be ~~is~~ sent to the provider of the service, a copy must be sent to the individual and/or legal guardian along with the reconsideration process, and a copy must be placed in the individual's file.

**Note:** When a reduction is requested by the individual, a ten (10) calendar day waiting period is not required. The effective date of reduction is the same day the form is completed.

Although reduction of services will be effective ten (10) calendar days from the date the form was completed and mailed to the individual/legal guardian, the individual/legal guardian has thirty (30) calendar days to request reconsideration. If the request is received within ten (10) calendar days of the notification, the individual may choose to have the service(s) uninterrupted while awaiting the outcome of the reconsideration. However, if the reconsideration is upheld, the individual/legal guardian may be liable for payment of those services.

**Note:** If the individual/legal guardian requests reconsideration within ten (10) calendar days and chooses to continue services at the previously authorized amount during the reconsideration process, you must contact the provider of service and ensure that the service is uninterrupted. This contact must be documented in the individual's record.

**If a request for appeal/reconsideration is received by SCDDSN Central Office, you will be notified immediately and receive instructions on how to proceed with the case.**

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS  
COMMUNITY SUPPORTS (CS) WAIVER**

**Cost Cap Acknowledgement**

**I, (print name) \_\_\_\_\_, individual/legal guardian, have been informed of the individual cost cap for the Community Supports waiver.**

**I understand that all CS waiver services must be funded within this amount each waiver year. If waiver funding is exhausted before the waiver year ends, I understand that I will be disenrolled from the waiver.**

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**Print Service Coordinator Name: \_\_\_\_\_**

**Service Coordinator Signature: \_\_\_\_\_**

**DSN Board/Qualified Provider: \_\_\_\_\_**

**Date: \_\_\_\_\_**

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

**COMMUNITY SUPPORTS WAIVER  
NOTICE OF DENIAL OF SERVICE**

DATE: \_\_\_\_\_

TO: \_\_\_\_\_ (Please check one):  Individual  Legal Guardian

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

INDIVIDUAL: \_\_\_\_\_

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**YOU ARE HEREBY NOTIFIED THAT THE REQUEST FOR THE FOLLOWING SERVICE(S)  
FOR THE PERSON NAMED ABOVE HAS BEEN DENIED PURSUANT TO 42. C. F. R 440.230 (d).  
YOUR RIGHT TO APPEAL IS ATTACHED.**

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- |   |   |
|---|---|
| <input type="checkbox"/> Respite Services         | <input type="checkbox"/> Personal Care II Services            |
| <input type="checkbox"/> Adult Day Health Care    | <input type="checkbox"/> Psychological Services               |
| <input type="checkbox"/> Assistive Technology     | <input type="checkbox"/> In-Home Support Services             |
| <input type="checkbox"/> Day Activity             | <input type="checkbox"/> Adult Day Health Care-Nursing        |
| <input type="checkbox"/> Employment Services      | <input type="checkbox"/> Adult Day Health Care-Transportation |
| <input type="checkbox"/> Career Preparation       | <input type="checkbox"/> Private Vehicle Modifications        |
| <input type="checkbox"/> Community Services       | <input type="checkbox"/> Environmental Modifications          |
| <input type="checkbox"/> Support Center Services  | <input type="checkbox"/> Behavior Support Services            |
| <input type="checkbox"/> Personal Care I Services |   |

**Reason:**

- Need(s) is/are not justified  
 Service(s) is available through the state plan  
 Exceeds individual cost limits
- Other: \_\_\_\_\_

Comments (required for all reasons): \_\_\_\_\_  
\_\_\_\_\_

Service Coordinator/Early Interventionist: \_\_\_\_\_

DSN Board/Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Original: Individual/Legal Guardian  
COMMUNITY SUPPORTS Form 16-A

Copy: File

## SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectually Disabled/Related Disabilities (ID/RD) Waiver, the Community Supports (CS) Waiver, the Head and Spinal Cord Injury (HASCI) Waiver and the Pervasive Development Disorder (PDD) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the:

State Director  
SCDDSN  
P. O. Box 4706  
Columbia, SC 29240

The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the individual, representative, or person assisting the individual in filing the request. If necessary, staff will assist the individual in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the individual/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the individual/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the individual/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

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If the individual/representative fully completes the above reconsideration process and is dissatisfied with the results, the individual/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The individual/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

Division of Appeals and Hearings  
SC Department of Health and Human Services  
P.O. Box 8206  
Columbia, SC 29202-8206

The individual/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the individual/representative must clearly state with specificity, which issue(s) the individual/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30<sup>th</sup>) calendar day following receipt of the SCDDSN written reconsideration decision. The individual/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS  
COMMUNITY SUPPORTS WAIVER ---NOTICE OF TERMINATION OF SERVICE**

DATE FORM IS COMPLETED: \_\_\_\_\_

PROVIDER: \_\_\_\_\_  
\_\_\_\_\_

RE: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Individual's Name Date of Birth

Medicaid #: \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

**YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE PURSUANT TO 42. C. F. R 440.230 (d). ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF \_\_\_\_/\_\_\_\_/\_\_\_\_ MAY BE BILLED.**

**For SC/EI: the effective date is 10 calendar days from the date the form is completed with the exception of death, loss of Medicaid, admission to a hospital, ICF/MR, NF, or jail, or exceeds the individual cost limit. This allows the individual 10 days notice prior to termination of service.**

- |   |   |
|---|---|
| <input type="checkbox"/> Respite Services         | <input type="checkbox"/> Personal Care II Services            |
| <input type="checkbox"/> Adult Day Health Care    | <input type="checkbox"/> Psychological Services               |
| <input type="checkbox"/> Assistive Technology     | <input type="checkbox"/> In-Home Support Services             |
| <input type="checkbox"/> Day Activity             | <input type="checkbox"/> Adult Day Health Care-Nursing        |
| <input type="checkbox"/> Employment Services      | <input type="checkbox"/> Adult Day Health Care-Transportation |
| <input type="checkbox"/> Career Preparation       | <input type="checkbox"/> Private Vehicle Modifications        |
| <input type="checkbox"/> Community Services       | <input type="checkbox"/> Environmental Modifications          |
| <input type="checkbox"/> Support Center Services  | <input type="checkbox"/> Behavior Support Services            |
| <input type="checkbox"/> Personal Care I Services |   |

**Reason:**

- |  |   |
|--|---|
| <input type="checkbox"/> Change in need no longer justifies original request | <input type="checkbox"/> Medical condition has improved   |
| <input type="checkbox"/> Change in/no longer meets ICF/MR Level of Care      | <input type="checkbox"/> Individual/legal guardian requested  |
| <input type="checkbox"/> Change in provider availability                     | <input type="checkbox"/> Medicaid ineligible  |
| <input type="checkbox"/> Entered an ICF/MR                                   | <input type="checkbox"/> Individual moved out of state  |
| <input type="checkbox"/> Voluntary withdrawal                                | <input type="checkbox"/> Hospital/Nursing home stay exceeded more than 30 consecutive calendar days |
| <input type="checkbox"/> Death (do not send a copy to the family)            | <input type="checkbox"/> Exceeds individual cost limit  |
| <input type="checkbox"/> Other: _____  |   |

Comments (required for all reasons): \_\_\_\_\_

Service Coordinator/Early Interventionist: \_\_\_\_\_

DSN Board/Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Original: Provider  
COMMUNITY SUPPORTS Form 16-B

Copy: Individual/Legal Guardian and File

## SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectually Disabled/Related Disabilities (ID/RD) Waiver, the Community Supports (CS) Waiver, the Head and Spinal Cord Injury (HASCI) Waiver and the Pervasive Development Disorder (PDD) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the:

State Director  
SCDDSN  
P. O. Box 4706  
Columbia, SC 29240

The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the individual, representative, or person assisting the individual in filing the request. If necessary, staff will assist the individual in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the individual/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the individual/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the individual/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

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If the individual/representative fully completes the above reconsideration process and is dissatisfied with the results, the individual/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The individual/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

Division of Appeals and Hearings  
SC Department of Health and Human Services  
P.O. Box 8206  
Columbia, SC 29202-8206

The individual/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the individual/representative must clearly state with specificity, which issue(s) the individual/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30<sup>th</sup>) calendar day following receipt of the SCDDSN written reconsideration decision. The individual/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS  
COMMUNITY SUPPORTS WAIVER--NOTICE OF SUSPENSION OF SERVICE**

DATE FORM IS COMPLETED: \_\_\_\_\_

PROVIDER: \_\_\_\_\_  
\_\_\_\_\_

RE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Individual's Name Date of Birth

Medicaid #: \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

**YOU ARE HEREBY NOTIFIED TO SUSPEND THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE PURSUANT TO 42. C. F. R 440.230 (d). ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF \_\_\_\_/\_\_\_\_/\_\_\_\_ MAY BE BILLED.**

**For SC/EI: the effective date is 10 calendar days from the date the form is completed with the exception of loss of Medicaid, admission to an ICF/MR, hospital, NF, or jail, or exceeds the individual cost limit. This allows the individual 10 days notice prior to suspension of the service.**

- |   |   |
|---|---|
| <input type="checkbox"/> Respite Services         | <input type="checkbox"/> Personal Care II Services            |
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| <input type="checkbox"/> Day Activity             | <input type="checkbox"/> Adult Day Health Care-Nursing        |
| <input type="checkbox"/> Employment Services      | <input type="checkbox"/> Adult Day Health Care-Transportation |
| <input type="checkbox"/> Career Preparation       | <input type="checkbox"/> Private Vehicle Modifications        |
| <input type="checkbox"/> Community Services       | <input type="checkbox"/> Environmental Modifications          |
| <input type="checkbox"/> Support Center Services  | <input type="checkbox"/> Behavior Support Services            |
| <input type="checkbox"/> Personal Care I Services |   |

**Reason:**

- Jail Other \_\_\_\_\_
- Entered hospital/rehab
- Entered nursing facility

Comments (required for all reasons): \_\_\_\_\_  
\_\_\_\_\_

Service Coordinator/Early Interventionist: \_\_\_\_\_

DSN Board/Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Original: Provider

Copy: Individual/Legal Guardian and File

**COMMUNITY SUPPORTS Form 16-C**

# SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

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State Director  
SCDDSN  
P. O. Box 4706  
Columbia, SC 29240

The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the individual, representative, or person assisting the individual in filing the request. If necessary, staff will assist the individual in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the individual/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the individual/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the individual/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

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If the individual/representative fully completes the above reconsideration process and is dissatisfied with the results, the individual/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The individual/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

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SC Department of Health and Human Services  
PO Box 8206  
Columbia, SC 29202-8206

The individual/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the individual/representative must clearly state with specificity, which issue(s) the individual/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30<sup>th</sup>) calendar day following receipt of the SCDDSN written reconsideration decision. The individual/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.



# SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

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SCDDSN  
P. O. Box 4706  
Columbia, SC 29240

The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

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SC Department of Health and Human Services  
PO Box 8206  
Columbia, SC 29202-8206

The individual/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the individual/representative must clearly state with specificity, which issue(s) the individual/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30<sup>th</sup>) calendar day following receipt of the SCDDSN written reconsideration decision. The individual/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.