

# South Carolina Department of Disabilities and Special Needs

## PDD State Funded Program Notice of Slot Allotment

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

Consumer: \_\_\_\_\_

SSN: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

Case Manager/District Office Rep: \_\_\_\_\_

Chosen Case Management Provider: \_\_\_\_\_

The above referenced individual has been awarded a **PDD State Funded Program** slot. The Case Manager should proceed with offering the parent/legal guardian a choice of a provider and initiate the assessment and budget approval process.

\_\_\_\_\_  
PDD Program Contact or Designee

\_\_\_\_\_  
Date