South Carolina Department of Disabilities and Special Needs

Authorization for PDD Waiver Case Management Services

Assessment Year: Initial _____ Year 2 _____ Year 3 _____

TO: _____

_____

RE: _____

Participant's Name / Date of Birth

_____

Address

Medicaid # /_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/

You are hereby authorized to provide the following service(s) to the recipient named above. Only the number of units rendered may be billed.

Case Management Services:

Number of units per year: _____

Authorization Effective Date: _____

_____ _____

Authorizing Case Manager Date Authorization Issued

_____ _____

Approved By **(Authorizing Case Manager's Supervisor)** Date Approved