

South Carolina Department of Disabilities and Special Needs Authorization for Temporary EIBI State Funded Program Services

TO BE INVOICED TO SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Assessment Year: Initial _____ Year 2 _____ Year 3 _____

EIBI Provider's Name and Address

Participant's Name

Date of Birth

Enrollment Date

Parent's Name/Address/Telephone Number/E-Mail

Service Authorization Number

You are hereby authorized to provide the following service(s) to the participant named above. By accepting this authorization, the EIBI provider agrees to comply with all applicable DDSN policies, procedures, rules and regulations. Only the number of units rendered may be billed.

Early Intensive Behavior Intervention Services

Assessment (H2000): _____ Per 365 Days Assessment Authorization Effective Date: _____

The EIBI Provider has 30 days from the Assessment Authorization Effective Date to complete and disseminate the Assessment.

The EIBI services listed below are authorized only after the Assessment has been received and the Autism Division has loaded the consumer's budget.

EIBI Program Development & Training (T2025): _____ (Is this a Program Transfer? ___ Yes ___ No)

EIBI Plan Implementation (H0032): _____ hours per month

EIBI Lead Therapy (G0177): _____ hours per week

EIBI Line Therapy (H0046): _____ hours per week

Program Development & Training Authorization Effective Date: _____

The EIBI Provider has 30 days from the Program Development & Training Authorization Effective Date to complete the Program Development & Training and implement EIBI services.

This authorization for services is **VOID** effective 1 year and 45 days from the above "Assessment Authorization Effective Date" **UNLESS** the child's 11th birthday or 3rd year anniversary occurs first. In such cases, those dates become the VOID date.

This authorization will be void after this date: _____

Signature of Person Authorizing Service

Date Authorization Issued