South Carolina Department of Disabilities and Special Needs
PDD Temporary State Funded Program Notice of Disenrollment

Date Form Completed: _____

Participant's Name: _____

Medicaid #: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

SSN#: |_____|_____|_____|_____|_____|_____|_____|_____|_____|

The participant named above is no longer eligible to receive services funded through the PDD State Funded Program for the reason noted below:

☐ Death ☐ Admitted to an ICF/ID ☐ Participant moved out of state
☐ Other_____ ☐ Voluntary withdrawal
☐ No services received in 30 days ☐ No services received since enrollment
☐ Placement in Nursing Facility/Hospital has exceeded 30 consecutive calendar days and the participant has no expectation to return to the PDD State Funded Program

☐ Participant has not received the needed service for 30 consecutive calendar days due to provider non-availability [The individual will be disenrolled, but will remain pending for 90 days; therefore, retaining the State Funded slot. If a Provider has not been located within 90 days, the individual will be removed from pending status and the slot will be revoked. If a Provider is secured within 90 calendar days, the participant must be re-enrolled.

EFFECTIVE DATE OF DISENROLLMENT: _____/_____/_____

The effective date is 10 calendar days from the date the form is completed with the exception of death, loss of Medicaid, or admission to an ICF/ID or Nursing Facility or the participant moves out-of-state. This allows the legal guardian notice prior to disenrollment/loss of services and the right to appeal without services being terminated.

As a result of this disenrollment, service(s) currently being provided will be terminated with this effective date. Contact your Case Manager about these services or any questions that you may have.

If form completed more than 2 days after the termination date, provide reason for delay:_____

_____

_____

Case Manager: _____

DSN Board/Provider:_____ Phone:_____

Address:_____

Signature: _____ Date: _____/_____/_____

Original: Legal Guardian Copy: Waiver Enrollment Coordinator, and File State Funded Appeals Process is Attached