## FORMS

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<td>MEDICAID RECIPIENT ID NUMBER: (if applicable)</td>
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| COMPLAINT: |

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<td>SIGNATURE: (SCDHHS Representative Receiving Report)</td>
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South Carolina Department of Health and Human Services
Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. Attach appropriate document(s) as listed in item 8.

1. Provider Name: ________________________

2. Medicaid Legacy Provider # [ ]

   (Six Characters)

OR

3. NPI# [ ] & Taxonomy [ ]

4. Person to Contact: ________________________ 5. Telephone Number: ______________________

6. Reason for Refund: [check appropriate box]
   - Other Insurance Paid (please complete a – f below and attach insurance EOMB)
     a. Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
     b. Insurance Company Name ____________________________
     c. Policy #: _______________________________________
     d. Policyholder: ____________________________________
     e. Group Name/Group: ________________________________
     f. Amount Insurance Paid: ____________________________
   - Medicare
     ( ) Full payment made by Medicare
     ( ) Deductible not due
     ( ) Adjustment made by Medicare
   - Requested by DHHS (please attach a copy of the request)
   - Other, describe in detail reason for refund:
     ___________________________________________________
     ___________________________________________________

7. Patient/Service Identification:

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<tr>
<th>Patient Name</th>
<th>Medicaid I.D. # (10 digits)</th>
<th>Date(s) of Service</th>
<th>Amount of Medicaid Payment</th>
<th>Amount of Refund</th>
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8. Attachment(s): [Check appropriate box]
   - Medicaid Remittance Advice (required)
   - Explanation of Benefits (EOMB) from Insurance Company (if applicable)
   - Explanation of Benefits (EOMB) from Medicare (if applicable)
   - Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

DHHS Form 205 (01/08)
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: ________________________________ Provider ID or NPI: ________________________________
Contact Person: ______________________ Phone #: ______________________ Date: ______________________

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: ________________________________ Date Referral Completed: ________________________________
Medicaid ID#: ________________________________ Policy Number: ________________________________
Insurance Company Name: ________________________________ Group Number: ________________________________
Insured's Name: ________________________________ Insured SSN: ________________________________
Employer's Name/Address: ________________________________

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

   _____ a. beneficiary has never been covered by the policy – close insurance.
   _____ b. beneficiary coverage ended - termite coverage (date) ________________________________
   _____ c. subscriber coverage lapsed - termite coverage (date) ________________________________
   _____ d. subscriber changed plans under employer - new carrier is ________________________________
   - new policy number is ________________________________
   _____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.
   (name) ________________________________

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).
Fax: 803-252-0870 or Mail: Post Office Box 101110
Columbia, SC 29211-9804

DHHS 931 – Updated February 2018
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER ____________________________________________  DOS _______________________

NPI or MEDICAID PROVIDER ID __________________________

MEDICAID BENEFICIARY NAME ____________________________

MEDICAID BENEFICIARY ID# _______________________________

INSURANCE COMPANY NAME ______________________________

POLICYHOLDER ____________________________________________________________________________

POLICY NUMBER ____________________________________________________________________________

ORIGINAL DATE FILED TO INSURANCE COMPANY ____________________________

DATE OF FOLLOW UP ACTIVITY __________________________________________________________________

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _________________________________

RESULT:

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

__________________________________________
(SIGNATURE AND DATE)

ATTACH A COPY OF THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014
South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.

1. Provider Name: _____________________________________________

2. Medicaid Legacy Provider # ________________ (Six Characters)
   NPI# ____________________________ Taxonomy ____________________________

3. Person to Contact: ________________________ Telephone Number: __________

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

   Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

5. Street Address for delivery of request:
   Street: ____________________________________________
   City: __________________________________________________________________
   State: ____________________________________________
   Zip Code: ____________________________________________

6. Charges for duplicate remittance advice(s) are as follows:
   Request Processing Fee - $20.00
   Page(s) copied - $.20 per page

   I understand and acknowledge that a charge is associated with this request and will be deducted from my provider’s payment by debit adjustment on a future remittance advice.

   ____________________________________________ Date ____________________________

   Authorizing Signature

SCDHHS (Revised 09/01/17)
CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. Note: Timely filing guidelines apply.

Section 1: Beneficiary Information

Name (Last, First, MI): ..........................................................
Date of Birth: ___________ Medicaid BeneficiaryID: ___________

Section 2: Provider Information

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): __________________________
NPI: ___________ Medicaid Provider ID: ___________ Facility/Group/Provider Name: ________________
Return Mailing Address: __________________________________________
Street or Post Office Box: __________________________ State: ___________ ZIP: ___________
Contact: ___________________ Email: ___________________ Telephone #: ___________ Fax #: ___________

Section 3: Claim Information (Only one CCN allowed per request.)

Communication ID: _______________ CCN: _______________ Date(s) of Service: _______________

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below):
☐ Ambulance Services
☐ Autism Spectrum Disorder (ASD) Services
☐ Clinic Services
☐ Community Long Term Care (CLTC)
☐ Community Mental Health Services
☐ Department of Disabilities and Special Needs (DDSN) Waivers
☐ Durable Medical Equipment (DME)
☐ Early Intervention Services
☐ Enhanced Services
☐ Federally Qualified Health Center (FQHC)
☐ Home Health Services
☐ Hospice Services
☐ Hospital Services
☐ Licensed Independent Practitioner’s Rehabilitative Services (LIPS)
☐ Local Education Agencies (LEA)
☐ Medically Complex Children’s (MCC) Waivers
☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
☐ Optional State Supplementation (OSS)
☐ Pharmacy Services
☐ Physicians Laboratories, and Other Medical Professionals Specify: __________________________________________
☐ Private Rehabilitative Therapy and Audiological Services
☐ Psychiatric Hospital Services
☐ Rehabilitative Behavioral Health Services (RBHS)
☐ Rural Health Clinic (RHC)
☐ Targeted Case Management (TCM)
☐ Other: ______________________________________________________________________
Section 5: Desired Outcome

Request submitted by:

Print Name: ________________________________

Signature: ________________________________ Date: __________
This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

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<thead>
<tr>
<th>PROVIDER ID</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
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<th>TITLE</th>
<th>COPAY</th>
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<tr>
<td>NUMBER</td>
<td>NUMBER</td>
<td>PY IND</td>
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<td>PROC.</td>
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| ABB2AA | 1403004804012700A | | 259.00 | 0.00 | S | 1112233333 | M | CLARK | 026 | 0.00 | 0.00 |
|        | 01 | 101713 | 74176 | 259.00 | 0.00 | S | 1112233333 | M | CLARK | 026 | 0.00 | 0.00 |
| ABB3AA | 1403004805012700A | | 24.00 | 0.00 | R | 1112233333 | M | CLARK | 000 | 0.00 | 0.00 |
|        | 01 | 071913 | A5120 | 12.00 | 0.00 | R | | | | 000 | 0.00 | 0.00 |
|        | 02 | 071913 | A4927 | 12.00 | 0.00 | R | | | | 000 | 0.00 | 0.00 |

|            | TOTALS | | 3 | 310.00 | |
|            | TOTALS | | 3 | 310.00 | |

|            | $6.72 | |

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<td>PHONE THE D.H.H.S. NUMBER</td>
<td>ABC HEALTH PROVIDER</td>
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<td>SPECIFIED FOR INQUIRY OF</td>
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| CLAIMS IN THAT MANUAL. | CHECK TOTAL | CHECK NUMBER |
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| ABB222222 | 1405200414812200A |        | 1001.50 | 42.75 | P1112233333 | M CLARK | 0.00 | 0.00 |

| VOID OF ORIGINAL CCN 1328300224481330A PAID 20131018 |
| REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018 |

CERTIFIED AMT MEDICAID TOTAL E = ENCOUNTER | FLORENCE SC 00000 |

FOR AN EXPLANATION OF THE ERRORS LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER | CHECK TOTAL CHECK NUMBER

SPECIFIED FOR INQUIRY OF PROVIDER NAME AND ADDRESS

PROVIDER NAME AND ADDRESS
Sample Remittance Advice (page 3)

This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.
### Sample Remittance Advice (page 4)

This page of the sample Remittance Advice shows four gross-level adjustments. Gross-level adjustments always appear on the final page of the Remittance Advice.

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<td>CHECK NUMBER</td>
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<td>FLORENCE SC 00000</td>
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</table>

**Page Total:** 4338.95 0.00
**Community Long Term Care**  
**Service Provision Form**

**PROVIDER:** VERIFY  
**MEDICAID ELIGIBILITY MONTHLY**  

**TYPE OF AUTHORIZATION:**  
New

**From:**

**AUTHORIZATION IS HEREBY GIVEN TO PROVIDE THE FOLLOWING SERVICE(S) UNDER YOUR CONTRACT WITH THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE PROVISION THEREOF.**

<table>
<thead>
<tr>
<th>Service(s) Authorized:</th>
<th>CLTC PROCEDURE CODE:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Authorized Start Date:</th>
<th>Authorized End Date:</th>
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<tbody>
<tr>
<td></td>
<td>(if applicable)</td>
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**Comments:**

<table>
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<tr>
<th>Total Units Authorized:</th>
<th>Sun</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thur</th>
<th>Fri</th>
<th>Sat</th>
<th>Unit Cost: $</th>
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### CLIENT INFORMATION

<table>
<thead>
<tr>
<th>NAME</th>
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<table>
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<th>SOCIAL SEC NO</th>
<th>MEDICAID NO.</th>
<th>ELIGIBILITY TYPE</th>
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<th>SECONDARY PHONE</th>
<th>THIRD PHONE</th>
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### RESPONSIBLE PARTY

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<table>
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<tr>
<th>RELATIONSHIP</th>
<th>HOME TELEPHONE</th>
<th>WORK TELEPHONE</th>
</tr>
</thead>
</table>

**Physician:**

**Directions to client's home:**

________________________________________________________

________________________________________________________

**Case Manager's Signature:**

**Sent:** ___________  **Date:** ___________  **Initials:** ___________

**☐ PROVIDER  ☐ BILLING CLERK  ☐ FILE**

SCDHHS FORM 175  JUL 92
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE **BILLED TO MEDICAID**

TO: ____________________________________________________________

______________________________________________________________

RE: ____________________________________________________________

Recipient’s Name / Date of Birth

Address

Medicaid # / / / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / / / /

Personal Care Services (T1020) – Attach ID/RD Form 10

☐ Personal Care I (PC I) S5130
☐ Personal Care II (PC II) T1019

Number of Units Per Week to be Provided: _________ (one unit = 15 minutes)
Start Date: ___________

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

____________________________________________

____________________________________________

____________________________________________

____________________________________________

Signature of Person Authorizing Services __________________________ Date ____________

ID/RD Form A-3 (04/17)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO MEDICAID

TO: ____________________________________________

______________________________________________

RE: ____________________________________________

______________________________________________

Recipient's Name / Date of Birth

Address

Medicaid # / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / /

PSYCHOLOGICAL SERVICES (H0046):

Assessment: Number of Units _________ (one unit = 30 minutes)

Counseling/Therapy: Start Date: ___________________________

Number of Units (one unit = 30 minutes) ___________________________

Frequency: ___________________________________________________

** NO MORE THAN 8 HOURS/16 UNITS PER DAY MAY BE AUTHORIZED **

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Signature of Person Authorizing Services ____________________________ Date

ID/RD Form A-9 (04/17)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZED FOR SERVICES
TO BE BILLED TO MEDICAID

TO: __________________________________________________________

______________________________________________________________

RE: __________________________________________________________

Recipient's Name / Date of Birth

Address

Medicaid # / / / / / / / / / / / / /

NOTE: The provider is responsible for pursuing all other resources prior to accessing Medicaid. State Plan Medicaid resources must be exhausted before accessing ID/RD Waiver. Our information indicates this person has:

☐ Medicaid Only ☐ 3rd Party liability ☐ Medicare

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / / / / / /

Nursing Services:

Total Number of Units Per Week to be Provided: __________ (one unit = 60 minutes)

☐ LPN Hours/Week (S9124) ______

☐ RN Hours/Week (S9123) ______

Start Date: __________

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Signature of Person Authorizing Services __________________________________ Date

ID/RD Form A-12 (04/17)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE *BILLED TO MEDICAID*

TO: ____________________________________________

__________________________________________

RE: ____________________________________________

__________________________________________

Recipient’s Name / Date of Birth

Address

Medicaid # / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / /

Private Vehicle Modification (X9322):

General Description: ___________________________________________________

____________________________________________________________________

____________________________________________________________________

Cost: ________________________
(Attach a copy of the bid)

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

__________________________________________

__________________________________________

__________________________________________

Signature of Person Authorizing Services ___________________________ Date __________

ID/RD Form A-13 (04/17)
TO: _____________________________________________________________

_______________________________________________________________

RE: _____________________________________________________________

Recipient's Name          /          Date of Birth

Address

Medicaid #   /   /   /   /   /   /   /   /   

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization #   /   /   /   /   /   /   /   /   

Adult Day Health Care Services (X6987)

Number of Units Per Week: ___________ one unit = 1 (5 hour) day

Start Date: ___________________________

OR

The above named recipient cannot tolerate 5 hour day. Therefore you are authorized to provide:

Number of Units Per Week: _________ (one unit = ______ hours per day)

Start Date: ___________________________

Service coordinator: Name / Address / Phone # (Please Print):

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

Signature of Person Authorizing Services ___________________________ Date ___________________________

ID/RD Form A-23 (04/17)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO DSN BOARD

TO: _____________________________________________

______________________________________________

RE: _____________________________________________

Recipient's Name / Date of Birth

Address

Medicaid # / / / / / / / / / / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Respite Services

Hourly Respite
Number of Units Per Week: _______________ (one unit = 1 hour of service)

Daily Respite:
Number of Units Per _______________; ________________
(one unit = 1 respite period of more than 8 consecutive hours)

REMIT BILL TO (Please print):

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Signature of Person Authorizing Services ___________________ Date ________________

ID/RD Form A-25 (04/17)
TO: ____________________________________________________________

______________________________________________________________

RE: ____________________________________________________________

Recipient’s Name / Date of Birth

Address

Medicaid # / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / /

BEHAVIOR SUPPORT SERVICES (H0045)

Assessment: Number of Units ___________ (one unit = 30 minutes)

Number of Units (one unit = 30 minutes) ___________

Frequency: __________________________

Start Date: __________________________

** NO MORE THAN 8 HOURS/16 UNITS PER DAY MAY BE AUTHORIZED**

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

______________________________________________                 _____________________________

Signature of Person Authorizing Services                                      Date

ID/RD Form A-27 (04/17)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO DSN BOARD

TO: ________________________________________________

______________________________________________

RE: ____________________________

Recipient’s Name / Date of Birth

Address

Medicaid # ________________________________

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Residential Habilitation

Hourly:
Number of Units Per Week: ________________
(one unit = 1 hour of service provided to someone in an SLP I setting)

Daily:
Number of Units Per Year: ________________
(one unit = 1 night (present at midnight) in a CTH I, CTH II, CRCF or SLP II)

REMIT BILL TO (Please print):

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Signature of Person Authorizing Services __________________________ Date ________________

ID/RD Form A-28 (04/17)
S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZED FOR SERVICES
TO BE BILLED TO MEDICAID

TO: ____________________________

RE: ____________________________

Recipient's Name _______ Date of Birth _______

Address ________________________

Medicaid # ______________________

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # ____________

Audiology Services:

___ Hearing Aid Evaluation: $49.00
___ Hearing Aid Orientation: $24.00
___ Hearing Aid Analysis: $10.50
___ Hearing Aid Re-Check: $16.00
___ Conduction Test: $8.50
___ Impedance Test: $10.25
___ Hearing Consultation: $13.00

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

Signature of Person Authorizing Services ____________________________ Date ____________

MR/RD Form A-31 (7/01)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR ICF/IID (INSTITUTIONAL) RESPITE SERVICES
TO BE BILLED TO DSN BOARD

☐ Center-Based Respite
☐ Community ICF/MR

☐ Coastal Center
☐ Midlands Center
☐ Pee Dee Center
☐ Saleeby Center
☐ Whitten Center

Name of facility

TO:
For Center Based: Claims and Collections (See Attached)
For Community ICF/IID: Board/Provider Finance Director

Address

RE:
Recipient’s Name / Date of Birth

Medicaid # / / / / / / / / /

Social Security # / / / / / / / / / / / /

You are hereby authorized to provide institutional respite to the consumer named above. The consumer cannot be admitted to the ICF/IID (DHHS 181 completed) without first notifying the Service Coordinator (noted below) and verifying that the consumer has been disenrolled from the ID/RD Waiver. Please note: This nullifies any previous authorization to this provider for this service.

Institutional Respite

☐ Number of Units _________ (one unit = number of nights spent in the ICF/IID)

Start Date: ______________________

Service Coordinator: ____________________________________________________________

Board/Provider: ________________________________________________________________

Address: ___________________________________________________________________

Phone Number (with extension when appropriate): _________________________________

Signature of Person Authorizing Services ____________________________ Date __________

ID/RD Form A-32 (04/17)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER-NOTICE OF TERMINATION OF SERVICE

DATE FORM IS COMPLETED: _________________________________

PROVIDER: _____________________________________________

RE:

Recipient’s Name __________________________ Date of Birth ____________ / _______ / _______

Medicaid # ___________ ___________ ___________ ___________ ___________ ___________ ___________ ___________ ___________

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE. 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, or admission to an ICF/IID or NF. This allows the consumer 10 days notice prior to termination of service.

☐ Respite Care
☐ Adult Day Health Care
☐ Personal Care Services
☐ Medicaid Waiver Nursing Services
☐ Habilitation (specify)
  ☐ Residential habilitation
  ☐ Day Habilitation
  ☐ Prevocational services
  ☐ Supportive Employment services
☐ Assistive Technology: __________________________
☐ Environmental Modifications
☐ CheckBox14
☐ CheckBox15
☐ CheckBox22
☐ Medical Condition has improved
☐ No longer meets ICF/IID Level of Care
☐ Medicaid ineligible
☐ Consumer moved out of state
☐ Hospital/Nursing home stay exceeded more than 30 consecutive calendar days

Reason:
☐ Change in need no longer justifies original request
☐ Change in ICF/IID Level of Care
☐ Change in provider availability
☐ CheckBox28
☐ CheckBox30
☐ Death (do not send a copy to the family)

Comments (required for all reasons): ____________________________________________________________________________________

_________________________________________________________________________________________________

Service Coordinator/Early Interventionist: ________________________________

DSN Board/Provider: __________________________________________________________________________ Phone: ________________________

Address: ______________________________________________________________________________________

Signature: ____________________________________________________________________________________ Date: ____________ / __________ / __________

Original: Provider Copy: Consumer/Legal Guardian and File

ID/RD Form 16 (04/17)
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 Intellectual Disabled/Related Disabilities (ID/RD) Waiver and the Head and Spinal Cord Injury (HASC1) Waiver. A request for reconsideration of an adverse decision must be sent in writing to the State Director at 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 consumer, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the consumer/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 consumer/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 consumer/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the consumer/representative fully completes the above reconsideration process and is dissatisfied with the results, the consumer/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 consumer/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
PO Box 8206
Columbia, SC 29202-8206

The consumer/representative must attach a copy of the written reconsideration decision received from the SCDDSN regarding the specific matter on appeal. In the appeal request the consumer/representative must clearly state with specificity, which issue(s) the consumer/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 (30th) calendar day following receipt of the SCDDSN written reconsideration decision. The consumer/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
Head and Spinal Cord Injury Waiver
Authorization for Medicaid Waiver Nursing Services

Medicaid #: __________________________________________

Referred To: __________________________________________

Individually Name: __________________________ Address: __________________________

Date of Birth: __________________________ City/State/Zip: __________________________

Prior Authorization Number: __________________________ Billing should be submitted to: ☐ DHHS  ☐ DSN Board

You are hereby authorized to provide:

Medicaid Waiver Nursing Services: ☐ LPN (S9124)  ☐ RN (S9123)

Start Date: __________________________

Authorized Total: __________________________ Units per __________________________

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for Medicaid Waiver Nursing Services.

The service is authorized for the individual named above. Only medical services may be billed to the Waiver under Medicaid Waiver Nursing Services and documentation must be provided for any services rendered. The services must be specifically for the Waiver participant and must be medically necessary, as indicated by the individual’s physician.

The following services are requested:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Comments: __________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

PLEASE PRINT

DSN Board Name: __________________________ Svc. Coord.: __________________________

Address: __________________________

Phone: ( ) __ ______ ext. __________________________

Signature: __________________________ Date: __________________________

HASC1 Form 12-D (Revised 02/04)
South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Psychological Services

Medicaid #: _______________________________________

Referred To: _______________________________________

__________________________________________________

Individuals Name ____________________________ Address ____________________________

Date of Birth ____________________________ City/State/Zip ____________________________

Prior Authorization Number: __________________________

Billing should be submitted to: □ DHHS  □ DSN Board

You are hereby authorized to provide:

Psychological Services

□ Psychological Assessment (H0023)  □ Family/Individual Therapy - LISW (H0023)
□ Cognitive Rehabilitation Therapy (H0023)  □ Family/Individual Therapy - BA/MH Practitioner (H0023)
□ Drug and Alcohol Abuse Counseling (T1007)  □ Psychiatric Services (H0023)
□ Family/Individual Therapy - Psychologist (H0023)  □ Neuropsychological Assessment (G0114)

Start Date: ____________________________

Authorized Total: ____________________________ Units per ____________________________

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for psychological services.

Comments: ________________________________________________________________

______________________________________________________________

PLEASE PRINT

DSN Board Name: ____________________________ Svc. Coord.: ____________________________

Address: ________________________________________________________________

Phone: ( ) - ext. ____________________________

Signature: ____________________________ Date: ____________________________

HASCI Form 12-E (Revised 02/04)
South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for PERS Services

Medicaid #: ____________________________

Referred To: __________________________
______________________________
______________________________

<table>
<thead>
<tr>
<th>Individuals Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>City/State/Zip</td>
</tr>
</tbody>
</table>

Prior Authorization Number: ____________________________

Billing should be submitted to: □ DHHS  □ DSN Board

You are hereby authorized to provide:

☐ PERS Services
☐ PERS Installation (S5160)  Start Date: _____________
☐ PERS Monitoring (S5161)   Start Date: _____________

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for PERS Services.

PLEASE PRINT
DSN Board Name: ____________________________  Svc. Coord.: ____________________________

Address: ________________________________________________________________

Phone: ( ) - ext.________________________________________________________

Signature: ____________________________  Date: ____________________________

HASIC Form 12-F (Revised 02/04)
South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Respite Services

Medicaid #: ____________________________

Referred To: ____________________________

______________________________

______________________________

Individuals Name ____________________________ Address _________________

Date of Birth ____________________________ City/State/Zip __________________

Prior Authorization Number: ____________________________ Billing should be submitted to: □ DHHS □ DSN Board

You are hereby authorized to provide:

Respite Services:

Services will be provided in the following location:

☐ Individual’s Home ☐ Hourly (X7028) ☐ Daily (X7027)
☐ Caregiver’s Home (must be licensed by DDSN) ☐ Hourly (X7028) ☐ Daily (X7027)
☐ Licensed Respite Care Facility (X7027)
☐ ICF/MR (H6045)
☐ Nursing Facility (H6045)
☐ Hospital (H6045)
☐ CRCF (T1020)

Start Date: ____________________________

Authorized Total: ____________________________ Units per ____________________________

Only the number of units rendered may be billed.

Please note: This nullifies any previous authorization to this provider for respite services.

Comments: ________________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

PLEASE PRINT

DSN Board Name: ____________________________ Svc. Coord.: ____________________________

Address: ____________________________

Phone: ____________________________ ext. ____________________________

Signature: ____________________________ Date: ____________________________

HASC1 Form 12-H (Revised 02/04)