Reset

SOUTH CAROLINA
DEPARTMENT OF SOCIAL SERVICES

PURCHASE OF SERVICE REIMBURSEMENT REQUEST

PAGE _____ OF _____

SECTION A GENERAL INFORMATION

PROVIDER'S NAME:

PROVIDER CODE:

PROVIDER'S ADDRESS:

PERIOD COVERED BY REQUEST:

FROM: TO:

CONTRACT PERIOD:

FROM: TO:

SERVICE	TYPE OF PROVIDER
☐ SINGLE	☐ PRIVATE NON-PROFIT
MULTIPLE	☐ PRIVATE PROFIT
☐ 4 OR LESS	☐ PUBLIC
☐ 5 OR MORE	

SECTION B SERVICE DELIVERY CLIENT CLASSIFICATION AND DOLLAR AMOUNT SCHEDULE

SERVICE CODE _____	UNIT COST $ CLIENTS	UNIT COST $ UNITS	DOLLARS	SERVICE CODE _____	UNIT COST $ CLIENTS	UNIT COST $ UNITS	DOLLARS
1. SSI				1. SSI			
2. AFDC				2. AFDC			
3. Income Eligible				3. Income Eligible			
4. Without Regard to Income				4. Without Regard to Income			
5. WIN				5. WIN			
SERVICE TOTAL				SERVICE TOTAL			

SERVICE CODE _____	UNIT COST $ CLIENTS	UNIT COST $ UNITS	DOLLARS	SERVICE CODE _____	UNIT COST $ CLIENTS	UNIT COST $ UNITS	DOLLARS
1. SSI				1. SSI			
2. AFDC				2. AFDC			
3. Income Eligible				3. Income Eligible			
4. Without Regard to Income				4. Without Regard to Income			
5. WIN				5. WIN			
SERVICE TOTAL				SERVICE TOTAL			

TOTAL AMOUNT OF DOLLARS SUMMARY $ _____

SECTION C FUND REIMBURSEMENT CATEGORY RECAP.

		FOR DSS ONLY	AMOUNT
1. FEDERAL FINANCIAL PARTICIPATION	75% F.F.P.		$
2.	% F.F.P.		$
3. MATCH SHARE	25%		$
4.	%		$
5. DSS STATE APPROPRIATION	25%		$
6. DSS STATE APPROPRIATION	%		$
7. CERTIFIED PUBLIC EXPENDITURE	25%		XXXXXXXXXXXXXXXXXX
8. CERTIFIED PUBLIC EXPENDITURE	% $		XXXXXXXXXXXXXXXXXX
9.			( )
TOTAL OR NET CLAIM AMOUNT			$

SECTION D CERTIFICATION BY PROVIDER

I DO SOLEMNLY SWEAR (OR AFFIRM) THAT I HAVE EXAMINED THE INFORMATION CONTAINED IN THIS REQUEST. THAT ALL SUCH INFORMATION HAS BEEN PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER NAMED WITHIN. THAT THE AFORESAID INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF: AND THAT NO OTHER REQUEST FOR REIMBURSEMENT FROM OTHER FEDERAL AND/OR STATE FUNDS HAS BEEN MADE NOR HAS ANY OTHER REIMBURSEMENT BEEN RECEIVED, APPLIED FOR, NOR WILL THEY BE APPLIED FOR, FOR THE SERVICES HEREIN DESCRIBED. THAT OUR AGENCY HAS ON FILE PROPER CLIENT AUTHORIZATIONS FOR THESE SERVICES CLAIMED AND THE NECESSARY DOCUMENTATION TO SUPPORT THESE CLAIMS. THAT ALL CLAIMS REPORTED ARE WITHIN THE PERIOD OF AUTHORIZED ELIGIBILITY.

PROVIDER'S SIGNATURE:	TITLE:	DATE:

REPORT PREPARED BY:	TITLE:	ADDRESS:	TELEPHONE: