State of South Carolina
Department of Social Services

Supplemental Benefits Medical Reimbursement Request

SBMA payments must be submitted to DSS using this form and emailed to supplementalreimbursementrequests@dss.sc.gov, faxed to 803-898-1209, or mailed to PO Box 1520 Columbia SC 29202. DSS will determine whether the payments and amount are allowable expenses. DSS may deny the payment if sufficient funds are not available or if the child's funding level for the year has been reached.

Important Information: ***An itemized paid receipt must be included with the reimbursement request. All requests must be submitted on a timely basis but no later than 45 days from the end of their authorization year or the child's 21st birth month. The authorization year begins on the date you sign the Adoption Subsidy Agreement. Example: Sign date is 1/1/2025, end date will be 12/31/2026. SBMA funding may supplement, but does not replace, private health insurance, Medicaid, Baby Net, Individualized Education Program, or other resources available to the family to support the diagnoses and/or behaviors listed in the Adoption Subsidy Agreement. The family must access these sources first, before requesting SBMA funds. DSS does not reimburse for past authorization years or prepay out of upcoming authorization years. It can take up to 90 days for reimbursement to be received once our office submits for payment.***

SECTION A: Basic Information (complete by Adoptive Parent)

Child's Birth Name: (First and Last)	Date of Birth	Child's Adopted Name (First and Last)
Adoptive Parents Names (First and Last)	Phone	Email
Current Address (#, Street, City, State, Zip)		

SECTION B: Prior Approval Required for all Reimbursement Requests Each Authorization Period

Is this State Office Adoption Representative Approved?

☐ Yes ☐ No

If YES, name of person who authorized reimbursement: _____

If NO, contact State Office Adoption for approval prior to submitting, 803-898-3956_____

SECTION C: Respite (for a child(ren) 18-20 medical necessity letter and prior approval required)

Who (name of person who provided respite)	Amount paid	Dates of Respite Care
	$	

SECTION D: Professional Services

Name of Provider:	
Type and Date of Service	
Documentation: (itemized paid receipt is required for reimbursement):	**Total Payment Amount:** $

SECTION E: Adoptive Family Certification

I certify that the above services were provided on behalf of this child.	
Adoptive Family's Signature	Date