South Carolina
CONTINUUM OF CARE
Dept. of Children's Advocacy

Updated 8/5/2025

Dear Parent/Legal Guardian:

The Continuum of Care's (COC) philosophy is that children are more successful when served in their families' homes and in their community. COC works to ensure that children with the most severe and complex emotional or behavioral health challenges, whose needs are not being adequately met by existing services and programs, have the services and supports in place to support both youth and family in the least restrictive setting.

COC provides intensive care coordination by developing a team to work with your family and your providers as partners in managing your child's care through monthly meetings.

Intensive care coordination can help avoid out-of-home placements, improve school attendance and performance, decrease interactions with the legal system, and enhance the overall quality of life for your family. The following information is needed to apply:

- Completed Application
- Referral Form
- Copy of Medicaid card and/or other insurance card
- Documentation of a child's diagnosis

After the application information is received by the regional office, a COC staff member will contact you to schedule a face-to-face visit. With your consent additional providers will be contacted to gather information to help determine your child's needs. If your child is determined to be eligible, COC will help you assemble your Child & Family Team to begin developing a Plan of Care. Questions regarding the application should be directed to the regional office serving your county of residence.

Sincerely,

Gregory B. Wright, LPCS
Division Director
Continuum of Care
Department of Children's Advocacy
1205 Pendleton Street, Suite 453A, Columbia, SC 29201

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STATE OFFICE

1205 Pendleton Street, Suite 453
Columbia, South Carolina 29201

Office: (803) 734-4500
Fax: (803) 734-4538
Web: coc.sc.gov

Division Director: Gregory B. Wright, LPCS

REGIONAL OFFICES AND COUNTIES SERVED

Midlands Regional Office

810 Dutch Square Blvd, Suite 390
Columbia, South Carolina 29210

Office: (803) 737-1601
Fax: (803) 737-1610

Counties Served:
Aiken, Bamberg, Barnwell, Chester, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, McCormick, Richland, Saluda, York

Pee Dee Regional Office

183 South Coit Street, Suite A
Florence, South Carolina 29501

Office: (843) 317-4021
Fax: (843) 317-4018

Counties Served:
Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg

Upstate Regional Office

Piedmont Center, East Building
37 Villa Road, Suite 300
Greenville, South Carolina 29615

Office: (864) 271-4321
Fax: (864) 271-4473

Counties Served:
Abbeville, Anderson, Cherokee, Greenville, Greenwood, Laurens, Newberry, Oconee, Pickens, Spartanburg, Union

Lowcountry Regional Office

3955 Faber Place, Suite 201
North Charleston, South Carolina 29405

Office: (843) 569-3079
Fax: (843) 569-2403

Counties Served:
Allendale, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg

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INITIAL SCREENING CRITERIA

A youth must meet the following initial screening criteria:

- Be a legal resident of South Carolina; parent or guardian must remain a resident of South Carolina for the child to continue to be eligible for Continuum services;

- Have not yet reached his/her eighteenth (18) birthday; if 18 or older, be enrolled in a special education program;

- Have confirmation of a severe emotional or behavioral health diagnosis documented by a physician, licensed clinical psychologist, counseling psychologist, licensed master social worker, licensed independent social worker-clinical practice, licensed professional counselor, licensed marriage and family therapist, developmental pediatrician, or a licensed physician with the Department of Behavioral Health and Developmental Disabilities' Office of Mental Health;

- Have treatment needs that are not being met by the existing service delivery systems and which require a comprehensive and organized system of care that can be met by programs designed to accept and serve children with emotional and behavioral health concerns;

- Be in the custody of his or her parents, other legal custodian/guardian, or the South Carolina Department of Social Services. Preference is for the youth to be living in the community, relative placement, foster home, or group home;

- Have an application submitted with the signed consent of the parent or guardian; if 18 years or older and competent to do so, the consent must be signed by the applicant.

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Section 1: Youth Information

Child's Name: _____

Date of Birth: _____ Age: _____ Medicaid? ☐ Yes ☐ No Medicaid#: _____

Medicaid MCO: _____

Private Insurance Name: _____

Youth's Home Address: _____

_____

Youth's Phone: _____ ☐ Cell ☐ Home SSN: _____

If youth is not living with parent/caregiver, give location name and address: _____

_____

Child's Gender: ☐ Male ☐ Female ☐ Transgender

Child's Race *(Select all that apply):* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Decline to Specify

Section 2: Who created this referral for Wraparound?

Referral Date: _____ Agency: _____ Contact Person: _____

Relationship to child: _____ Phone: _____ Email: _____

Address: _____ Fax: _____

Are there other state agencies involved with the care of this child? Select all that apply:

☐ DBHDD-OIDD - Autism Division ☐ DBHDD-OIDD - ID/RD Division ☐ DBHDD-OMH ☐ DJJ ☐ DSS ☐ School

Section 3: Parent/Caregiver Information

Parent/Caregiver 1 Name: _____ Relationship to child: _____

Primary Caregiver: ☐ Yes ☐ No Legal Guardian ☐ Yes ☐ No Same Address as Child ☐ Yes ☐ No

If not living at the same address as the child, please list address: _____

_____

Phone: _____ ☐ Cell ☐ Home ☐ Work Is this the same phone number for the child? ☐ Yes ☐ No

If not, what is the best number for the child? _____ Email: _____

Do you have legal custody to make decisions on behalf of the youth? ☐ Yes ☐ No

If no, who does? _____

(if proof of legal custody, please attach. COC wil request documentation)

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Parent/Caregiver 2 Name:_____ Relationship to child:_____

Primary Caregiver: ☐Yes ☐No Legal Guardian ☐Yes ☐No Same Address as Child ☐Yes ☐No

If not living at the same address as the child, please list address: _____

_____

Phone:_____ ☐Cell ☐Home ☐Work Is this the same phone number for the child? ☐Yes ☐No

If not, what is the best number for the child? _____ Email: _____

Do you have legal custody to make decisions on behalf of the youth? ☐Yes ☐No

If no, who does?_____

(if proof of legal custody, please attach. COC wil request documentation)

Section 4: Educational Information

Currently enrolled in school? ☐Yes ☐No Grade:_____ School district: _____

School name:_____ Phone: _____ Email:_____

School Placement: ☐General Education ☐Special Education Is an IEP/504 Plan in Place? ☐Yes ☐No

If Special Education, please select a classification: ☐ED ☐LD ☐OHI ☐Other:_____

Section 5: Youth's Medical Information

DSMV/ICD10 Diagnosis(es): _____

_____

Start date of diagnosis(es):_____

Who completed this diagnostic assessment? _____

(if assessment is available, please attach)

What date was it completed?_____ Phone:_____

List all medication(s), dosage, frequency, and the date the child started taking it/them: _____

_____

_____

List any in-home services currently in place (ie. family support services, or crisis intervention specialists, etc.)

_____

Why are you referring this child to **COC**? _____

_____

_____

Parent/Caregiver Signature:_____ Date:_____

☐ *Please check here if no signature above to indicate that parent/guardian is unavailable to sign, but has been notified about this referral to COC and will be expecting contact and referral review with COC staff.*