

<b>AGENCY NAME:</b>	SC Patients' Compensation Fund		
<b>AGENCY CODE:</b>	R140	<b>SECTION:</b>	38-79-410



## Fiscal Year 2016-17 Agency Budget Plan

### FORM A – SUMMARY

**RECURRING FUNDS  
(FORM B  
DECISION PACKAGES)**

My agency is submitting the following recurring decision packages (Form B):	
For FY 2016-17, my agency is (mark "X"):	
<input type="checkbox"/>	Requesting a net increase in recurring General Fund appropriations.
<input checked="" type="checkbox"/>	Not requesting a net increase in recurring General Fund Appropriations.

**CAPITAL &  
NON-RECURRING  
FUNDS  
(FORM C  
DECISION PACKAGES)**

My agency is submitting the following one-time decision packages (Form C):	
For FY 2016-17, my agency is (mark "X"):	
<input type="checkbox"/>	Requesting capital and/or non-recurring funds.
<input checked="" type="checkbox"/>	Not requesting capital and/or non-recurring funds.

**PROVISOS**

For FY 2016-17, my agency is (mark "X"):	
<input type="checkbox"/>	Requesting a new proviso and/or substantive changes to existing provisos.
<input type="checkbox"/>	Only requesting technical proviso changes (such as date references).
<input checked="" type="checkbox"/>	Not requesting any proviso changes.

Please identify your agency's preferred contacts for this year's budget process.

	<u>Name</u>	<u>Phone</u>	<u>Email</u>
<b>PRIMARY CONTACT:</b>	Terry Coston	803-896-5291	terry.coston@pcf.sc.gov
<b>SECONDARY CONTACT:</b>			

I have reviewed and approved the enclosed FY 2016-17 Agency Budget Plan, which is complete and accurate to the extent of my knowledge.

	<u>Agency Director</u>	<u>Board or Commission Chair</u>
<b>SIGN/DATE:</b>		
<b>TYPE/PRINT NAME:</b>	Terry A. Coston	JAMES E. MEDCETER

This form must be signed by the department head – not a delegate.