Reset

South Carolina Department of Social Services
Economic Services

DEPENDENT CARE PAYMENT VERIFICATION FORM

Part I.

Return Form To:

South Carolina Department of Social Services

Address: _____

_____

Applicant/Recipient's Name: _____

Case No.: _____

Case Name: _____

DSS Worker's Name: _____

Part II.

I certify that the above named applicant/recipient is billed or charged $ _____

☐ Daily ☐ Biweekly ☐ Weekly ☐ Semimonthly ☐ Monthly ☐ Other: (Explain) _____

for the following dependent(s): _____

_____

_____

Does SC Voucher pay any portion of the above charge? ☐ Yes ☐ No If yes, how much? _____

I ☐ Do ☐ Do Not receive Temporary Assistance for Needy Families (TANF) benefits.

I ☐ Do ☐ Do Not receive Supplemental Nutrition Assistance Program (SNAP) benefits.

Name of Caregiver: (Please print) _____

Address: _____

Telephone No.: _____

Caregiver's Signature: _____

Date: _____

Instructions for DSS Form 1670

This form is used to inform the Agency how much an applicant/recipient is paying for dependent care.

Part I is completed by the DSS Worker sending this form.

Address: The DSS Worker inputs his/her county office's address or the client's local DSS office into this field.

DSS Worker's Name: Self-explanatory.

Applicant/Recipient's Name: Self-explanatory.

Case No.: Client's CHIP case number.

Case Name: Name of case given in CHIP.

Part II is completed by the Dependent Care Provider.

Name of Caregiver: Caregiver prints his or her name.

Address: Caregiver inputs the address of the location of where dependent care services are provided.

Telephone No.: Caregiver inputs his/her telephone number.

Caregiver's Signature: Self-explanatory.

Date: Caregiver inputs the date in which he/she completes the form.