

**South Carolina Department of Social Services  
SC Voucher Program  
LEVEL A AND B PROVIDER ENROLLMENT FORM**

New  Updated

FEIN No.: \_\_\_\_\_ ( ) or Social Security No.: \_\_\_\_\_ ( )

Provider/Agency Name: \_\_\_\_\_

Facility Name: (If different from Provider Name) \_\_\_\_\_

Facility Co. Name: \_\_\_\_\_ Facility Telephone: \_\_\_\_\_

Director's Name: \_\_\_\_\_

Alternate Contact Person/Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Owner's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Facility Street Address, P.O. Box or Route Number

\_\_\_\_\_ City State Zip Code

Payment Address: \_\_\_\_\_

Facility Street Address, P.O. Box or Route Number

\_\_\_\_\_ City State Zip Code Payment Telephone

**Hours of Operation**

- 1st Shift \_\_\_\_\_ M to \_\_\_\_\_ M
- 2nd Shift \_\_\_\_\_ M to \_\_\_\_\_ M
- 3rd Shift \_\_\_\_\_ M to \_\_\_\_\_ M

**Days of Operation**

- |   |   |   |    |   |    |    |
|---|---|---|----|---|----|----|
| M | T | W | TH | F | SA | SU |
| M | T | W | TH | F | SA | SU |
| M | T | W | TH | F | SA | SU |

**1) Provider Type**

(Check only one)

- Center
- Accredited Center
- Group Day Care
- Family Day Care
- Exemption

**2) Regulatory Requirement**

(Check only one)

- License
- Approval
- Registration
- Exemption Letter
- DDSN
- Military

**3) Provider Category**

(Check as many as apply)

- Church Sponsored
- Private-for-profit
- Private-nonprofit
- Public Facility
- Head Start
- School District
- Less than 4 Hours/Day
- Summer Camp

**4) Ownership Status**

(Check one from each of the 3 categories below)

- Minority Owned
- Non-Minority Owned
- Sole Proprietor
- Partnership
- Corporation
- Other
- State Employee
- Non-State Employee
- Legislator

**Regulatory Information:** Number: \_\_\_\_\_ Capacity: \_\_\_\_\_

If applicable, number of infants under 24 months of age: \_\_\_\_\_ Date of Expiration: \_\_\_\_\_

**Care Types Provided:** (Check all that apply)  0-2 Full  3-5 Full  6-12 Full  0-2 Half  3-5 Half  6-12 Half  
Check Here If Provider Is Re-enrolling:  Yes

\_\_\_\_\_ Program Reviewer

\_\_\_\_\_ Review Date

\_\_\_\_\_ Provider Enrollment Date

\_\_\_\_\_ Processed By