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

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

Days of Operation

1) Provider Type
☐ Center
☐ Accredited Center
☐ Group Day Care
☐ Family Day Care
☐ Exemption

2) Regulatory Requirement
☐ License
☐ Approval
☐ Registration
☐ Exemption Letter
☐ DDSN
☐ Military

3) Provider Category
☐ Church Sponsored
☐ Private-sponsored
☐ Private-for-profit
☐ Private-nonprofit
☐ Public Facility
☐ Head Start
☐ School District
☐ Less than 4 Hours/Day
☐ Summer Camp

4) Ownership Status
☐ 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 __________________________

DSS Form 37108 (FEB 15) Edition of NOV 11 is obsolete.