

South Carolina Department of Social Services
 ABC Child Care Program
FAMILY, FRIEND, AND NEIGHBOR
CHILD CARE ENROLLMENT AND AGREEMENT FORM

Social Security No.: _____ Relative of Child: Yes No _____
If Yes, Relationship to Child

Provider Name: _____

Provider County: _____ Provider Telephone: (____) _____

Provider Home Address: _____
Street Number or Route Number

Provider City/State: _____ Provider Zip Code: _____

Provider Mailing Address (If different than above)

Address: _____
P.O. Box, Street Number or Route Number

City/State: _____ Zip Code: _____ Alternate Telephone: (____) _____

Provider Category: (Mark one "X" in each column)

Private-for-Profit	X	Minority Owned		Sole Proprietor	X	State Employee	
		Non-Minority Owned				Non-State Employee	

I am available to provide care: (Fill in all that apply)

Monday From _____ AM To _____ PM Friday From _____ AM To _____ PM
 Tuesday From _____ AM To _____ PM Saturday From _____ AM To _____ PM
 Wednesday From _____ AM To _____ PM Sunday From _____ AM To _____ PM
 Thursday From _____ AM To _____ PM

Do you operate more than one shift? Yes No

The child will be cared for in: (Check only one)

The child's home and I am: (Check one) A Relative A Neighbor A Friend
 My home and I am: (Check one) A Relative A Neighbor A Friend

The rates I will charge: (Per child per week)

Age Group	Full-Time	Half-Time	Less Than Half-Time
0-2 Years			
3-5 Years			
6-12 Years			
13-18 Years			

Password for ABC: _____

The password will be used for you to access information from the ABC Child Care Program about your payments, client services, etc. **Note: The password must be at least six characters (letters, numbers or a combination of the two). Please do not use punctuations or symbols.**

By my signature I confirm that the above information is true and correct:

Provider Signature: _____ Date: _____

INSTRUCTIONS FOR ENROLLMENT FORM 3774

- Social Security No.:** Enter your Social Security number as it is on your Social Security card.
- Relative of Child:** Check Yes if you are related by blood or law to the child, and write in how you are related. Check No if you are not related by blood or law to the child.
- Provider Name:** Write in your full legal name as it appears on your Social Security card.
- Provider County:** Write in the name of the county where you live.
- Telephone Number:** Write in your home telephone number or the telephone number where you can be reached while the child is in your care.
- Provider Address:** Write your complete address with street number and name. If you live on a rural route, please put the name of the road or highway.
- Provider City/State:** Write your city or town name and state.
- Provider Zip Code:** Write your 5- or 9-digit zip code.
- Provider Mailing Address:** Write in the address where you want us to send your payments and all information, if it is different from your home address.
- Provider Category:** Mark the correct box under each category.
- Mark Non-Minority if you are a white male, otherwise, mark minority owned.
- Mark state employee if you are an employee of the State of South Carolina, non-state if you are NOT an employee of the State of South Carolina
- Availability of Care:** Write in the start and end time for each day you are available to provide care.
- Where the child will be cared for:** Check in the home of the child if you are caring for the child in the child's home.
- Check in my home and I am a relative if you are a family member and will provide care in your home.
- Check in my home and I am a friend if you are a friend caring for the child in your home.
- Check in my home and I am a neighbor if you are a neighbor caring for the child in your home.
- The rates I will charge:** Indicate in each box the rates you will charge for each care type listed for full, half, and/or less than half time care. The ABC Child Care Program will pay up to the highest rate charged within a care type not to exceed the maximum rate established.
- Password for ABC:** Write in a password of your choice. This password will be used to verify your identity when you call into the ABC Child Care Control Center for information regarding your payment, client services, etc.

NOTE: If you are applying to provide child care services in the child's home, and you are not related to the child as an aunt, uncle (first generation only), sibling, grandparent, or great-grandparent, you will not be approved as an in-home care provider.

Additionally, if you are applying to provide child care services in the child's home, and you are not related to the child as stated above, and the client does not have at least 5 children needing child care services, you will not be approved as an in-home care provider.

Family, Friend, and Neighbor Child Care Provider Agreement

The child will be cared for in:

- The child's home and I am: (Check one) A Relative A Neighbor A Friend
 My home and I am: (Check one) A Relative A Neighbor A Friend

Provider Name: _____ Social Security No.: _____

Parent Name: _____ Social Security No.: _____

AS A CONDITION OF PARTICIPATION AND PAYMENT, I AGREE:

- that this Agreement shall not be assigned or transferred to another individual.
- that all services provided and claims submitted shall be in accordance with 45CFR98 (1991), Provider Business Procedures issued by the South Carolina Department of Social Services (DSS), and all applicable federal and state laws, rules and regulations.
- that I will provide child care only at the address listed on this agreement.
- to allow parents immediate access to the child in my care.
- to accept children without discrimination with regard to race, color, national origin, age, sex, religion or physical or mental disability.
- to provide children with adequate food, shelter, rest, and age appropriate activities.
- not to allow anyone else to care for the children under this Agreement.
- to collect client fees from parents as indicated on the connection letter, along with any difference between what ABC pays and I charge.
- to protect children from abuse/neglect and to report any suspicion of child abuse and neglect to DSS.
- to submit the Service Voucher Log (SVL) for payments for active, eligible children who have been authorized by DSS.
- that I will not be paid for services when the Service Voucher Log (SVL) is submitted to DSS more than 12 months following the end of service.
- to maintain daily attendance records, payment records and fee receipts for a minimum of three years and provide these records to county, state, federal officials and others as authorized in writing by DSS.
- to become familiar with the policies and procedures in the Family, Friend, and Neighbor Child Care Provider Business Procedures.
- to notify DSS within 3 working days of excessive absences or irregular child care usage.
- to notify DSS within one working day if a child is no longer in my care for reasons other than termination by DSS.
- that I shall not stop serving any child without prior notification to DSS. This notification must include the reason for stopping services and must be properly documented.
- that if I refuse or deny service for a week, or do not allow a child to finish a week of care, I will not be paid for that week.
- that I will not be paid by DSS for services I provide prior to receiving written authorization from DSS.
- that I understand this Agreement may be terminated by either me or DSS with proper notice given as outlined in the ABC Child Care provider termination policy.
- this Agreement may also be terminated immediately and without advance notification if a child's health or safety is endangered.
- that I will safeguard the use and disclosure of information concerning clients or recipients of services in accordance with all applicable federal and state laws and regulations and restrict access to, and use disclosure of such information in compliance with said laws and regulations.

- that I have the right to receive a fair hearing regarding any decision that results in the denial or termination of services, provided that the decision is not due to funding. Requests for fair hearings shall be submitted in writing to Individual and Provider Rights, SCDSS, P.O. Box 1520, Columbia, South Carolina, 29202-1520.
- that if any dispute of an adverse action by DSS shall arise under the terms of this Agreement, the sole and exclusive remedy shall be the filing of a Notice of Appeal within 30 calendar days of receipt of written notice of the South Carolina Department of Social Services' (DSS) action or decision which forms the basis of the appeal. Administrative appeals shall be in accordance with the DSS regulation R. 126-150, et seq., Code of Laws of South Carolina (1976, as amended), Volume 27, and in accordance with the Administrative Procedures Act, Section 1-23-380, Code of Laws of South Carolina (1976, as amended).

By signing this agreement, I certify that I have read, understand, and agree to all terms and conditions of this Agreement and the enrollment information I have furnished is true, accurate, and complete.

I also acknowledge receipt of information regarding the rules and policies of the South Carolina Department of Social Services ABC Child Care Program.

Family, Friend, and Neighbor Child Care Provider:

Signature of Provider: _____ Date: _____

Print Your Name: _____

Home Address: _____

Mailing Address: _____ City: _____ State: _____

Telephone: (____) _____ County: _____

Client Name: _____

Print Name: _____