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