APPLICATION TO OPERATE
RESIDENTIAL, DAY OR RESPITE FACILITY

Date of Application:_____

Reason for Application: ☐Initial Licensing of a New Facility

☐Termination/Closure
Reason for termination/closure:_____

☐Change
☐in location ☐in facility type
☐in number of people served

1. Facility Information (Name):_____

Address:_____

County:_____ Telephone Number (*include area code*):_____

Type of Facility:

☐SLP-II ☐CIRS ☐CTH-I ☐CTH-II ☐ASW

☐AAC ☐WAC ☐Respite ☐Camp ☐Unclassified Program

Capacity (Number of): Children:_____ Adult(s):_____ Respite:_____
(under age 21)

2. Changed Information (Updated):_____

Address:_____

County:_____ Telephone Number (*include area code*):_____

Type of Facility:

☐SLP-II ☐CIRS ☐CTH-I ☐CTH-II ☐ASW

☐AAC ☐WAC ☐Respite ☐Camp ☐Unclassified Program

Capacity (Number of): Children:_____ Adult(s):_____ Respite:_____
(under age 21)

3. For CTH-I or Respite locations: Please Identify all household members (including child(ren) 21 years or younger):

Full Name	Age	Relationship to Caregiver
_____ Add/Delete/Same	_____	_____
_____ Add/Delete/Same	_____	_____
_____ Add/Delete/Same	_____	_____
_____ Add/Delete/Same	_____	_____

4. List all licenses and/or certificates maintained by the facility:

Type of license and/or certificate	By Whom
_____	_____
_____	_____

5. Provider organization having jurisdiction over the facility:

Name: _____

Address: _____

County: _____ Telephone Number (*include area code*): _____

When requesting a new license, please submit Electrical, HVAC and State Fire Marshal Inspection reports. If a consumer is under 21 years of age and moving into a CTH-I or CTH-II, also submit DHEC Sanitation Inspection. Send to Central Office Attn: Quality Management/Licensing. Documents should be submitted as a single packet.

Statements contained in this application are correct. I understand the facility must be in compliance with all applicable Federal, State, and local laws and regulations, and all applicable DDSN contracts, policies, procedures, and standards, and that noncompliance with these terms may results in enforcement actions as identified in DDSN Directive 104-01-DD and/or DDSN/Provider Contract.

_____ _____

Signature/Head of the Provider Organization Title

_____

Notary Public

_____County, South Carolina

My Commission Expires: _____