Provider Information

Please provide the following information for the Company/Entity submitting the Application:	
Company/Entity Name:	
Mailing Address:	
Telephone Number:	
Email Address:	
State Vendor Number:	
Please provide contact information for the representative of the Company/Entity to be contacted regarding this Application:	
Representative Name:	
Mailing Address:	
Telephone Number:	
Email Address:	

Regarding the **service(s)** the company/entity is applying to be qualified to deliver, please indicate the service(s) for which qualification as a provider is being requested.
Please check or otherwise indicate all that apply:

☐	Case Management (Medicaid Targeted Case Management /State Funded Case Management)
☐	Waiver Case Management
☐	Residential Habilitation
☐	Day Services (Day Activity, Career Preparation, Community Services, and/or Support Center)
☐	Employment Services (Group, Individual)
☐	Early Intervention [EI 0-3 and/or EI 3-6]
☐	Home Support Services (Respite, Adult Companion)
☐	Independent Living Skills
☐	Intake

Once qualified to provide a service noted above, the company / entity may deliver services to authorized DDSN eligible participants in any county of South Carolina. For each service noted above please indicate where, upon approval, the company/entity intends to deliver the service. *(e.g., Intake - statewide; Home Support Services - Richland and Lexington Counties)* In addition, please indicate which specific population(s) the company/entity intends to serve. *(e.g., Intellectual Disabilities/Related Disabilities (ID/RD); Autism; Head and Spinal Cord Injuries (HASCI).*

Service Name:	Counties included in Service Area:	Target Population: