South Carolina Department of Probation, Parole and Pardon Services
Service Provider Application Form

Completion of this form serves as a request that this Service Provider be listed in the Department's Service Provider Directory. The following information will be used to identify the Service Provider's role in providing rehabilitative services for offenders under Department supervision. NOTE: All service fees/costs are at the offender's expense and are not the responsibility of the SC Department of Probation, Parole and Pardon Services (SCDPPPS). Referral to the Service Provider does not constitute a contract or obligation with or by SCDPPPS.

Resident County: **Counties Served:**

Service Provider Name		**Contact Person and Title**	
Physical Address		**Phone Number**	
		Fax Number	
Mailing Address (If Different)		**E-mail Address**	
		Website	

Licensure/Certifications:

Genders Served: **Male** **Female** **Both**

Transportation Assistance Available: **Yes or No**

Services are: **Inpatient** **Outpatient** **Does not Apply**

- **Handicap Accessible** **Yes or No**
- **Veterans Only** **Yes or No**
- **Sex Offenders Allowed** **Yes or No**
- **Victims Only** **Yes or No**
- **Violent Offenders Allowed** **Yes or No**

Service Notes:

Services offered in:
English____
French____
German____
Spanish____

Intake Process Notes:

Eligibility Notes:

Provider Type: **Government** **Private** **Non-Profit**

Indicate which type of services that the organization provides:

☐ **Alcohol, Drug Abuse, and other Addiction Services** (e.g. AOD Commissions, substance abuse treatment or education, inpatient/outpatient services):

Description of Service:

Cost of Services, If any (Insurance accepted, hourly rate, fees, sliding scale, Medicaid accepted, Financial Assistance; Indigent Waiver Accepted):

Duration of Services: (e.g. 8 weeks or Need Based)

☐ **Vocational/Employment Services** (e.g. Vocational Rehabilitation, Employment Assistance, Job Readiness):

Description of Service:

Cost of Services, If any (Insurance accepted, hourly rate, fees, sliding scale, Medicaid accepted, Financial Assistance; Indigent Waiver Accepted):

Duration of Services: (e.g. 8 weeks or Need Based):

☐ **Emotional/Psychological/Relational Instability Services** (e.g. Crisis Intervention, Housing for Emotionally Disturbed, Medications Monitoring Services, Interpersonal Relationship Counseling, Marriage Intervention Services, CDV Perpetrator Counseling):

Description of Service:

Cost of Services, If any (Insurance accepted, hourly rate, fees, sliding scale, Medicaid accepted, Financial Assistance; Indigent Waiver Accepted):

Duration of Services: (e.g. 8 weeks or Need Based):

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☐ **Sensitivity/Awareness/Social Adjustment Services** (e.g. MADD Panels, Victim Sensitivity/Awareness Panels, Anger Management, Life Skills, Community Awareness Programs):

Description of Service:
Cost of Services, If any (Insurance accepted, hourly rate, fees, sliding scale, Medicaid accepted, Financial Assistance; Indigent Waiver Accepted): Duration of Services: (e.g. 8 weeks or Need Based):

☐ **Intellectual Impairment Services** (e.g. Evaluation for Mental Retardation, Support Groups, Housing for Intellectually Impaired):

Description of Service:
Cost of Services, If any (Insurance accepted, hourly rate, fees, sliding scale, Medicaid accepted, Financial Assistance; Indigent Waiver Accepted): Duration of Services: (e.g. 8 weeks or Need Based):

☐ **Educational Services** (e.g. Learn and Earn, other GED Programs, Adult Education Services):

Description of Service:
Cost of Services, If any (Insurance accepted, hourly rate, fees, sliding scale, Medicaid accepted, Financial Assistance; Indigent Waiver Accepted): Duration of Services: (e.g. 8 weeks or Need Based):

☐ **Sex Offender Services** (e.g. Sex Offender Perpetrator Counseling Services):

Description of Service:
Cost of Services, If any (Insurance accepted, hourly rate, fees, sliding scale, Medicaid accepted, Financial Assistance; Indigent Waiver Accepted): Duration of Services: (e.g. 8 weeks or Need Based):

Submitted by:		**Title:**		**Date:**	

All providers must sign and submit the SCDPPPS Minimum Standards for Service Providers (Form 1482) along with this application.

Mail completed Service Provider Application to the address listed below:

Field Programs - Service Provider Directory
SCDPPPS
Post Office Box 50666
Columbia, South Carolina 29250