



**LICENSURE APPLICATION  
for  
In-Home Care Provider  
  
REGULATION 60-122**

**Return all documentation to:**

Email Address (preferred method):

[IHCP@dph.sc.gov](mailto:IHCP@dph.sc.gov)

OR

Mailing Address:

Bureau of Health Facilities Licensing

P.O. Box 2046

West Columbia, SC 29171

For additional questions, contact us at: 803-545-4370.

## INSTRUCTIONS FOR COMPLETING THE APPLICATION

**NOTICE:** Your license must be renewed prior to the expiration date. The current licensee is responsible for renewal of the license prior to the expiration date regardless of any changes or pending approvals (i.e., ownership changes or capacity increases/decreases) from the Department that are in progress at the time the license is due for renewal.

Application must be complete and legible. Any missing information may result in delays in processing this application. Any section that requires additional space or documentation shall be included as an attachment in the 8.5" x 11" format and be labeled to identify the appropriate section. Proof of payment is required for all applications submitted.

### Reason for the Application

- Initial: Check this box only if this is the first time you are applying for a license with the Department. DO NOT check this box if this is a change of ownership for an existing licensed service/facility.
- Renewal: Check this box only if you are renewing your license. Enter the license number and expiration date. The name of the service/activity must appear exactly as it did the prior year.
- Amended License Request: Check this box if you are applying for a change that will alter the information on the face of your license; then, ensure that you ONLY complete Parts C & D.
- If you are making changes to the Name and/or Location OR if your business is changing ownership, complete Part C & D ONLY

### Part A: Provider Information

- Provider Information-Please complete the applicant information for the provider.
- Contact Person and Corresponding Mailing Address: All correspondence coming from Healthcare Quality will be sent to this person and address.
- Administrator: Please complete each field.

### Part B: Operation/Ownership Disclosure

- Licensee Information: Name of the person(s) or entity to be licensed to operate the provider at the site(s) indicated in Part A.
- Indicate the ownership type.
- Complete the requested information:
  - For partnerships, you must provide the name of each partner;
  - For limited liability company (LLC), you must provide the names of members and attach a list with the names and address of the members of the limited liability company;
  - For a corporation, you must provide the name and title of each corporate officer

### Part D: Licensure Changes

- For Name or Location changes, complete Section 1.
- For Ownership changes, complete Section 2.
- For Addition of multiple locations, complete Section 3.

### Additional Documents (to be submitted with your Initial and/ Renewal Application)

- A copy of your Random Drug Testing Policy
- A copy of your Liability Insurance Coverage: Either liability insurance coverage or, in lieu of liability insurance coverage, a surety bond. The provider shall maintain such coverage for the duration of the license period. The minimum amount of coverage is one hundred thousand dollars (\$100,000) per occurrence and three hundred thousand dollars (\$300,000) aggregate;
- A copy of your Workman's Comprehensive Insurance Coverage: Workers compensation insurance in accordance with S.C. Code Section 42-5-10 et seq.;

### Office Mechanics & Filing

The completed form will be stored on the Bureau of Operations Support's SharePoint Site / OneDrive. This form is maintained by retention schedule 16327 — Masterfiles. Once the 10-year retention period has been met and quality review has been completed, an ARM-11 destruction request should be submitted and approved prior to disposal of the original form.



## Application for In-Home Care Providers Regulation 60-122

| Reason for Application                                                                                                                                                                                    |                                                                                                                   |                  |                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------|
| <input type="checkbox"/> Initial                                                                                                                                                                          | <input type="checkbox"/> Renewal                                                                                  |                  | <input type="checkbox"/> Change Request |
|                                                                                                                                                                                                           | License Number:                                                                                                   | Expiration Date: | (Complete Part C and D)                 |
| Part A. Provider Information                                                                                                                                                                              |                                                                                                                   |                  |                                         |
| Facility Name:                                                                                                                                                                                            |                                                                                                                   |                  |                                         |
| Primary Office Address:                                                                                                                                                                                   |                                                                                                                   |                  |                                         |
| City:                                                                                                                                                                                                     | State:                                                                                                            | Zip:             | County:                                 |
| Telephone Number:                                                                                                                                                                                         |                                                                                                                   | Fax Number:      |                                         |
| Multiple Location(s) (DO NOT include the primary office location.)                                                                                                                                        |                                                                                                                   |                  |                                         |
| <b>Location 1</b>                                                                                                                                                                                         | <input type="checkbox"/> Check this box if this is a new location being added or a relocation of existing office. |                  |                                         |
| Facility Name:                                                                                                                                                                                            |                                                                                                                   |                  |                                         |
| Physical Address:                                                                                                                                                                                         |                                                                                                                   |                  |                                         |
| City:                                                                                                                                                                                                     | State:                                                                                                            | Zip:             | County:                                 |
| Telephone Number:                                                                                                                                                                                         |                                                                                                                   | Fax Number:      |                                         |
| <b>Location 2</b>                                                                                                                                                                                         | <input type="checkbox"/> Check this box if this is a new office being added or a relocation of existing office.   |                  |                                         |
| Facility Name:                                                                                                                                                                                            |                                                                                                                   |                  |                                         |
| Physical Address:                                                                                                                                                                                         |                                                                                                                   |                  |                                         |
| City:                                                                                                                                                                                                     | State:                                                                                                            | Zip:             | County:                                 |
| Telephone Number:                                                                                                                                                                                         |                                                                                                                   | Fax Number:      |                                         |
| <b>Location 3</b>                                                                                                                                                                                         | <input type="checkbox"/> Check this box if this is a new office being added or a relocation of existing office.   |                  |                                         |
| Facility Name:                                                                                                                                                                                            |                                                                                                                   |                  |                                         |
| Physical Address:                                                                                                                                                                                         |                                                                                                                   |                  |                                         |
| City:                                                                                                                                                                                                     | State:                                                                                                            | Zip:             | County:                                 |
| Telephone Number:                                                                                                                                                                                         |                                                                                                                   | Fax Number:      |                                         |
| <input type="checkbox"/> Check this box if adding more than three multiple locations and attach an 8.5 x 11 sheet with requested information.                                                             |                                                                                                                   |                  |                                         |
| Administrator                                                                                                                                                                                             |                                                                                                                   |                  |                                         |
| Name:                                                                                                                                                                                                     |                                                                                                                   |                  |                                         |
| Telephone Number:                                                                                                                                                                                         |                                                                                                                   | Fax:             |                                         |
| Email Address:                                                                                                                                                                                            |                                                                                                                   |                  |                                         |
| Contact Person and Correspondence Mailing Address:                                                                                                                                                        |                                                                                                                   |                  |                                         |
| (Name of person who can make licensure/operation decisions about facility and address where you want to receive ALL correspondence, including the license, from the Bureau of Health Facility Licensing.) |                                                                                                                   |                  |                                         |
| Name:                                                                                                                                                                                                     |                                                                                                                   | Title:           |                                         |
| Address:                                                                                                                                                                                                  |                                                                                                                   |                  |                                         |
| City:                                                                                                                                                                                                     | State:                                                                                                            | Zip:             |                                         |
| Telephone Number:                                                                                                                                                                                         |                                                                                                                   |                  |                                         |
| Primary Email:                                                                                                                                                                                            |                                                                                                                   |                  |                                         |

| Part B. Operation Disclosure                                                                                                                                                                                                                      |        |                                                                                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------|--|
| Licensee Information: <i>(name of the person(s) or legal entity licensed to operate the business at that site as indicated in Part A)</i><br><b>*This can be found on your current license OR your documentation from the Secretary of State.</b> |        |                                                                                                                                           |  |
| Licensee Name:                                                                                                                                                                                                                                    |        |                                                                                                                                           |  |
| Address:                                                                                                                                                                                                                                          |        |                                                                                                                                           |  |
| City:                                                                                                                                                                                                                                             | State: | Zip:                                                                                                                                      |  |
| Telephone Number:                                                                                                                                                                                                                                 |        | Fax Number:                                                                                                                               |  |
| <b>Ownership Type</b>                                                                                                                                                                                                                             |        |                                                                                                                                           |  |
| <input type="checkbox"/> Sole Proprietorship<br><input type="checkbox"/> Partnership<br><input type="checkbox"/> Limited Partnership                                                                                                              |        | <input type="checkbox"/> Corporation*<br><input type="checkbox"/> Limited Liability Company (LLC)*<br><input type="checkbox"/> Government |  |
|                                                                                                                                                                                                                                                   |        | <input type="checkbox"/> Other: _____                                                                                                     |  |
| *Submit SC Secretary of State documentation, if applicable                                                                                                                                                                                        |        |                                                                                                                                           |  |

Licensee or Owner Documents Required

1. Secretary of State documentation, if applicable ☐ Attached ☐ N/A
2. If the licensee is a corporation or partnership, attach a list identifying all officers. ☐ Attached ☐ N/A
3. If the licensee is a corporation, partnership, limited liability company, or limited partnership, attach a list with the name, address, and percentage of all shareholders, partners, or members that possess 5% or more ownership of the corporation, partnership, limited liability company, or limited partnership." ☐ Attached ☐ N/A

**Part C: ONLY COMPLETE THIS SECTION FOR LICENSURE CHANGES**☐ Change of Facility  
Name/Location  
(Complete Section 1)☐ Change of Ownership  
(Complete Section 2)☐ Adding Multiple Locations  
(Complete Section 3)**Section 1 (PROVIDER INFORMATION)****PRIOR TO CHANGE****Current** License Number:**Current** Facility Name:**Current** Facility Address:

City:

State:

Zip:

County:

Facility Telephone Number:

Fax Number:

**AFTER CHANGE****New** Facility Name:**New** Facility Address:

City:

Zip:

County:

New Facility Telephone Number:

Fax Number:

**Section 2 (LEGAL IDENTITY OF OWNERSHIP)***Application must be completed by new owner, as licenses are not transferable.***PRIOR TO CHANGE**

Name of Current Owner:

License Number:

Address of Current Owner:

City:

State:

Zip:

County:

Telephone Number of Current Owner:

Signature of current owner:

Date:

**AFTER CHANGE**

Name of New Owner:

Address of New Owner:

City:

Zip:

County:

Telephone Number of New Owner:

Signature of new owner:

Date:

| Section 3 (Multiple Locations)                                                                                                                |                                                                                                                   |             |         |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------|---------|
| <input type="checkbox"/> Check this box to affirm that all multiple locations are providing full scope of service.                            |                                                                                                                   |             |         |
| <b>Location 1</b>                                                                                                                             | <input type="checkbox"/> Check this box if this is a new location being added or a relocation of existing office. |             |         |
| Facility Name:                                                                                                                                |                                                                                                                   |             |         |
| Physical Address:                                                                                                                             |                                                                                                                   |             |         |
| City:                                                                                                                                         | State:                                                                                                            | Zip:        | County: |
| Telephone Number:                                                                                                                             |                                                                                                                   | Fax Number: |         |
| <b>Location 2</b>                                                                                                                             | <input type="checkbox"/> Check this box if this is a new office being added or a relocation of existing office.   |             |         |
| Facility Name:                                                                                                                                |                                                                                                                   |             |         |
| Physical Address:                                                                                                                             |                                                                                                                   |             |         |
| City:                                                                                                                                         | State:                                                                                                            | Zip:        | County: |
| Telephone Number:                                                                                                                             |                                                                                                                   | Fax Number: |         |
| <b>Location 3</b>                                                                                                                             | <input type="checkbox"/> Check this box if this is a new office being added or a relocation of existing office.   |             |         |
| Facility Name:                                                                                                                                |                                                                                                                   |             |         |
| Physical Address:                                                                                                                             |                                                                                                                   |             |         |
| City:                                                                                                                                         | State:                                                                                                            | Zip:        | County: |
| Telephone Number:                                                                                                                             |                                                                                                                   | Fax Number: |         |
| <input type="checkbox"/> Check this box if adding more than three multiple locations and attach an 8.5 x 11 sheet with requested information. |                                                                                                                   |             |         |

**Part D: Verification**

The application shall be signed by the following:

- If an individual, the **owner(s)**
- If a limited liability company, the **head of the limited liability company**
- If a corporation, **two** of its **officers**
- If governmental unit, the **head of the governmental department** having jurisdiction

I, the undersigned, being duly sworn on my oath, depose and say that I have read the foregoing application (and attachments) and know the contents thereof; that the statements contained are correct and true to the best of my knowledge and belief. Furthermore, I understand that I must comply with the standards set forth in South Carolina Regulation 60-122. I understand that non-compliance with these standards may result in the Department pursuing enforcement actions as provided in Regulation 60-122.

|             |
|-------------|
| Signature:  |
| Print Name: |
| Date:       |

|             |
|-------------|
| Signature:  |
| Print Name: |
| Date:       |

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
(Month) (Year)

**NOTARY PUBLIC** \_\_\_\_\_

My commission expires \_\_\_\_\_

**NOTARY SEAL**