

How to Submit Family/Group T.E.A.C.H Early Childhood Education Information Form

This form is only for Family/Group Childcare Centers

1

Navigate to providerportal.dss.sc.gov/#/dece/teach-apps/stu...



Alert! Note: Please be aware that you will have 72 hours to finish this application section. The section link will become invalid after 72 hours. It will be necessary to submit a new application if the link expires.



Alert!!! Listing the names of all the children and the weekly amount their parents pay on childcare center letterhead is the simplest way to submit proof of income. (See below example)

ABC Home Childcare Center
Monday- Friday
7am to 5pm
888-888-8888
123 Main Street

ABC Home Childcare Center weekly rates are \$XXX.XX. I have # of children enrolled Children enrolled here at ABC Home Childcare Center.

Names of current enrollees: (List names of children enrolled into your center)

Thank You
ABC Home Childcare Center Director

2 Select "Proof of Income"

Provider Portal

T.E.A.C.H. EARLY CHILDHOOD® SOUTH CAROLINA SCHOLARSHIP APPLICATION

Reference Number: NNY0000025 To be completed by family/group providers ONLY

FCCH

*** If you are unable to submit application, please recheck to ensure all fields are completed. ***

FAMILY/GROUP HOME INFORMATION

Facility Type:

- Proof Of Income*
- Reimburse Receipts CACFP (if applicable)
- Reimburse Receipts SC Voucher (if applicable)

SECTION A

FACILITY INFORMATION

DSS License/Registration Number/CC Number: 25266 Center Type*: Please select one

Center Name*: Aja Shered

Mailing Address*: 523 Starlight Drive

3 Click "+ to add proof of income document"

Provider Portal

T.E.A.C.H. EARLY CHILDHOOD® SOUTH CAROLINA SCHOLARSHIP APPLICATION

Reference Number: NNY0000025 To be completed by family/group providers ONLY

FCCH

*** If you are unable to submit application, please recheck to ensure all fields are completed. ***

FAMILY/GROUP HOME INFORMATION

Facility Type:

- Proof Of Income*

Copies of receipts from each of the children in your care OR Letter detailing your weekly rate and names of the children you serve*

Proof of Income uploaded?:

Please upload Proof of Income documents.

- Reimburse Receipts CACFP (if applicable)
- Reimburse Receipts SC Voucher (if applicable)

SECTION A

FACILITY INFORMATION

DSS License/Registration Number/CC Number: Center Type*

+ Choose + Upload

4 Click "Upload to finish uploading document"

The screenshot shows the 'Provider Portal' interface for the 'T.E.A.C.H. EARLY CHILDHOOD® SOUTH CAROLINA SCHOLARSHIP APPLICATION'. The page includes a header with the 'SOUTH CAROLINA' logo and 'A Program of SC Endeavors'. Below the header, there are fields for 'Reference Number' (NW0000026) and 'FCC#'. A warning message states: '*** If you are unable to submit application, please recheck to ensure all fields are completed. ***'. The main content area is titled 'FAMILY/GROUP HOME INFORMATION' and contains a 'Facility Type' section with a checked 'Proof Of Income*' option. Below this, there is a text prompt: 'Copies of receipts from each of the children in your care OR Letter detailing your weekly rate and names of the children you serve*'. A file upload box is visible, containing a 'Choose' button, an 'Upload' button (highlighted with an orange arrow), and a file named 'Attendance Form_List #4.pdf' (664 KB). Below the upload box, there is a 'Proof of Income uploaded?*' dropdown menu set to 'No'. At the bottom, there are checkboxes for 'Reimburse Receipts CACFP (if applicable)' and 'Reimburse Receipts SC Voucher (if applicable)'. The page also includes a 'SECTION A' header and a 'FACILITY INFORMATION' section.

5 Select "Reimburse Receipts CACFP (if applicable)"

The screenshot shows the same 'Provider Portal' interface as above. The 'Proof of Income*' checkbox is checked, and the 'Attendance Form_List #4.pdf' file is still present in the upload box. The 'Proof of Income uploaded?*' dropdown menu is now set to 'Yes'. An orange arrow points to the 'Reimburse Receipts CACFP (if applicable)' checkbox, which is now checked. The 'Reimburse Receipts SC Voucher (if applicable)' checkbox remains unchecked. The rest of the page content, including the header, reference numbers, and facility information, remains the same.

6 Click "+ to add reimburse receipts document"

Provider Portal

T.E.A.C.H. EARLY CHILDHOOD® SOUTH CAROLINA SCHOLARSHIP APPLICATION

Reference Number: NWK0000025 To be completed by family/group providers ONLY

FCCH

*** If you are unable to submit application, please recheck to ensure all fields are completed. ***

FAMILY/GROUP HOME INFORMATION

Facility Type:

Proof Of Income*

Copies of receipts from each of the children in your care OR Letter detailing your weekly rate and names of the children you serve*

Proof of Income uploaded?: Yes

Reimburse Receipts CACFP (if applicable)

Child & Adult Care Food Program*

Reimbursement Receipts uploaded?: No

Please upload Reimbursement Receipts.

Attendance Form_List #4 pdf 664 KB

Missing signature_TEACH APP.pdf 373 KB

7 Click "Upload to finish uploading document"

Provider Portal

T.E.A.C.H. EARLY CHILDHOOD® SOUTH CAROLINA SCHOLARSHIP APPLICATION

Reference Number: NWK0000025 To be completed by family/group providers ONLY

FCCH

*** If you are unable to submit application, please recheck to ensure all fields are completed. ***

FAMILY/GROUP HOME INFORMATION

Facility Type:

Proof Of Income*

Copies of receipts from each of the children in your care OR Letter detailing your weekly rate and names of the children you serve*

Proof of Income uploaded?: Yes

Reimburse Receipts CACFP (if applicable)

Child & Adult Care Food Program*

Reimbursement Receipts uploaded?: No

Attendance Form_List #4 pdf 664 KB

Missing signature_TEACH APP.pdf 373 KB

8 Select "Reimburse Receipts SC Voucher (if applicable)"

Provider Portal

Facility Type:

Proof Of Income*

Copies of receipts from each of the children in your care OR Letter detailing your weekly rate and names of the children you serve*

Attendance Form_List #4.pdf 664 KB

Proof of Income uploaded?: Yes

Reimburse Receipts CACFP (if applicable)

Child & Adult Care Food Program*

Missing signature_TEACH APP.pdf 373 KB

Reimbursement Receipts uploaded?: Yes

Reimburse Receipts SC Voucher(if applicable) ←

SECTION A

FACILITY INFORMATION:

DSS License/Registration Number/CC Number: 23268 Center Type*: Please select one

9 Click "+ to add Reimburse Receipts SC Voucher document"

Provider Portal

Facility Type:

Proof Of Income*

Copies of receipts from each of the children in your care OR Letter detailing your weekly rate and names of the children you serve*

Attendance Form_List #4.pdf 664 KB

Proof of Income uploaded?: Yes

Reimburse Receipts CACFP (if applicable)

Child & Adult Care Food Program*

Missing signature_TEACH APP.pdf 373 KB

Reimbursement Receipts uploaded?: Yes

Reimburse Receipts SC Voucher(if applicable)

SC Voucher Receipts*

Reimbursement Receipts uploaded?: No

Please upload SC Voucher Receipts.

10 Click "Upload to finish uploading document"

Provider Portal

Facility Type:

- Proof Of Income*

Copies of receipts from each of the children in your care OR Letter detailing your weekly rate and names of the children you serve*

+ Choose Upload

Attendance Form_List #4.pdf 664 KB

Proof of Income uploaded?: Yes

- Reimburse Receipts CACFP (if applicable)

Child & Adult Care Food Program*

+ Choose Upload

Missing signature_TEACH APP.pdf 373 KB

Reimbursement Receipts uploaded?: Yes

- Reimburse Receipts SC Voucher (if applicable)

SC Voucher Receipts*

+ Choose Upload

SS Acceptance Letter.pdf 187 KB

Reimbursement Receipts uploaded?: No

11 Select "Center Type"

Provider Portal

Reimbursement Receipts uploaded?: Yes

SECTION A

FACILITY INFORMATION

DIS license/Registration Number/CC Number: 25266

Center Name: Aja Sherred

Mailing Address: 123 Starlight Drive

City: GREENVILLE State: SC Zip: 29605

Phone Number: 864560278 Fax Number:

Facility Email: ashered5@gmail.com

Center Type: Please select one

- Family
- Group



Alert! All amounts should be 4 digits. eg. 0040 for \$40 and 0300 for \$300

12

Enter " What is the total amount paid to you by parents each week?" (Please read yellow highlighted area before completing this question)

Provider Portal

Center Name *
Aja Sherred

Mailing Address *
323 Starlight Drive

City * GREENVILLE State * SC Zip * 29605

Phone Number 8645400276 Fax Number

Facility Email
ashered85@gmail.com

SECTION B


FACILITY INFORMATION

The amounts should be in 4 digits, eg: 0040 for \$40, 0300 for \$300

1. * What is the total amount paid to you by parents each week? _____

2. Total Monthly Parent Fees (Line 1 X 4.33 = Monthly Fees) _____

3. * How much was your monthly Child & Adult Care Food Program Reimbursement? _____



13 Question 2 amount will auto-populate

Provider Portal

Mailing Address *
123 Starlight Drive

City * GREENVILLE State * SC Zip * 29605

Phone Number 8645460278 Fax Number

Facility Email ashmed85@gmail.com

SECTION B

FACILITY INFORMATION

The amounts should be in 4 digits, eg: 0040 for \$40, 0300 for \$300

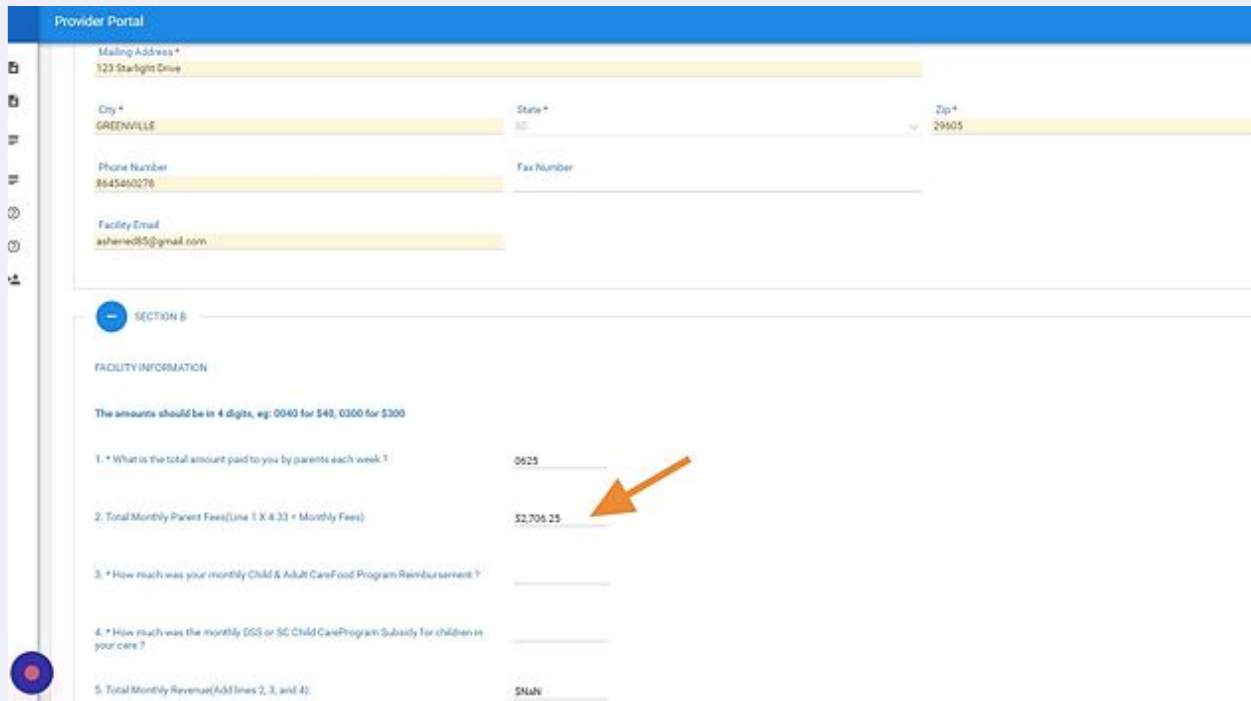
1. * What is the total amount paid to you by parents each week? 0625

2. Total Monthly Parent Fees (Line 1 X 4.33 + Monthly Fees) 52,706.25

3. * How much was your monthly Child & Adult Care Food Program Reimbursement?

4. * How much was the monthly DSS or SC Child Care Program Subsidy for children in your care?

5. Total Monthly Revenue (Add lines 2, 3, and 4): \$NaN



14 Enter "How much was your monthly Child & Adult Care Food Program Reimbursement?"

Provider Portal

Mailing Address *
123 Starlight Drive

City * GREENVILLE State * SC Zip * 29605

Phone Number 8645460278 Fax Number

Facility Email ashmed85@gmail.com

SECTION B

FACILITY INFORMATION

The amounts should be in 4 digits, eg: 0040 for \$40, 0300 for \$300

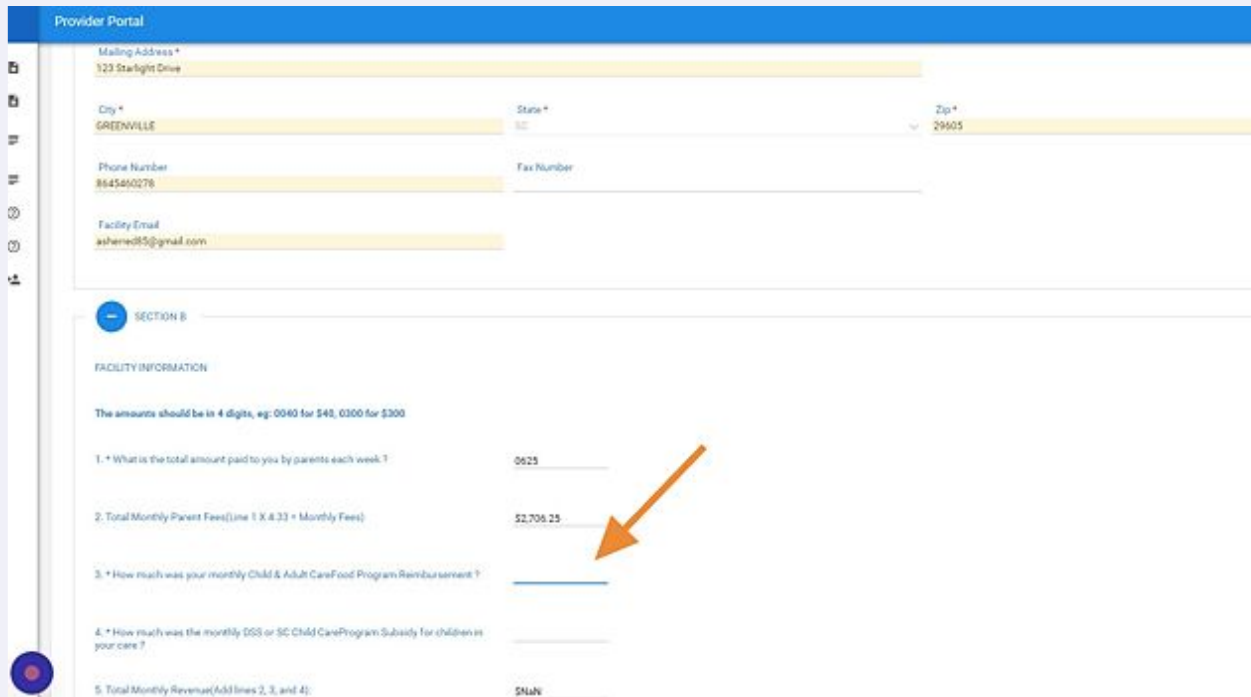
1. * What is the total amount paid to you by parents each week? 0625

2. Total Monthly Parent Fees (Line 1 X 4.33 + Monthly Fees) 52,706.25

3. * How much was your monthly Child & Adult Care Food Program Reimbursement?

4. * How much was the monthly DSS or SC Child Care Program Subsidy for children in your care?

5. Total Monthly Revenue (Add lines 2, 3, and 4): \$NaN



15

Enter "How much was the monthly DSS or Child Care Program Subsidy for children in your care?"

Provider Portal

Facility Email
ashemed05@gmail.com

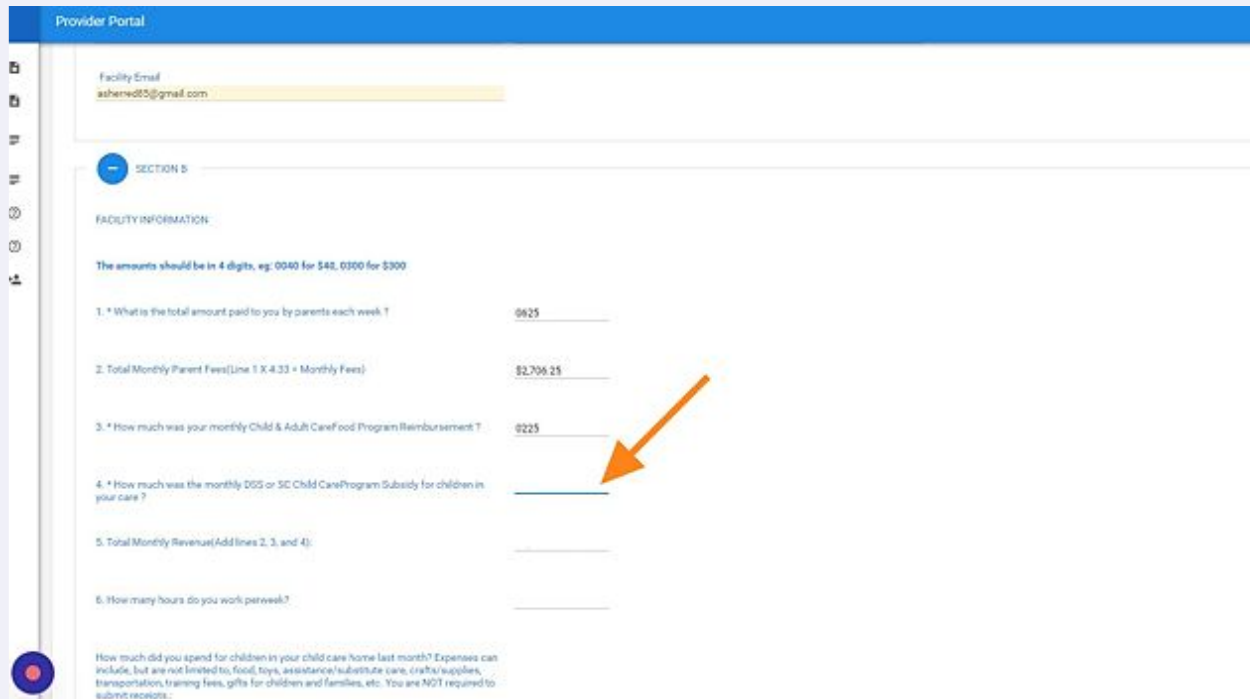
SECTION 5

FACILITY INFORMATION

The amounts should be in 4 digits, eg: 0040 for \$40, 0300 for \$300

1. * What is the total amount paid to you by parents each week?	0625
2. Total Monthly Parent Fees (Line 1 X 4.33 = Monthly Fees)	\$2,706.25
3. * How much was your monthly Child & Adult Care Food Program Reimbursement?	0225
4. * How much was the monthly DSS or SC Child Care Program Subsidy for children in your care?	
5. Total Monthly Revenue (Add lines 2, 3, and 4):	
6. How many hours do you work per week?	

How much did you spend for children in your child care home last month? Expenses can include, but are not limited to, food, toys, assistance/substitute care, crafts/supplies, transportation, training fees, gifts for children and families, etc. You are NOT required to submit receipts.



16

Question 5 amount will auto-populate

Provider Portal

Facility Email

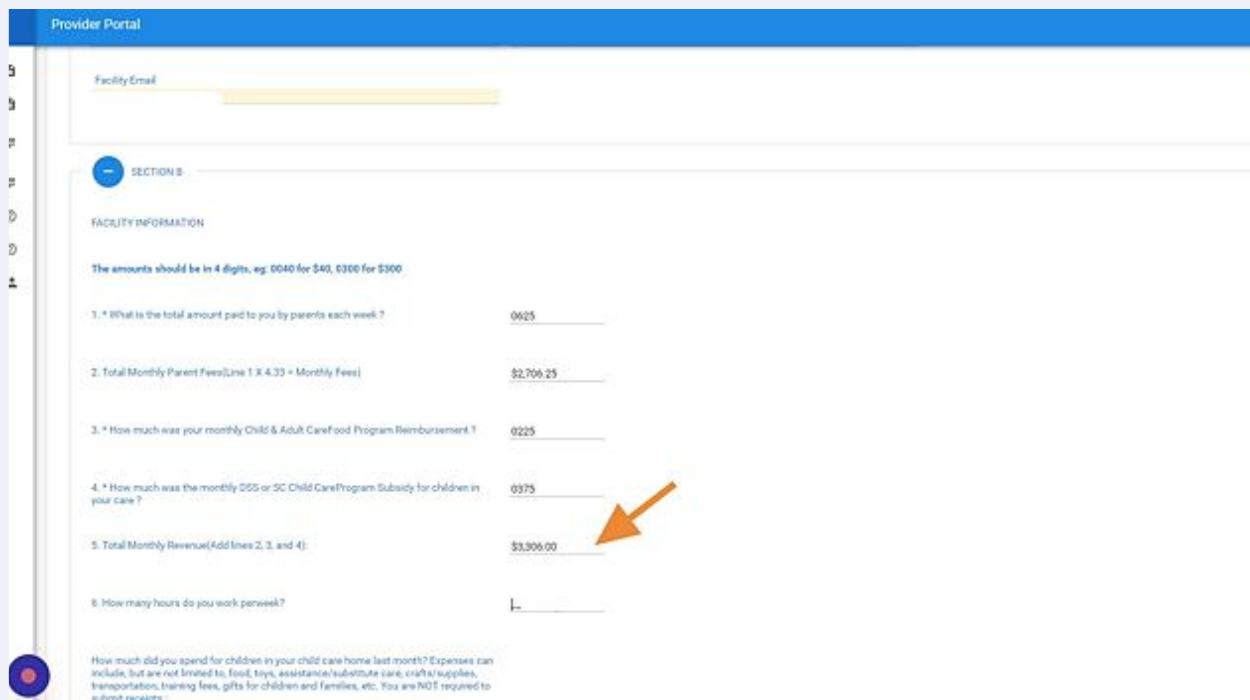
SECTION 5

FACILITY INFORMATION

The amounts should be in 4 digits, eg: 0040 for \$40, 0300 for \$300

1. * What is the total amount paid to you by parents each week?	0625
2. Total Monthly Parent Fees (Line 1 X 4.33 = Monthly Fees)	\$2,706.25
3. * How much was your monthly Child & Adult Care Food Program Reimbursement?	0225
4. * How much was the monthly DSS or SC Child Care Program Subsidy for children in your care?	0375
5. Total Monthly Revenue (Add lines 2, 3, and 4):	\$3,306.00
6. How many hours do you work per week?	

How much did you spend for children in your child care home last month? Expenses can include, but are not limited to, food, toys, assistance/substitute care, crafts/supplies, transportation, training fees, gifts for children and families, etc. You are NOT required to submit receipts.



17 Enter "How many hours do you work per week?"

Provider Portal

Facility Email
ashemed05@gmail.com


SECTION 5

FACILITY INFORMATION

The amounts should be in 4 digits, eg: 0040 for \$40, 0300 for \$300

1. * What is the total amount paid to you by parents each week?	0625
2. Total Monthly Parent Fees (Line 1 X 4.33 = Monthly Fees)	\$2,706.25
3. * How much was your monthly Child & Adult Care Food Program Reimbursement?	0225
4. * How much was the monthly DSS or SC Child Care Program Subsidy for children in your care?	0375
5. Total Monthly Revenue (Add lines 2, 3, and 4):	\$3,306.00
6. How many hours do you work per week?	<input type="text"/>

How much did you spend for children in your child care home last month? Expenses can include, but are not limited to, food, toys, assistance/substitute care, crafts/supplies, transportation, training fees, gifts for children and families, etc. You are NOT required to submit receipts.



18 Enter " Total monthly expenses"

Provider Portal

3. * How much was your monthly Child & Adult Care Food Program Reimbursement?	0225
4. * How much was the monthly DSS or SC Child Care Program Subsidy for children in your care?	0375
5. Total Monthly Revenue (Add lines 2, 3, and 4):	\$3,306.00
6. How many hours do you work per week?	40

How much did you spend for children in your child care home last month? Expenses can include, but are not limited to, food, toys, assistance/substitute care, crafts/supplies, transportation, training fees, gifts for children and families, etc. You are NOT required to submit receipts.


7. Total Monthly Expenses:	<input type="text"/>
Monthly Earnings (Line 5 - Line 7):	\$3,306.00

Signature First Name: * Signature Last Name: * Email Address: *

Please sign in the space provided below by left clicking and moving your mouse *

Clear

Submit



19 Monthly Earnings amount will auto-populate

Provider Portal

3. * How much was your monthly Child & Adult Care Food Program Reimbursement?	0225
4. * How much was the monthly DDS or SC Child Care Program Subsidy for children in your care?	0375
5. Total Monthly Revenue (Add lines 2, 3, and 4):	\$3,306.00
6. How many hours do you work per week?	40
7. Total Monthly Expenses:	0200

How much did you spend for children in your child care home last month? Expenses can include, but are not limited to, food, toys, assistance/substitute care, crafts/supplies, transportation, training fees, gifts for children and families, etc. You are NOT required to submit receipts.

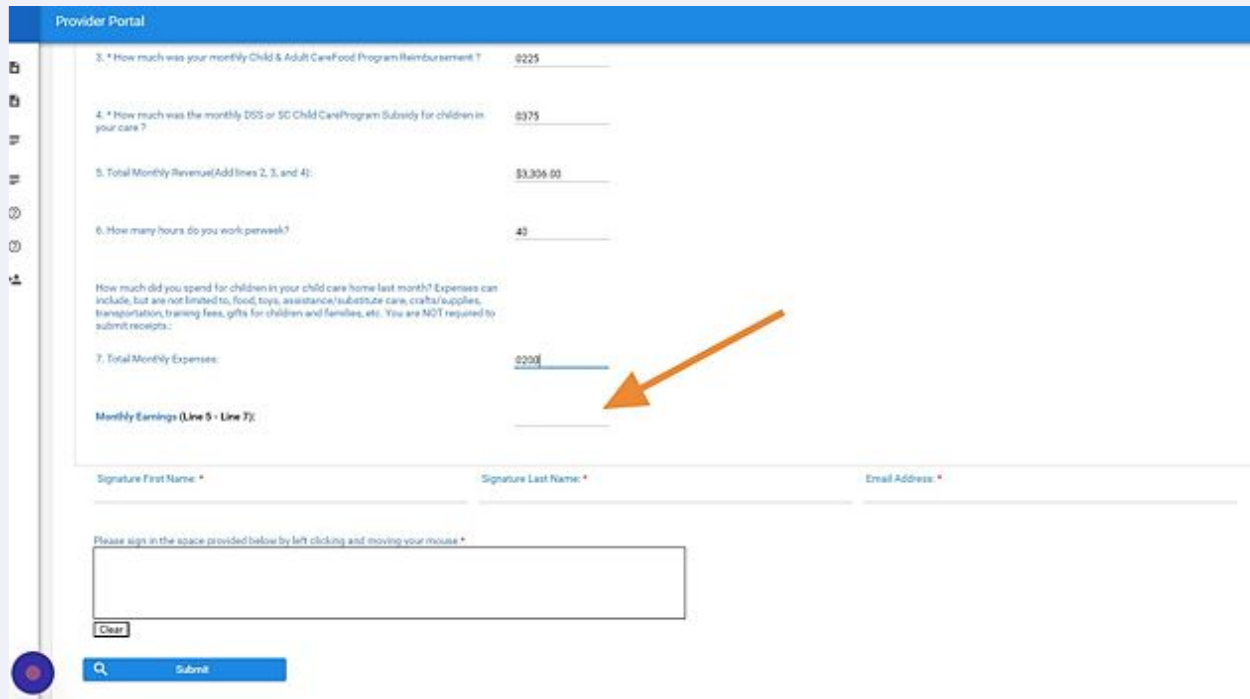
Monthly Earnings (Line 5 - Line 7):

Signature First Name: * Signature Last Name: * Email Address: *

Please sign in the space provided below by left clicking and moving your mouse *

Clear

Submit



20 Enter "First and Last Name"

Provider Portal

3. * How much was your monthly Child & Adult Care Food Program Reimbursement?	0225
4. * How much was the monthly DDS or SC Child Care Program Subsidy for children in your care?	0375
5. Total Monthly Revenue (Add lines 2, 3, and 4):	\$3,306.00
6. How many hours do you work per week?	40
7. Total Monthly Expenses:	0200

How much did you spend for children in your child care home last month? Expenses can include, but are not limited to, food, toys, assistance/substitute care, crafts/supplies, transportation, training fees, gifts for children and families, etc. You are NOT required to submit receipts.

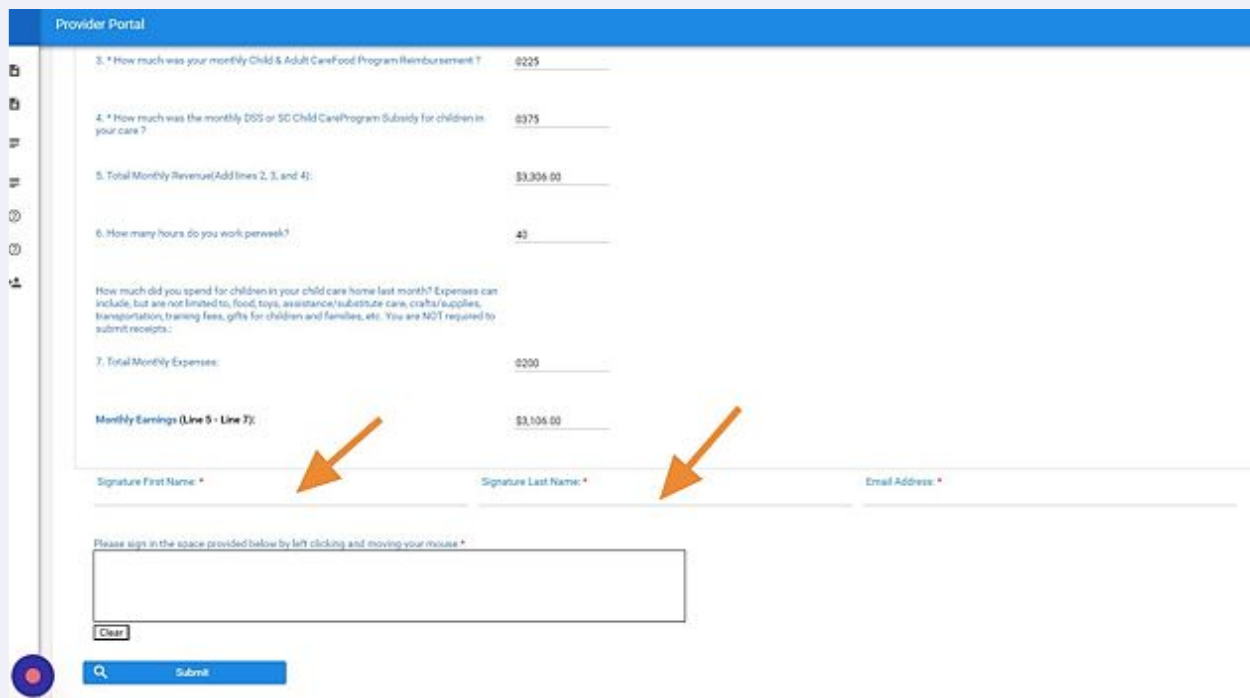
Monthly Earnings (Line 5 - Line 7):

Signature First Name: * Signature Last Name: * Email Address: *

Please sign in the space provided below by left clicking and moving your mouse *

Clear

Submit



21 Enter "Email Address"

Provider Portal

3. * How much was your monthly Child & Adult Care Food Program Reimbursement?

4. * How much was the monthly DDS or SC Child Care Program Subsidy for children in your care?

5. Total Monthly Revenue (Add lines 2, 3, and 4):

6. How many hours do you work per week?

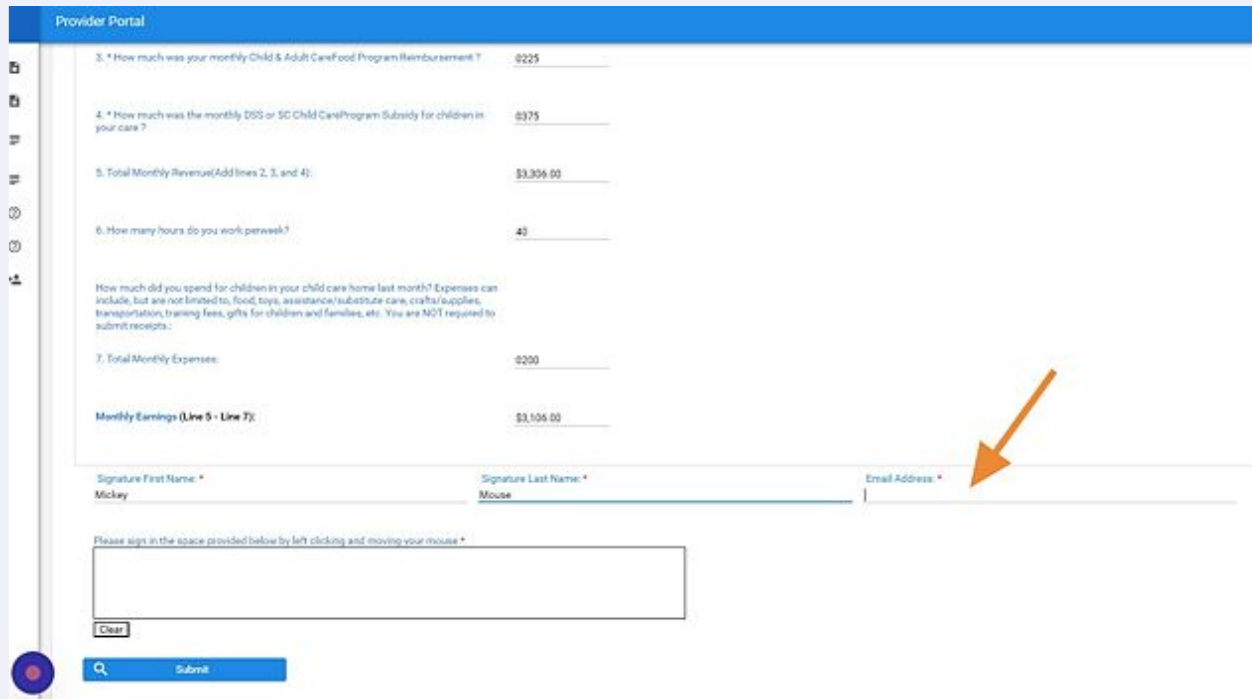
How much did you spend for children in your child care home last month? Expenses can include, but are not limited to, food, toys, assistance/substitute care, crafts/supplies, transportation, training fees, gifts for children and families, etc. You are NOT required to submit receipts.

7. Total Monthly Expenses:

Monthly Earnings (Line 5 - Line 7):

Signature First Name: * Signature Last Name: * Email Address: *

Please sign in the space provided below by left clicking and moving your mouse *



22 Sign form electronically

Provider Portal

3. * How much was your monthly Child & Adult Care Food Program Reimbursement?

4. * How much was the monthly DDS or SC Child Care Program Subsidy for children in your care?

5. Total Monthly Revenue (Add lines 2, 3, and 4):

6. How many hours do you work per week?

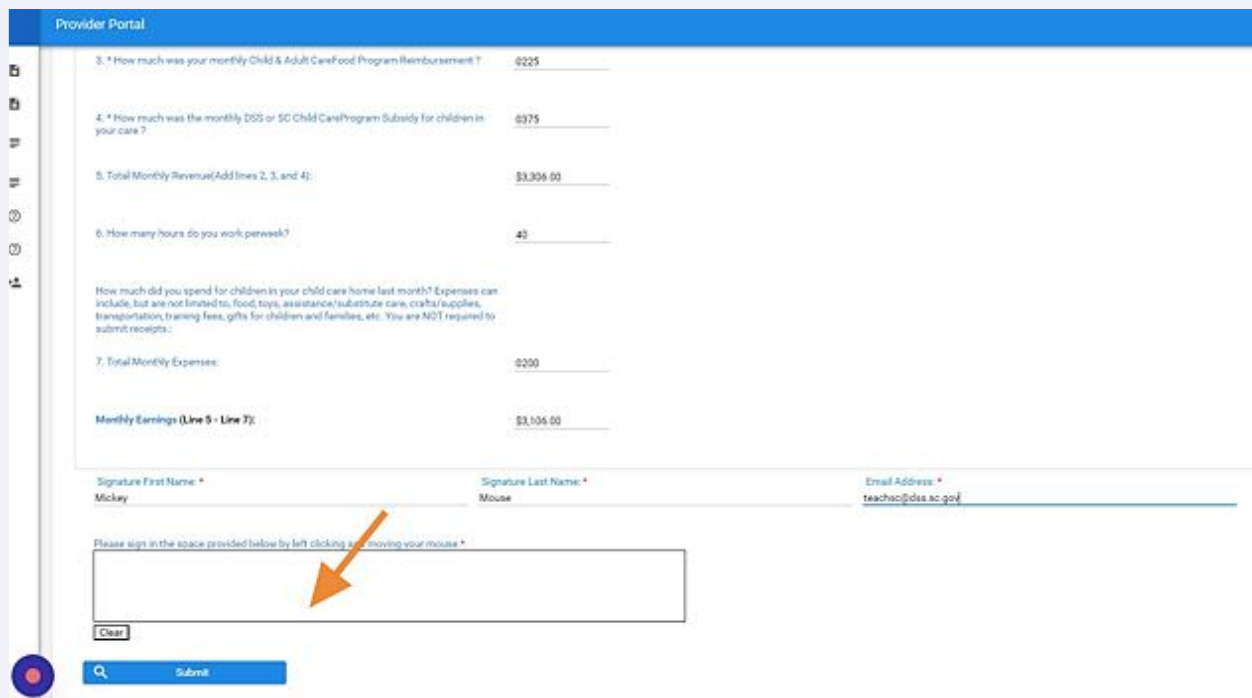
How much did you spend for children in your child care home last month? Expenses can include, but are not limited to, food, toys, assistance/substitute care, crafts/supplies, transportation, training fees, gifts for children and families, etc. You are NOT required to submit receipts.

7. Total Monthly Expenses:

Monthly Earnings (Line 5 - Line 7):

Signature First Name: * Signature Last Name: * Email Address: *

Please sign in the space provided below by left clicking and moving your mouse *



23 Click "Submit"

Provider Portal

3. * How much was your monthly Child & Adult Care Food Program Reimbursement?	0225
4. * How much was the monthly DDS or SC Child Care Program Subsidy for children in your care?	0375
5. Total Monthly Revenue (Add lines 2, 3, and 4):	\$3,306.00
6. How many hours do you work per week?	40
How much did you spend for children in your child care home last month? Expenses can include, but are not limited to, food, toys, assistance/substitute care, crafts/supplies, transportation, training fees, gifts for children and families, etc. You are NOT required to submit receipts.	
7. Total Monthly Expenses:	0200
Monthly Earnings (Line 5 - Line 7):	\$3,106.00

Signature First Name: * Mickey
Signature Last Name: * Mouse
Email Address: * teachco@des.sc.gov

Please sign in the space provided below by left clicking and moving your mouse *

Clear

Submit



Alert! Note: Please be aware that you will have 72 hours to finish this application section. The section link will become invalid after 72 hours. It will be necessary to submit a new application if the link expires.