SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MINORITY BUSINESS FORM

State agencies are required to report the purchase of supplies, equipment and contractual services from minority businesses to the Governor's Office of Small and Minority Business Assistance. To assist the SCDHHS in meeting this requirement, please read this document and provide the requested information.

(ALL RESPONDENTS AND/OR PROVIDERS MUST COMPLETE AND SIGN THIS FORM)

Provider
Name: ____________________________

Provider #: ________________________ SSN or EIN: ________________________

What is the Provider’s legal status?

   Public_____  Private non-profit_____  Private for profit_____  NA- Individual_____


Does your organization qualify as a Minority Business Enterprise?
   Yes_____  No_____  

If yes, do you qualify as:

   1. African American Male_____
   2. African American Female_____
   3. Caucasian Female_____
   4. Hispanic_____
   5. Department of Transportation (DOT) Certified African American_____
   6. DOT Certified Caucasian Female_____
   7. Native American_____
   8. Small Business Association (SBA) Certified_____
   9. Asian Pacific American/Other_____

Is your organization registered with the Governor’s Office of Small and Minority Business Assistance?
   Yes_____  No_____  

If yes, what is your certification and/or vendor number? ________________________

__________________________________________

Authorized Signature

Rev.03/10