

Dear Applicant:

Thank you for your interest in becoming a Department of Education, Division of Vocational Rehabilitation (DVR). In order to be eligible for registration, potential providers must be authorized by Additionally, all potential providers must first register in MyFloridaMarketPlace (MFMP) and submit a substitute W-9 to the Department of Financial Services via the State of Florida Vendor Website.

Please read all the instructions included in the application package carefully and complete each item as requested. Incomplete applications will result in process delays and possible denial. If you have any questions regarding the application package or process, please contact the Vendor Registration Unit at 866-580-7438 or 850-245-3401 or via email at VRVendors@vr.fldoe.org.

Please mail or fax completed applications and all required documentation to:

Division of Vocational Rehabilitation
Vendor Registration Unit
4070 Esplanade Way 2nd Floor
Tallahassee, FL 32399-7016
Fax Number: 850-245-3394

Thank you for your commitment to helping people with disabilities find and maintain employment and enhance their independence. We look forward to working with you.

Division of Vocational Rehabilitation
Vendor Registration Unit

Enclosures

ALLISON FLANAGAN

Director, Division of Vocational Rehabilitation

2nd Floor • 4070 Esplanade Way • Tallahassee, FL 32399-7016

Toll Free: 1-800-451-4327 • 850-245-3399 • FAX: 850-245-3392 • www.rehabworks.org

TTY users dial 711 • VP users connect via VRS



**DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
PERSONAL CARE ASSISTANT (PCA)
VENDOR APPLICATION**



VENDOR INFORMATION			
MYFLORIDAMARKETPLACE (Federal Tax ID) NUMBER:			
* PROVIDER NAME:			
INDIVIDUAL'S NAME (IF DIFFERENT):			
* MAILING ADDRESS:			
	City	State	Zip Code + Four Digits
* REMITTANCE ADDRESS:			
	City	State	Zip Code + Four Digits
PRIMARY TELEPHONE NUMBER:		FAX NUMBER:	
CONTACT NAME:		CONTACT PHONE NUMBER:	
EMAIL ADDRESS:			
* This information should be the same reflected in MFMP and on your registration with the Department of State, Division of Corporations.			
Please list office locations where customers will be served. (Attach additional pages as necessary).			
	Location 1	Location 2	Location 3
Street address			
City/State/Zip			
Phone Number:			
Is each location fully accessible to persons with disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Other languages			
Could you assist customers in other languages? <input type="checkbox"/> Yes <input type="checkbox"/> No			
(please mark all applicable)			
American Sign Language	Spanish	Creole	Other. Please Specify
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



**DEPARTMENT OF EDUCATION
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PERSONAL CARE ASSISTANT (PCA)
VENDOR APPLICATION**



Qualification Requirements

- A completed DVR Personal Care Assistant Application
- Verifiable work experience (with years of specific work experience) as a Personal Care Assistant
- OR
- Copy of APD certification in Personal Care Assistance
- OR
- Copy of AHCA's Medicaid approval letter AND Provider Enrollment Information form showing "114-Personal Care" as the provider specialty.
- Copy of DOH license for nursing profession (background check not required for this option)
 - Level 2 Background Screening
 - Note: Instructions to register in AHCA's Care Provider Background Screening Clearinghouse will be provided upon preliminary approval of qualifications. An Affidavit of Compliance with Background Screening and a copy of a previous screening may be accepted if criteria are met.
 - Note: Administrator, Financial Office, Director and any person employed by the provider who has direct, face-to-face contact with Vocational Rehabilitation customers is required to undergo a Level 2 background screening per F.S. 435.04 and F.S. 413.208. Instructions on how to obtain the screening through AHCA's Care Provider Background Screening Clearinghouse will be sent by the Vendor Registration office once preliminary qualifications are approved.

Confidentiality

Access to a VR customer's confidential information must be safeguarded at all times. Such information shall not be used or disclosed for any purpose not in conformity with State and Federal laws and regulations without written consent of the customer or their parent, guardian, or other authorized representative.

IS YOUR APPLICATION COMPLETE?

- Signed and dated application
- Resume documenting education and experience, OR
- Copy of AHCA's Medicaid approval letter AND Provider Enrollment Information form showing "114-Personal Care" as the Provider Specialty, OR
- Copy of DOH license for nursing profession (background check not required), OR
- Copy of APD certification in Personal Care Assistance
- List of areas and counties where services will be provided

Please mail, email or fax application and all required documents, if any, to:

Florida Department of Education
Division of Vocational Rehabilitation
Vendor Registration Unit
4070 Esplanade Way, 2nd Floor
Tallahassee, FL 32399-7016
Fax Number: 850-245-3394
VRVendors@vr.fldoe.org

If you have any questions that pertain to this application, please contact Vendor Registration Unit at 866-580-7438 or 850-245-3401

PLEASE READ AND SIGN BELOW:

We will accept and render services to clients of the Division of Vocational Rehabilitation (DVR) on a non-discriminatory basis without regard to race, color, religion, sex, national origin, age, disability, political affiliation or belief. I/We agree to comply with the Americans with Disability Act of 1990 as appropriate to the business

Signature

Date

Printed Name of Applicant:



DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
PERSONAL CARE ASSISTANT (PCA)
VENDOR APPLICATION



NOTE: Upon approval of this application, you will be sent instructions regarding registration in the Care Provider Background Screening Clearinghouse. Your registration will remain in “Pending” status until your screening is approved.

The Administrator, Financial Office, Director and any person employed by the provider who has direct, face-to-face contact with Vocational Rehabilitation customers is required to undergo a Level 2 background screening per F.S.435.04 and F.S.413.208. Instructions on how to obtain the screening through AHCA’s Care Provider Background Screening Clearinghouse will be sent by the Vendor Registration office once preliminary qualifications are approved.



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VENDOR APPLICATION**



DOE/VR AREAS & COUNTIES WHERE SERVICES WILL BE PROVIDED

Vendor Name: _____ FEID#: _____

Name of Authorized Representative: _____

Signature: _____

*Check all that apply:

<input type="checkbox"/> Area One	<input type="checkbox"/> Area Two	<input type="checkbox"/> Area Three	<input type="checkbox"/> Area Four	<input type="checkbox"/> Area Five	<input type="checkbox"/> Area Six
<input type="checkbox"/> Escambia	<input type="checkbox"/> Columbia	<input type="checkbox"/> Lake	<input type="checkbox"/> Pinellas	<input type="checkbox"/> Charlotte	<input type="checkbox"/> Miami-Dade
<input type="checkbox"/> Santa Rosa	<input type="checkbox"/> Union	<input type="checkbox"/> Sumter	<input type="checkbox"/> Hillsborough	<input type="checkbox"/> Lee	<input type="checkbox"/> Monroe
<input type="checkbox"/> Okaloosa	<input type="checkbox"/> Gilchrist	<input type="checkbox"/> Seminole	<input type="checkbox"/> Hernando	<input type="checkbox"/> Collier	
<input type="checkbox"/> Walton	<input type="checkbox"/> Dixie	<input type="checkbox"/> Orange	<input type="checkbox"/> Pasco	<input type="checkbox"/> Hendry	
<input type="checkbox"/> Holmes	<input type="checkbox"/> Clay	<input type="checkbox"/> Osceola		<input type="checkbox"/> Glades	
<input type="checkbox"/> Jackson	<input type="checkbox"/> St. Johns	<input type="checkbox"/> Brevard		<input type="checkbox"/> Manatee	
<input type="checkbox"/> Washington	<input type="checkbox"/> Nassau	<input type="checkbox"/> Polk		<input type="checkbox"/> Sarasota	
<input type="checkbox"/> Calhoun	<input type="checkbox"/> Baker	<input type="checkbox"/> Hardee			
<input type="checkbox"/> Liberty	<input type="checkbox"/> Putnam	<input type="checkbox"/> DeSoto			<input type="checkbox"/> Area Seven
<input type="checkbox"/> Bay	<input type="checkbox"/> Duval	<input type="checkbox"/> Highlands			<input type="checkbox"/> Palm Beach
<input type="checkbox"/> Gulf	<input type="checkbox"/> Alachua	<input type="checkbox"/> Indian River			<input type="checkbox"/> Broward
<input type="checkbox"/> Franklin	<input type="checkbox"/> Bradford	<input type="checkbox"/> St. Lucie			
<input type="checkbox"/> Gadsden	<input type="checkbox"/> Levy	<input type="checkbox"/> Martin			
<input type="checkbox"/> Leon	<input type="checkbox"/> Marion	<input type="checkbox"/> Okeechobee			
<input type="checkbox"/> Wakulla	<input type="checkbox"/> Citrus				
<input type="checkbox"/> Jefferson	<input type="checkbox"/> Flagler				
<input type="checkbox"/> Madison	<input type="checkbox"/> Volusia				
<input type="checkbox"/> Hamilton					
<input type="checkbox"/> Taylor					
<input type="checkbox"/> Suwannee					
<input type="checkbox"/> Lafayette					