Dear Applicant,

Thank you for your interest in becoming a Department of Education, Division of Vocational Rehabilitation (DVR) Employment Network Provider (EN). In order to be eligible for registration, potential providers must be authorized by the Social Security Administration (SSA) to provide, or coordinate the provision of, employment and rehabilitation services to SSA beneficiaries under the Ticket-to-Work Program. Additionally, all potential providers must first register in MyFlorida Market place (MFMP) and submit a substitute W-9 to the Department of Financial Services via the State of Florida Vendor Website.

Please read all of the instructions included in the application package carefully and complete each items 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
325 West Gaines Street, Suite 1144
Tallahassee, FL 32399-0400
Fax Number: 850-245-3394

Division of Vocational Rehabilitation
Vendor Registration Unit

Enclosures: Employment Network Application

Leah Compagnone-Bolt, Director
Division of Vocational Rehabilitation
325 West Gaines Street, Suite 1144 • Tallahassee, FL 32399-0400
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

VENDOR INFORMATION
MYFLORIDA MARKET PLACE (Federal Tax ID) NUMBER:
* PROVIDER NAME:
**AUTHORIZED AGENT NAME & TITLE:
* 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

**The authorized agent must have the authority to sign binding documents on behalf of the Provider.

PLEASE LIST LOCATIONS WHERE CUSTOMERS WILL BE SERVED
(Attach additional pages as necessary)

LOCATION 1:

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

LOCATION 2:

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

LOCATION 3:

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Is each location fully accessible to persons with disabilities? YES ◯ NO ◯

If you do not have an office, please attach a description of where you will meet VR customers to provide services and how you will ensure these locations are accessible to persons with disabilities.

OTHER LANGUAGES

Could you assist customers in other languages? YES ◯ NO ◯

Please mark all applicable:

☐ American Sign Language ☐ Spanish ☐ Creole ☐ Other (Please specify below)

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DIVISION OF VOCATIONAL REHABILITATION
EMPLOYMENT NETWORK APPLICATION

VERIFICATIONS

Are you registered in MyFlorida Market Place? ◯ Yes ◯ No

Are you registered with the Florida Department of State, Division of Corporations? ◯ Yes ◯ No

Are you in Employment Network approved by the Social Security Administration (SSA)? ◯ Yes ◯ No

Do you have a W-9 on file with the Florida Department of Financial Services? ◯ Yes ◯ No

Have you previously held a contract with VR? ◯ Yes ◯ No

- If yes, Please provide approximate dates: _____ to _____

SERVICES TO BE PROVIDED

Upon final approval of this application, the registered Employment Network (EN) becomes eligible to receive referrals from VR for post-employment job-related services. At case closure, VR may refer a customer to the EN for job-related services that will aid the customer in achieving Substantial Gainful Activity (SGA) levels of employment.

Job-related services are provided to enable the customer to preserve or advance their employment at a competitive earnings level, as established under their post-employment Individualized Plan for Employment (IPE) and associated employment outcome. Services are provided in support of achieving the customer's weekly work hours and earnings goal for the purpose of helping the customer become self-supporting. Services may include:

1. Limited job development services that will refine the job to better meet the needs of the Employer;
2. Limited job coaching to aid the individual in stabilizing on the job;
3. Limited job training or retraining to further stabilize the individual in their job;
4. Follow-up services such as regular contact with the employers, the individuals, the parents, family members, guardians, advocates, or authorized representatives of the individuals, and other suitable professionals and informed advisors, in order to reinforce and stabilize the job placement;
5. Services that will assist the individual in adapting to the work environment and facilitate identification and access to natural supports at the work site;
6. Referral and other services that will assist an individual to secure needed services from other agencies and identify and access community resources needed in support of employment (e.g., transportation to and from work, affordable housing, public assistance/services, etc.);
7. Services that will aid the individual in developing/enhancing job skills needed to successfully, perform their current job or a job that will advance their level of employment and earnings; and
8. Job search and placement assistance to reemploy an individual.

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PAYMENT

The EN will be paid a fee for a referred customer who achieves and maintains a SGA level of earnings for seven (7) out of eight (8) months. For referred customers who were already achieving SGA level of earnings at the time of the referral, the fee to the EN shall be $1,000. For referred customers who were achieving less than SGA level of earnings at the time of the referral, the fee to the EN shall be $2,000. Payment will be made contingent upon receipt of a monthly synopsis of the post-employment job related services provided, as well as one of the following:

1. A wage verification letter on the employer's letterhead which indicates a breakdown of monthly wages. The verification letter should also include a contact person and a telephone number; or,
2. A Payroll Report from the employer which documents the consumer's name, Social Security Number, paycheck date, and breakdown of monthly payments, including a contact name and telephone number from the employer; or,
3. Copies of paycheck stubs covering the minimum required SGA period that includes the consumer's name and address, payroll period, date issued, and check amount; or,
4. A screen shot of a page of an electronic wage verification system showing the consumer's name, Social Security Number, wages, wage period and Employer's name; or
5. A combination of above that provides a complete wage and employment history for the requisite period.

REGISTRATION REVOCATION

Registration will be suspended or revoked immediately if the EN ceases to have approval from the Social Security Administration to participate in the Ticket-to-Work and Self-Sufficiency Program.

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IS YOUR APPLICATION COMPLETE

☐ All sections of the application have been completed, as required.

☐ The application has been signed and dated.

☐ Proof of Employment Network status with SSA is attached.

☐ A completed VR Area and Counties form is attached.

☐ A completed EN Employee Contact form is attached.

☐ Are you registered with the Florida Department of State, Division of Corporations (SunBiz).

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

Florida Department of Education
Division of Vocational Rehabilitation
Vendor Registration Unit
325 West Gaines Street, Suite 1144
Tallahassee, Florida 32399-0400
Fax Number: 850-245-3394
Email: VRVendors@vr.fldoe.org

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

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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.

BACKGROUND SCREENING REQUIREMENTS

Upon pre-approval of this application, you will be sent instructions regarding registration in the AHCA Care Provider Background Screening Clearinghouse web portal. Your registration will remain in "Pending" status until your screening is approved.

The Administrator, Financial Officer, Director, and any person employed by the provider who is expected to have direct face-to-face contact with Vocational Rehabilitation customers while providing services to those individuals, must undergo a Level 2 background screening per sections 413.208 and 435.04, Florida Statutes. Instructions on how to obtain the screening through the AHCA Care Provider Background Screening Clearinghouse will be sent by the Vendor Registration office once preliminary qualifications are approved.

PLEASE READ AND SIGN BELOW

I hereby acknowledge I am authorized to make application on behalf of the Provider to become an approved provider of post-employment job related services as described above. I further acknowledge that I have read and agree to be bound by the terms of registration outlined in this application and in section, 413.208, Florida Statutes. I acknowledge that the Provider is subject at all times to a due-diligence inquiry as to its fitness to undertake service responsibilities, and that the Provider's registration may be suspended pending such inquiry. If approved, we agree to accept and render services to customers of the Division of Vocational Rehabilitation (VR) on a non-discriminatory basis without regard to race, color, religion, sex, national origin, age, disability, political affiliation or belief.

Printed Name of Authorized Agent:
Date:
Signature:

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DIVISION OF VOCATIONAL REHABILITATION
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DOE/VR AREAS & COUNTIES WHERE SERVICES WILL BE PROVIDED

Vendor Name: **FEIN #:**

_____ _____

Name of Authorized Representative: _____

Signature: _____

*** Check all that apply:**

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

VR REGISTRATION FORM for
ADMINISTRATORS & EMPLOYEES REQUIRING BACKGROUND SCREENING PER F.S. 413.208

Please provide the name and contact information for the EN's Administrator, Financial Officer, and any employee who is expected to have direct, face-to-face contact with VR customers while providing services. This form must be submitted to VR's Vendor Registration Unit each time an employee is deleted or a new employee is added.

EN NAME:
MYFLORIDA MARKET PLACE NUMBER (Federal Tax ID):

TITLE	NAME	EMAIL	PHONE	DVR USE ONLY DATES OF APPROVAL
ADMINISTRATOR				
FINANCIAL OFFICER				
EMPLOYEE				
EMPLOYEE				
EMPLOYEE				
EMPLOYEE				
EMPLOYEE				

*Attach additional pages as needed

AUTHORIZED AGENT SIGNATURE:
NAME & TITLE:
DATE:

SUBMIT FORM VIA EMAIL, FAX OR MAIL TO:

Division of Vocational Rehabilitation, Attn: Vendor Registration
325 West Gaines Street, Suite 1144
Tallahassee, FL 32399-0400
Fax: 850-245-3394 or email: VRVendors@vr.fldoe.org