Vocational Rehabilitation
FLORIDA DEPARTMENT OF EDUCATION

Dear Applicant,

Thank you for your interest in becoming a Group Medical Provider vendor with the Department of Education, Division of Vocational Rehabilitation (DVR). In our Vendor Qualification Manual, this vendor is described as a group of two or more health care providers licensed by the Department of Health legally organized as a partnership, professional corporation, or similar association. In order to be eligible for registration, potential applicants must be authorized by the VR Vendor Registration Unit. 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 carefully all of the instructions included in the application package and complete each item as requested. Incomplete applications will result in process delays and possible denial. If you have any questions regarding this 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

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: Group Medical Application

Brent McNeal
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

DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
GROUP MEDICAL PROVIDER VENDOR APPLICATION

VENDOR INFORMATION
MYFLORIDA MARKET PLACE (Federal Tax ID) NUMBER:
* EMPLOYER NAME:
CONTACT PERSON'S NAME:
* 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

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GROUP MEDICAL PROVIDER VENDOR APPLICATION

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 ◯

OTHER LANGUAGES
Could you assist customers in other languages? YES ◯ NO ◯
Please mark all applicable: ☐ American Sign Language ☐ Spanish ☐ Creole ☐ Other (Please specify below)

DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
GROUP MEDICAL PROVIDER VENDOR APPLICATION

GROUP MEDICAL SPECIALTY

GROUP MEDICAL PROVIDER

Description of specialty licensed by the Florida Department of Health:

IS YOUR APPLICATION COMPLETE

☐ Attestation of Group Medical Vendor Status

☐ List of areas and counties where services will be provided

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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GROUP MEDICAL PROVIDER VENDOR APPLICATION

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.

PLEASE READ AND SIGN BELOW

I hereby acknowledge I am authorized to make application on behalf of the Vendor to become an approved DVR Vendor. 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:

DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
GROUP MEDICAL PROVIDER VENDOR APPLICATION

ATTESTATION OF GROUP MEDICAL VENDOR STATUS

As a condition of becoming a registered vendor to provide medical services in behalf of the Department of Education/Division of Vocational Rehabilitation (DOE/DVR), _____(registering entity) hereby attests that he/she/it and all or his/her/its employees/partners/associates, e.g., physicians, therapists, nurses, etc., who will provide medical/therapeutic services to DVR clients will maintain current and appropriate licensure and other necessary credentials as required of above registering entity and/or local/regional hospitals or other health care institutions where said employees/partners/associates may provide medical services to DVR clients.

Additionally, _____ (registering entity) ensures a minimal general liability insurance policy of $250,000 is held by respective employees/partners.

Additionally, _____ (registering entity) agrees and shall present proof of above referenced credentials and/or insurance policies upon request by the DOE/DVR in order to maintain a current Qualified Vendor Registration status. Failure to do so will result in revocation of its registration status and termination of all rights to provide medical services to DVR clients by the registering entity and its respective employees/partners/associates, including termination of any current registrations.
The _____ (registering entity) further understands that at any time the DOE/DVR determines that the registering entity is in violation of this attestation or vendor registration requirement(s), that the DOE/DVR shall terminate this registration and will withhold payments for any services that were provided to clients during the period of time that the registration entity was out of compliance.
This registration is in effect for five years or until cancelled by either party, or by default as determined by DOE/DVR.

_____
(Registering Entity/Company Name)
By: _____

_____
(Printed Name of Authorized Representative)

_____
(Signatory Capacity)

_____
(Address)

_____
_____
(Telephone)

_____
(Fax)

_____
(Date)

STATE OF FLORIDA
COUNTY OF _____
Sworn to and subscribed before me this ____ day of _____, 20 ___ by

_____
(Name of Person Making Statement)

_____
(Signature of Notary Public)

(Print, Type, or Stamp)

_____
(Commissioned Name of Notary Public)
Personally known ___ or Produced Identification ___

Type of Identification produced
_____

DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
GROUP MEDICAL PROVIDER VENDOR APPLICATION

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					