Washington State Department of Social & Health Services	**Division of Vocational Rehabilitation** **New Applicant Checklist**

Please use this checklist to show that you have submitted each required item.

Administrative Requirements

- ☐ New Applicant Checklist (this form)
- ☐ Exhibit B: Applicant Certification and Assurances Form DSHS 11-163
- ☐ Exhibit C: Contractor Intake Form DSHS 27-043
- ☐ Exhibit D: Additional Contractor Information Form DSHS 27-175
- ☐ Exhibit E: Copy of OFM Statewide Payee Registration and W-9 forms
- ☐ Copy of WA State Master Business License
- ☐ Copy of 501(c)(3) IRS letter designating your status as a nonprofit (if applicable)
- ☐ List of partners, members, directors, officers, and board members, including title, phone number, and e-mail. (not applicable to sole proprietors).
- ☐ Copy of Certificate of Insurance – conforming to minimum insurance requirements.

Management and Operations Requirements

- ☐ Exhibit F: Code of Ethics and Standards of Practice Form DSHS 05-252
- ☐ Fire/Safety Inspection Certificate; OR
  - ☐ Statement verifying that you do not own, lease, or rent a premises where you provide services, but meet clients in public locations.
- ☐ Responses to Management and Operations Requirements from solicitation.

Technical Requirements

- ☐ Exhibit G: BCS Access Request Form DSHS 17-253
- ☐ Exhibit H: Background Check Reporting Form DSHS 17-264
- ☐ Three Professional References
- ☐ Exhibit I: CRP Services and Qualifications Form DSHS 11-164 - including accreditation/certification
- ☐ Exhibit J: IL Services and Qualifications Form DSHS 11-165
- ☐ Exhibit K: Contractor Employee(s) to Provide IL Services Form DSHS 11-166

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DIVISION OF VOCATIONAL REHABILITATION (DVR)

Applicant Certification and Assurances

The Applicant must sign and include the full text of this Exhibit B with the Application Packet. Altering or conditioning your certification of this Exhibit B may result in your Application Packet considered non-responsive.

Under the penalties of perjury of the State of Washington, the Applicant makes the following certifications and assurances as a required element of its Application Packet. The Applicant affirms the truthfulness of these facts and acknowledges its current and continued compliance with these certifications and assurances as part of its Application Packet and any resulting contract awarded by DSHS.

1. The Applicant declares that all answers and statements made in the Application Packet are true and correct.
2. The Applicant certifies that its Application Packet is a firm offer for a period of 180 days following receipt, and DSHS may accept it without further negotiation from the Applicant (except where obviously required by lack of certainty in key terms) at any time within the 180-day period. In the case of a protest, the Application Packet will remain valid for 210 days or until the protest is resolved whichever is later.
3. The Applicant certifies that in preparing this Application Packet, the Applicant received no assistance from any current or former Washington State (including, but not limited to, DSHS) employees whose duties relate (or did relate) to this Solicitation, and who was assisting us in a manner outside his or her official capacity. Likewise, the Applicant received no assistance from any person whose immediate family has any financial interest in the outcome of this Solicitation.
4. The Applicant acknowledges that DSHS will not reimburse it for any costs incurred in the preparation and presentation of this Application Packet. All Application Packets become the property of DSHS and the Applicant claims no proprietary right to the ideas, writings, items, or samples.
5. The Applicant acknowledges that DSHS may elect to incorporate all or any part of the Solicitation, or Application Packet, into the Contract.
6. The Applicant certifies to make no attempt, nor any attempt, to persuade any other person or firm to submit, or not submit, a proposal to restrict competition.
7. The Applicant acknowledges its obligation to notify DSHS of any changes in the certifications and assurances above.

I hereby certify, under penalty of perjury under the laws of the State of Washington, that the certifications herein are true and correct and I am authorized to make these certifications on behalf of the Applicant.

CONTRACTOR'S SIGNATURE	DATE

CONTRACTOR'S PRINTED NAME	CONTRACTOR'S TITLE

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New Contractor Intake Instructions

All New DSHS Contractors must:

- Complete, sign and submit the **Intake Form** to the **Department of Social and Health Services (DSHS)**.
- Register in the **Statewide Payee Registration System.** This system is maintained by the Washington State Department of Enterprise Services (DES) to process payments for **all** Washington state agencies. To register, **follow the online instructions at** https://ofm.wa.gov/it-systems/accounting-systems/statewide-vendorpayee-services**.** You must complete this step in order to be paid.

  Please **do not** return this DSHS Contractor Intake Form to DES; they will **not** process it.

All Existing DSHS Contractors who have changed their business name or business organization, or experienced other significant changes, **must**:

- Update their information in the **Statewide Payee Registration System** by following the instructions at https://ofm.wa.gov/it-systems/accounting-systems/statewide-vendorpayee-services/changing-your-vendor-registration.
- Complete, sign and submit a new **Contractor Intake** form to the **Department of Social and Health Services (DSHS)**.

Section One: Contractor Name/Business Organization

1. **Contractor name.**
   - For an Individual or Sole Proprietor, enter your name as shown on your Social Security card on the "Name" line. Sole Proprietors provide Last Name, First Name, Middle Name, and Suffix.
   - Other entities. Enter your business name as shown on the legal document creating the entity.
2. **Business Organization.** Please mark only one.
   - If you are a nonresident alien foreign person or a business entity established in another state or country, the IRS may require you to complete Form W-8.
   - If you are a Non-profit Corporation or a Faith-Based Non-Profit Corporation **attach a copy of your 501(c) status**.
3. **Taxpayer Identification Number (TIN).**
   - Individual or Sole Proprietor - If you are a sole proprietor you may enter either your Social Security Number (SSN), or if you have one, your federal Employer Identification Number (EIN).
   - Other Business Entities - Enter the entity's Employer Identification Number (EIN). If the entity does not have an EIN, enter the SSN of the owner of the business.
   - Resident alien. - If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the SSN box.
4. **Default Reported, Waiver Certification, Fiscal Year, UBI Number, Business License, and Unique Entity Identifier (UEI) Number.**
   - List any contracts that you have had with the state that have been terminated for default.
   - Certify whether you require your employees to sign mandatory individual arbitration clauses or class or collective action waivers. For more information review https://des.wa.gov/services/contracting-purchasing/policies-training/resources/EO18-03.
   - Provide your fiscal year end date.
   - Provide your Washington State Uniform Business Identifier (UBI) Number.
   - **Attach a copy of your State Master Business License**. You may be exempt from registering with the State of Washington under certain circumstances. For more information review: http://bls.dor.wa.gov/faqlicense.aspx
   - Provide your Unique Entity Identifier (UEI) Number.

Section Two: Contractor Primary Address Enter the primary address information of your business. If this form is for a new DSHS contract, and you want to provide a contract-specific address in addition to your primary one, please do so in Section Five.

Section Three: Contractor Ownership Check those that, in your opinion, apply to your organization. Please provide a certification number, if available. For the definition of microbusiness, minibusiness and small business, see RCW 39.26.010 (16), (17) and (22).

Section Four: Contractor Contact Person(s) Enter the primary contact information, and job title, for your business. If you are completing this form for a new DSHS contract, and you want to provide a contract-specific contact person other than your primary one, please do so in Section Five.

Section Five: Additional Information

1. **Contractor Additional Addresses.** If applicable, provide additional addresses used for DSHS Contracts.
2. **Contractor Additional Staff.** If applicable, provide additional staff information for DSHS Contracts. Additional staff may include those who have authority to sign a DSHS contract on behalf of the business, and are referred to as a signatory.

Section Six: Contractor Certification You must sign, date, and return this form before DSHS will issue a contract.

Washington State Department of Social & Health Services
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New Contractor Intake

Section One: Contractor Name/Business Organization **(DSHS staff enter on ACD Intake Detail screen)**

1. CONTRACTOR NAME

DBA OR FACILITY NAME

2. BUSINESS ORGANIZATION

- ☐ Individual or Sole Proprietor
- ☐ Non-Profit Corporation (**Attach a copy** of 501(c) status)
- ☐ For Profit Corporation
- ☐ Faith Based (FBO) Non-Profit Corporation
- ☐ Faith Based (FBO) Unincorporated
- ☐ Governmental Entity
- ☐ Foreign Person or Entity
- ☐ General Partnership
- ☐ Limited Liability Partnership (LLP)
- ☐ Limited Liability Limited Partnership (LLLP)
- ☐ Limited Liability Company, filing as a Corporation
- ☐ Limited Liability Company, filing as a Partnership
- ☐ Limited Liability Company, filing as a Sole Proprietor

If your business is **NOT** a sole proprietorship,
attach a list of the partners, members, directors, officers, and board members.

3. TAXPAYER IDENTIFICATION NUMBER (TIN)

Enter your TIN in the appropriate box.

- For individuals, this may be your Social Security Number (SSN).
- For other entities, it is your Employer Identification Number.

Social Security Number

OR

Employer Identification Number

_____ (Enter all 9 numbers, NO DASHES)

_____ (Enter all 9 numbers, NO DASHES)

4. DEFAULT REPORTED, DETERMINATION OF CONTRACTOR STATUS, WAIVER CERTIFICATION, FISCAL YEAR, UBI NUMBER, BUSINESS LICENSE, AND UEI NUMBER

Have you had any contract with the state terminated for default?
☐ Yes ☐ No
If yes, **attach a list** of terminated contracts with an explanation why each contract was terminated.

Are you or any member of your staff a current employee of DSHS?
☐ Yes ☐ No
If yes, attach a brief explanation describing you or your employees duties as a DSHS employee.

Does your business require its employees to sign or agree to, as a condition of employment, mandatory individual arbitration clauses or class or collective action waivers?
☐ Yes ☐ No

Is your fiscal year end the same as the calendar year (January 1 through December 31)?
☐ Yes ☐ No
If the answer is no, what is your fiscal year end date? _____

What is your Washington State Uniform Business Identifier (UBI) Number? _____ (Enter all 9 numbers, NO DASHES)

Attach a copy of your current Washington State **Master Business License** or explain below why you are exempt from registering your business with the State of Washington. (See page 1 for information on exemptions.)

What is your Unique Entity Identifier (UEI) number? (Enter all numbers, NO DASHES).

Section Two: Contractor Primary Address **(DSHS staff enter on ACD Intake Detail screen)**

CONTRACTOR PRIMARY ADDRESS (NUMBER, STREET, AND APARTMENT OR SUITE NUMBER)

CITY, STATE, AND ZIP CODE

EMAIL ADDRESS	COUNTY WHERE PRIMARY ADDRESS IS (FOR OUT-OF-STATE CONTRACTORS)
PHONE NUMBER (INCLUDE AREA CODE) ( )	FAX NUMBER (INCLUDE AREA CODE) ( )

Section Three: Contractor Ownership Type **(DSHS staff enter, as applicable, on ACD Intake Detail screen)**

Is your business owned by a person (or persons) who is (or are) **(Check all that apply)**:

	No	Yes; but we are NOT certified*	Yes and we ARE Certified*	Certification Number
A Woman?	☐	☐	☐	
A Minority?	☐	☐	☐	
A Veteran?	☐	☐	☐	

*Certified means either the business entity (or, when the business is a sole proprietorship, the individual) has received a certification number from Washington State's Office of Minority and Women-Owned Business Enterprises (OMWBE) www.omwbe.wa.gov, or Department of Veterans' Affairs (DVA).

Is your business a certified Disadvantaged Business Entity? ☐ No ☐ Yes, Certification No.

Does your business qualify as a Microbusiness, Minibusiness, or Small Business under RCW 39.26.010? ☐ No ☐ Yes

Section Four: Contractor Primary Contact Person **(DSHS staff enter on ACD Intake Detail screen)**

Primary contact person is a(n):

☐ Owner ☐ Officer or Board Member ☐ Partner ☐ Staff Member ☐ Elected Official

☐ Other (please identify) _____ (DSHS staff enter as applicable on ACD)

Is the primary contact person authorized to sign contracts? ☐ Yes ☐ No

PRIMARY CONTACT NAME AND JOB TITLE	PHONE NUMBER (INCLUDE AREA CODE) ( )

FAX NUMBER (INCLUDE AREA CODE) ( )	PRIMARY CONTACT EMAIL ADDRESS	CELLULAR PHONE NUMBER (INCLUDE AREA CODE) ( )

Section Five: Additional Information **(DSHS staff enter on Intake Detail – Sub Information Summary screens)**

1. ADDITIONAL CONTRACTOR ADDRESSES: IF YOU HAVE MORE THAN TWO ADDITIONAL ADDRESSES, YOU MAY **ATTACH** A LISTING OF ADDITIONAL ADDRESSES.

ADDRESS DESCRIPTION	ADDITIONAL ADDRESS (NUMBER, STREET, AND APARTMENT OR SUITE NUMBER)
☐ Billing address ☐ Facility address ☐ Mailing address	CITY, STATE, AND ZIP CODE

PHONE NUMBER (INCLUDE AREA CODE) ( )	COUNTY WHERE PRIMARY ADDRESS IS (FOR OUT-OF-STATE CONTRACTORS)
FAX NUMBER (INCLUDE AREA CODE) ( )	EMAIL ADDRESS

ADDRESS DESCRIPTION	ADDITIONAL ADDRESS (NUMBER, STREET, AND APARTMENT OR SUITE NUMBER)
☐ Billing address ☐ Facility address ☐ Mailing address	CITY, STATE, AND ZIP CODE

PHONE NUMBER (INCLUDE AREA CODE) ( )	COUNTY WHERE PRIMARY ADDRESS IS (FOR OUT-OF-STATE CONTRACTORS)
FAX NUMBER (INCLUDE AREA CODE) ( )	EMAIL ADDRESS

2. ADDITIONAL STAFF: IF YOU HAVE MORE THAN TWO ADDITIONAL STAFF (LISTED BELOW), WHO ARE ALSO RELEVANT TO YOUR DSHS CONTRACTS, PLEASE PROVIDE INFORMATION ABOUT THOSE STAFF ON A SEPARATE PAGE.

Additional staff person is a(n):

☐ Officer or Board Member ☐ Partner ☐ Staff Member ☐ Elected Official

☐ Other (please identify) _____ (DSHS staff enter as applicable on ACD)

Is the additional staff authorized to sign contracts? ☐ Yes ☐ No

Is the additional staff a contact for DSHS contracts? ☐ Yes ☐ No

ADDITIONAL STAFF NAME AND TITLE	ADDITIONAL STAFF EMAIL ADDRESS

PHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	CELLULAR PHONE NUMBER (INCLUDE AREA CODE)
( )	( )	( )

Additional staff person is a(n):

☐ Officer or Board Member ☐ Partner ☐ Staff Member ☐ Elected Official

☐ Other (please identify) _____ (DSHS staff enter as applicable on ACD)

Is the additional staff authorized to sign contracts? ☐ Yes ☐ No

Is the additional staff a contact for DSHS contracts? ☐ Yes ☐ No

ADDITIONAL STAFF NAME	ADDITIONAL STAFF EMAIL ADDRESS

PHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	CELLULAR PHONE NUMBER (INCLUDE AREA CODE)
( )	( )	( )

Section Six: Contractor Certification **(DSHS staff enter on ACD Intake Detail as Intake Form Date)**

You must sign, date, and return this form.

I certify, under penalty of perjury as provided by the laws of the State of Washington, that all of the foregoing statements are true and correct, and that I will notify DSHS of any changes in any statement.

SIGNATURE	DATE	PRINTED NAME
		TITLE

ATTACHED SUPPORTING DOCUMENTATION CHECKLIST

☐ Copy of your W-9 - Request or Taxpayer Identification Number and Certification
☐ Copy of statement showing non-profit 501(c) status (if applicable)
☐ List of partners, members, directors, officers, and board members (not applicable to sole proprietors)
☐ Copy of your Washington State Master Business License or proof of exemption
☐ List of any contracts you have had with the state that have been terminated for default, including a brief explanation (if applicable)
☐ List of Additional Addresses (if applicable)
☐ List of Additional Staff (if applicable)
☐ Copy of your Certificate of Insurance (if applicable)

Washington State Department of Social & Health Services
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DIVISION OF VOCATIONAL REHABILITATION

DVR Additional Contractor Information

1. Contractor Information. Please PRINT clearly in all boxes, except for signature box.

CONTRACTOR NAME AS REGISTERED WITH THE IRS	CONTRACTOR DBA (IF ANY) FOR THIS CONTRACT

2. Contracting Information

A. Years of experience your organization has providing the type of services purchased through this contract?

years

B. Is this the first contract with DSHS or other state agencies for your organization? ☐ Yes (skip to C) ☐ No

B.1. Is your organization currently or has your organization been the subject of any investigation or finding(s) due to a DSHS or other state agency investigation regarding the performance of a criminal act, abridgement of human rights, or improper billing practices? ☐ Yes ☐ No

If YES, please provide details below or on a separate sheet of paper.

B.2. Has your organization had a contract terminated for default by DSHS or other state agencies? ☐ Yes ☐ No.

B.3. Have you received any audit findings related to state contracts in the past two (2) years? ☐ Yes ☐ No.

C. Do you currently have other active DSHS, state agency, or other government contracts?
☐ Yes (How many:) ☐ No

C.1. Do you have contract(s) or receive funds for the provision of similar services as purchased through this contract?
☐ Yes ☐ No.

D. Do you have any unresolved invoicing or service issues with any current contracts? ☐ Yes ☐ No.

3. Contractor Financial Information

Please provide your company's Statewide Vendor Number (SWV) as assigned by the Department of Enterprise Services (DES): SWV number

If you have not yet received a SWV number, please provide the date you submitted the registration paperwork to DES:

4. Signature

CONTRACTOR'S SIGNATURE	DATE

PRINTED NAME	TITLE

Office of Financial Management
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Vendor/Payee Registration Form

Instructions For Completing the Vendor/Payee Registration Form

The Registration Form should be used to perform the following:

- Register for a new Washington Statewide Vendor Number.
- New legal name (ex: change of last name, change of company name).
- New taxpayer identification number.

Note: If writing instead of typing, please PRINT clearly in blue or black ink only. Forms will not be accepted if they have whiteout, have been crossed off, or have been written over. If you are a foreign entity, please submit an IRS form W-8. You can find this form at the IRS Website. You must have a US Taxpayer Identification Number (TIN) to register with Washington State.

Part A – Contact Information:

- Mailing Address – Please indicate the address you wish to receive remittance and/or correspondence.
- Contact Name – The person named here will be contacted to approve any future changes to your registration including direct deposit. (If you are a business, a contact person's name MUST be provided.
- Telephone Number – The telephone number of the authorized contact person.
- Email Address – The Email address provided will be used as the primary contact method (you will be contacted via email with your Statewide Vendor Number).

Part B – Registration (W-9):

- All numbered sections except section 4 are required.
- If you are a medical or legal/attorney entity and file with the IRS a corporation or partnership, please indicate your entity type in box 4.
- You MUST provide your Social Security Number (SSN) or Employee Identification Number (EIN). Do NOT provide both.

Direct Deposit Banking:

To set up direct deposit, complete and submit a Direct Deposit Authorization Form.

Changes and Adding Additional Locations:

To make changes to an existing registration or to add/delete locations to an existing registration, please complete and submit a Change Form.

Signature Block:

Please sign with a pen (a "wet signature"). Electronic, inserted or stamped signatures will not be accepted. This form is not considered valid unless it is signed.

Submitting the Vendor/Payee Registration Form:

Please PRINT and SIGN the completed form
SCAN to PDF format and EMAIL to: payeeforms@ofm.wa.gov
FAX to: (360) 664-3363 OR
MAIL to: Statewide Payee Registration, PO Box 41450, Olympia, WA 98504-1450
For questions about the form, please contact the Payee Registration Unit at (360) 407-8180 ext. 5 or any other questions, please contact the agency you are expecting payment from.

Office of Financial Management

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PLEASE DO NOT STAPLE

Vendor/Payee Registration Form

PART A – Contact Details

Mailing Address: _____

City, State, Zip: _____

Contact Name: _____

Telephone Number: _____

Email Address: _____

PART B – Vendor/Payee Registration

Request for Taxpayer Identification Number and Certification – Substitute Form W-9

1. Legal Name (as shown on your income tax return):

_____

2.Business Name, if different from Legal Name above – e.g., Doing Business As (DBA) Name**:**

_____

3. Check ONLY ONE box:

☐ Individual/Sole Proprietor (Including LLC-Sole Proprietor)
☐ Non-Profit Organization
☐ Corporation (Including S-Corp, LLC S-Corp and LLC-Corp)
☐ Local Government
☐ State Government
☐ Federal Government (including Tribal)
☐ Tax Exempt Organization
☐ Volunteer
☐ Partnership (Includes LLC)
☐ Board/Committee member
☐ Trust/Estate

4. For Corporation or Partnership ONLY, check one box below if applicable:

☐ Medical
☐ Attorney/Legal

5. Legal Address (number street and apt or suite no) This should be the address on file with the IRS:

_____

6. City, State, Zip: _____

7. Tax Identification Number (TIN) PLEASE CHECK ONE

☐ For individuals, this is your social security number (SSN)

☐ For other entities, this is your employer identification number (EIN)

Enter your EIN or SSN (do NOT enter both):

8. Certification

Under penalty of perjury, I certify that

I. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

II. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

III. I am a U.S. person, including a U.S. resident alien (defined in the W-9 instructions to be found at www.irs.gov), and

IV. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. Please note this form does not include a FATCA exemption code field, and therefore item 4 does not apply.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

_____ _____

SIGNATURE OF U.S. PERSON (No electronic, stamped or inserted signatures) Date: This form is valid for 90 days

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DIVISION OF VOCATIONAL REHABILITATION (DVR)

Code of Ethics and Standards of Practice

The following Code of Ethics outlines the guiding principles that should underlie the actions of all individuals and organizations delivering DVR Services to Consumers. Consumers are current DVR Clients, students who are potentially eligible for VR services who are recipients of DVR Pre-employment Transition Services (PreETS), or other individuals who are neither a current DVR client nor a current recipient of PreETS but who are eligible for a service under a DVR contract. The Standards of Practice describe how the Code of Ethics should be applied operationally. These standards will provide a foundation and basis of adjudication should DVR learn of possible ethical violations on the part of DVR Services Contractors who interact with Consumers as defined above.

Code of Ethics

To promote the highest standards of ethical conduct, all personnel of DVR Services Contractors shall:

- Hold paramount the well-being of people served professionally.
- Respect and uphold Consumer rights.
- Uphold the principles of informed choice.
- Practice only in area(s) of competency.
- Respect Consumer privacy and release no information about the Consumer without his/her expressed, written permission.
- Engage in no conduct that constitutes a conflict of interest or that adversely reflects on his or her professional practice.
- Seek only deserved, honest and reasonable monetary reimbursement for services.
- Issue only objective and truthful statements regarding services.
- Comply with the laws and policies that guide professional practice.

Standards of Practice

In the following areas, all personnel of DVR Services Contractors shall:

Respect for DVR Clients, Recipients of PreETS, and Title VII Part B Consumers

- Hold the Consumer's well-being paramount and consider each Consumer's individuality.
- Not discriminate in the provision of services or products on the basis of disability, race, national origin, religion, creed, gender, age, veteran status, marital status, or sexual orientation.
- Only recommend, support, or implement services that do not expose the Consumer (or others) to unreasonable risk, exploitation, and/or personal injury. Inform the Consumer as fully as possible to all risks.

Informed Choice

- When recommending services, fully involve the Consumer and inform him or her of all reasonable options available, including costs. These recommendations shall not be limited to anyone's perceptions about the availability of resources.
- Fully inform the Consumer or his or her advocate about all aspects of any final recommendations and make only reasonable statements about expected outcomes.
- Consider the current and future needs of the Consumer when developing recommendations and fully inform the Consumer of those perceived needs.
- Fully and accurately disclose to the Consumer the qualifications of all staff members who will serve them directly.

Professionalism and Competency

- Comply with all licensing, credentialing and/or accreditation requirements recognized in their fields of service, and as required by the contract.
- Provide services only within the scope of their competency, taking into account their education, experience, and training and recognizing the limits of their own skills and knowledge in any professional area.
- Take on only those professional commitments and agreements that they can fulfill, and carry out those obligations in a timely way.
- Stay current in all aspects of their professional practice through ongoing education. Topics should include accessibility, funding, legal issues, recommended rehabilitation practices, clinical practice, and emerging services or technologies.
- Not provide professional services, nor allow any representative to provide services, while under the influence of drugs or alcohol or while substance abuse or a health condition influences their judgment.
- Not engage in conduct that reflects adversely on their profession or calls into question their fitness to serve Consumers.
- Avoid any action, intentional or accidental, professional or personal, that would exploit the dependency and trust of the Consumer.

Service Delivery

- When the Consumer's best interest requires it, collaborate or "team up" with providers from other professional disciplines for service delivery, in accordance with the vendor's contract with DVR. DVR Services Contractors shall present only complete and factual information about other providers.
- Within the scope of their competency, use every resource reasonably available to meet the Consumer's needs. This may require referring the Consumer to other service providers for services.
- Maintain procedures to measure the effectiveness and efficiency of their operations and to enhance service quality.

Conflict of Interest

- Maintain only those **professional** relationships that do not create a real or perceived conflict of interest. DVR Services Contractors shall inform the Consumer or their advocates of any employment relationships, professional affiliations, or fiduciary interests that may be perceived as a conflict of interest. DVR Services Contractors must decline to provide services when any such affiliation or interest is likely to influence their professional judgment.
- Make every effort to avoid **personal** relationships that could influence their professional judgment or be perceived as a conflict of interest.

Sound Business Practices

- Not engage in fraud, waste, or abuse when charging for services.
- Be truthful and accurate in all public statements about the services and products they provide.
- Stay within the scope of services agreed upon by the Consumer and DVR.
- Maintain sound business practices and financial records by using Generally Accepted Accounting Principles (GAAP).
- Maintain adequate records of evaluations, assessments, services, recommendations, reports, or products provided and preserve the confidentiality of those records, unless disclosure is required by law, or for the protection of the Consumer or the public.
- Disseminate contract terms and requirements to employees performing work under the contract.

I acknowledge that I have read and understood the preceding statements, and agree to its terms.

CONTRACTOR'S SIGNATURE	DATE

PRINTED NAME	TITLE

Washington State Department of Social & Health Services
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BACKGROUND CHECK SYSTEM (BCS)

DSHS BCS Access Request

BACKGROUND CHECK SYSTEM
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

DSHS authorized service providers who serve vulnerable adults, juveniles, and children may request access to the online Background Check System (BCS) through SecureAccess Washington (SAW) to process background checks. The purpose of this form is for external contracted / authorized service providers (Entity) to request a new Primary Account Administrator (PAA), remove PAA access, or update user name or email address in BCS. This form must be signed by the BCS User and User's manager, administrator, or authorizer (if necessary), and sent to the Background Check Central Unit (BCCU). BCS access may take up to three (3) business days. If the adding or removal of access is urgent, please include that information with the completed form.

BCS Account Information

REQUIRED: ACCOUNT OR LICENSE NUMBER

REQUIRED: ENTITY PHONE NUMBER (AREA CODE)

REQUIRED: ENTITY NAME

REQUIRED: PHYSICAL ADDRESS OF ENTITY / PROVIDER / FACILITY

BCS Primary Account Administrator (PAA) Request

REQUIRED:

☐ ADD New PAA access ☐ REMOVE PAA access ☐ CHANGE user name / email

* DSHS BCS Access Request form only needed for PAA updates. PAA will add and remove all other BCS users.

BCS Administrator Information

REQUIRED: FIRST NAME MIDDLE INITIAL **REQUIRED:** LAST NAME

REQUIRED: POSITION / TITLE

PHONE NUMBER (AREA CODE)

REQUIRED: INDIVIDUAL EMAIL ADDRESS (NO GENERIC / SHARED EMAIL ADDRESSES)

FBI Requirement - CJIS (Criminal Justice Information System) Security Awareness Training

Individuals with access or potential access to Criminal History Record Information (CHRI) as it pertains to fingerprint-based background checks completed by the Background Check Central Unit (BCCU) must complete and pass the CJIS Security Awareness training as required by the FBI. Based on FBI requirements, new individuals with access to CHRI must take and pass the training within six (6) months of hire and retake the training / test every two (2) years thereafter. If you have access to CHRI and have not taken CJIS Security Awareness training, please speak with your program contact.

BCS Access Authorization

I, the undersigned Authorizer, verify that the individual for whom this access is being requested has a business need to access this data, will complete the required CJIS training and has signed the required User Agreement on System Usage and Non- Disclosure of Personal Information included with this Access Request. I have also ensured that the necessary steps have been taken to validate the user's identity before approving access to confidential and protected information.

Authorizing Signature (if applicable)

SUPERVISOR'S (AUTHORIZER'S) SIGNATURE DATE

PRINTED NAME

POSITION / TITLE

PROGRAM / ENTITY NAME

EMAIL ADDRESS

PHONE NUMBER (AREA CODE)

DSHS BCS User Agreement on System Usage and Non-Disclosure of Confidential Information

The online Background Check System (BCS) is for authorized entities, such as Department programs and authorized service providers, to complete background checks for those who serve vulnerable adults, juveniles, and children, or have access to sensitive information. Prior to accessing this Information, you must sign this DSHS User Agreement System Usage and Non-Disclosure of Confidential Information.

Confidential Information

"Confidential Information" includes "Personal Information" or "Criminal History Record Information."

"Confidential Information" means a report of abandonment, abuse, financial exploitation, or neglect made under chapter 74.34 RCW, the identity of the person making the report, and all files, reports, records, communications, and working papers used or developed in the investigation or provision of protective services.

"Personal Information" means information that is identifiable to any person, including, but not limited to: information that relates to a person's name, health, finances, education, business, use of receipt of governmental services or other activities, addresses, telephone numbers, Social Security Numbers, driver license numbers, other identifying numbers, and any financial identifiers.

"Criminal History Record Information (CHRI)" means information about the history of an individual's contacts with state, federal, or foreign law enforcement agencies. CHRI (aka "FBI rap sheet", "national criminal history record", or "fingerprint criminal history record") includes details of an individual's arrest date, the arrest charge, and the disposition of the arrest, if known..

Regulatory Requirements and Penalties

State and Federal laws prohibit unauthorized access, use, or disclosure of Confidential Information, Personal Information, and Criminal History Record Information (including, but not limited to, chapter 42.56 RCW; RCW 74.34.095; U.S. Department of Justice, Criminal Justice Information Services Security Policy, Version 5.9 (CJISD-ITS-DOC-08140-5.9) (June 1, 2020), as amended; 28 U.S. Code § 534; 28 CFR § 20.33; and 28 CFR § 50.12). Violation of these laws may result in criminal or civil penalties or both.

User Assurance of Confidentiality

In consideration for DSHS granting me access to the Background Check System (BCS) and the Confidential Information in this system, I AGREE, I UNDERSTAND AND ACCEPT THE FOLLOWING TERMS OF USE FOR ACCESSING THE BACKGROUND CHECK SYSTEM (BCS):

1) BCS is a restricted information system maintained by the Washington State Department of Social and Health Services (DSHS).
2) BCS contains confidential and restricted information that I will protect as required by federal and state law.
3) I will comply with applicable DSHS confidentiality and security policies.
4) Unauthorized use of BCS or any records accessed through BCS is prohibited and may be subject to criminal and/or civil penalties or may result in formal disciplinary action by DSHS, including termination of my employment or contract.
5) If I have potential access to CHRI (national (fingerprint) criminal history records), I have completed Criminal Justice Information System (CJIS) Security Awareness Training.
6) The use of criminal history record information obtained through a national (fingerprint) check must comply with the CJIS Security Policy, 28 CFR Part 20 – Criminal Justice Information Systems, and 28 U.S. Code § 534.
7) Dissemination or use of national criminal history records for any other purpose is a violation of federal law.
8) System usage may be monitored, recorded, and is subject to audit.
9) If I have any questions regarding federal, state, or DSHS requirements around system usage, or require access to applicable confidentiality and security policies, I will contact my direct supervisor or program contact.
10) Use of this system indicates consent to monitoring and recording of my system usage and indicates I understand and agree to comply with the above terms.

Signature

REQUIRED: BCS USER'S SIGNATURE	DATE	**REQUIRED:** BCS USER'S PRINTED NAME

BCS access may take up to three (3) business days. If the adding or removal of access is urgent, please include that information with the request. BCCU will review your request and contact the Authorizer with any questions.

Send your completed and signed DSHS BCS Access Request Form to BCCU one of the following ways:

EMAIL: bccuinquiry@dshs.wa.gov **FAX**: (360)902-7954 **MAIL**: PO BOX 45025, Olympia WA 98504-5025

DIVISION OF VOCATIONAL REHABILITATION (DVR)

DVR Background Check Reporting

Attach additional sheets if needed.

CONTRACTOR'S NAME
CONTRACT NUMBER

NAME (FULL NAME INCLUDING INITIALS)	DATE OF HIRE	TERMINATION DATE	CONTRACT TYPE	NEW HIRE CHECK	RENEWAL	EMPLOYEE, INTERN, OR VOLUNTEER	CHARACTER, COMPETENCE, AND SUITABILITY (IF YES, PROVIDE A COPY)
			☐ CRP ☐ IL ☐ Pre-ETS	☐	☐	☐ Employee ☐ Intern ☐ Volunteer	☐ Yes ☐ No
			☐ CRP ☐ IL ☐ Pre-ETS	☐	☐	☐ Employee ☐ Intern ☐ Volunteer	☐ Yes ☐ No
			☐ CRP ☐ IL ☐ Pre-ETS	☐	☐	☐ Employee ☐ Intern ☐ Volunteer	☐ Yes ☐ No
			☐ CRP ☐ IL ☐ Pre-ETS	☐	☐	☐ Employee ☐ Intern ☐ Volunteer	☐ Yes ☐ No
			☐ CRP ☐ IL ☐ Pre-ETS	☐	☐	☐ Employee ☐ Intern ☐ Volunteer	☐ Yes ☐ No
			☐ CRP ☐ IL ☐ Pre-ETS	☐	☐	☐ Employee ☐ Intern ☐ Volunteer	☐ Yes ☐ No
			☐ CRP ☐ IL ☐ Pre-ETS	☐	☐	☐ Employee ☐ Intern ☐ Volunteer	☐ Yes ☐ No
			☐ CRP ☐ IL ☐ Pre-ETS	☐	☐	☐ Employee ☐ Intern ☐ Volunteer	☐ Yes ☐ No
			☐ CRP ☐ IL ☐ Pre-ETS	☐	☐	☐ Employee ☐ Intern ☐ Volunteer	☐ Yes ☐ No
			☐ CRP ☐ IL ☐ Pre-ETS	☐	☐	☐ Employee ☐ Intern ☐ Volunteer	☐ Yes ☐ No
			☐ CRP ☐ IL ☐ Pre-ETS	☐	☐	☐ Employee ☐ Intern ☐ Volunteer	☐ Yes ☐ No

BACKGROUND CHECK DESIGNEE'S SIGNATURE	DATE	PRINTED NAME

Email this form to DVR Contracts Unit when additions are made, or should staff no longer be employed, within 14 days of the change. Email to DVRContractsUnit2@dshs.wa.gov.

Washington State Department of Social & Health Services
Transforming lives

DIVISION OF VOCATIONAL REHABILITATION (DVR)

Community Rehabilitation Program (CRP)
Services and Qualifications

CONTRACTOR'S NAME AS REFLECTED WITH THE IRS	CONTRACTOR DBA (IF ANY) FOR THIS CONTRACT

☐ I am a new contractor (never had CRP / IL contract before).

☐ I had a CRP / IL contract in 2020 - 2023.

New Contractors have two-years to obtain and provide the required qualifications / accreditations for the following services: Community Based Assessment, Trial Work Experience, Job Placement Services, Intensive Training Services, Job Retention Services, Extended Services, Pre-ETS: Work Based Learning Experience, Work Readiness Training, Informational Interview, and Job Shadow (denoted with asterisk " * " after service).

Contractor Instructions: Check all boxes that apply.

Step 1: Select the countries in which your company intends to provide services.

Step 2: Check only those boxes for services your organization will provide.

Step 3: Check the applicable box showing which type of license, certification, or accreditation you have. Note there are options for organizations consisting of one person or organizations with more than one person.

Step 4: Submit copies of the applicable licenses, certifications, or accreditations as they relate to the services your company will provide as selected below.

Step 5: Sign and date the end of the form.

County Served by CRP Contractor: Check only counties your organization is able to serve at this time.

☐ **Statewide**	☐ Cowlitz	☐ Jefferson	☐ Okanogan	☐ Spokane
☐ Adams	☐ Douglas	☐ King	☐ Pacific	☐ Stevens
☐ Asotin	☐ Ferry	☐ Kitsap	☐ Pend Oreille	☐ Thurston
☐ Benton	☐ Franklin	☐ Kittitas	☐ Pierce	☐ Wahkiakum
☐ Chelan	☐ Garfield	☐ Klickitat	☐ San Juan	☐ Walla Walla
☐ Clallam	☐ Grant	☐ Lewis	☐ Skagit	☐ Whatcom
☐ Clark	☐ Grays Harbor	☐ Lincoln	☐ Skamania	☐ Whitman
☐ Columbia	☐ Island	☐ Mason	☐ Snohomish	☐ Yakima

Vocational Evaluations

☐ **Vocational Evaluations – Qualification requirement applies to ALL, including first time contractors.**

Each staff person in your organization that will provide Vocational Evaluation Services must meet one of the qualifications below. Please provide one of the following for **EACH staff member** that will provide Vocational Evaluation Services or the Contractor's CARF accreditation report.

☐ Certified as a Vocational Evaluator (CVE) maintained by the Commission of Rehabilitation Counselor Certification (CRCC); **OR**

☐ Certified Rehabilitation Counselor (CRC) by the Commission of Rehabilitation Counselor Certification (CRCC) and have successfully completed three graduate level courses from an accredited college or university in vocational evaluation, standardized assessment, psychological testing and measurement, or any combination of the above mentioned coursework**; **OR**

** **This option requires both a copy of your current CRCC certificate and original college or university transcript indicating your successful completion of all required graduate coursework.**

☐ Accredited in Comprehensive Vocational Evaluation Services by the Commission on Accreditation of Rehabilitation Facilities (CARF).

List individuals here and attach proof of credential. If you need more space, please add additional page.

First Name	Last Name	Credential and Date Attained

Trial Work Experience and Community Based Assessment

Both services below require the same qualifications. Mark the services your organization will provide.

☐ **Trial Work Experience***

☐ **Community Based Assessment***

Mark the accreditation / certification that applies to your organization.

Contractors consisting of one (1) person must have current certification as:

- ☐ Certified as a Vocational Evaluator (CVE) maintained by the Commission of Rehabilitation Counselor Certification (CRCC); **OR**
- ☐ Certified Rehabilitation Counselor (CRC) by the Commission of Rehabilitation Counselor Certification (CRCC) and have successfully completed three graduate level courses from an accredited college or university in vocational evaluation, standardized assessment, psychological testing and measurement, or any combination of the above mentioned coursework; **OR**

  *** This option requires both a copy of your current CRCC certificate and original college or university transcript indicating your successful completion of all required graduate coursework.**
- ☐ Accredited in Employment Planning Services by CARF; **OR**
- ☐ Accredited in Vocational Service Provision by RSAS; **OR**
- ☐ Certified as a Mental Health Clubhouse by the Department of Health; **OR**
- ☐ Certification from the International Center for Clubhouse Development (ICCD).

Contractors consisting of more than one person must be:

- ☐ Accredited in Employment Planning Services by CARF; **OR**
- ☐ Accredited in Vocational Service Provision by RSAS; **OR**
- ☐ Licensed as a Behavioral Health Agency by the Department of Health; **OR**
- ☐ Certified as a Mental Health Clubhouse by the Department of Health; **OR**
- ☐ Certification from the International Center for Clubhouse Development (ICCD).

Discovery Services and Customized Job Placement Services

Both services below require the same qualifications. These two services are intended to be provided sequentially by the same provider so if Contractors choose to add these to their contract, they would need to provide both.

☐ **Discovery Services**

☐ **Customized Job Placement Services**

Qualification requirement applies to ALL, including first time contractors.

Contractors shall be individually approved to provide this service. The individual providing this service must have completed one of the following certificates or trainings:

- ☐ ACRE Approved Certificate of Achievement in Customized Employment (Basic)*; **OR**
- ☐ ACRE Approved Certificate of Achievement in Employment Services (Basic); **OR**
- ☐ Completion of Wise Online Academy (WOA) 200; **OR**
- ☐ CESP and 2 years' experience providing CE services (Discovery, analyzing tasks and creating positions to fit the customer's abilities and interests and meet employer need); **OR**
- ☐ Professional Certificate from Highline Community College - completed within last 6 years; **OR**
- ☐ Other training that meets ACRE Customized Employment Competencies: reviewed and approved by Community Program Manager - please submit as much information as possible for review.

  ***** Offered by one of the training programs listed here (includes WISE WOA 100 level class)

List Individuals here and attach proof of credential. If you need more space, please add additional page.

First Name	Last Name	Credential and Date Attained

Job Placement Services

☐ **Job Placement Services***

Mark the accreditation / certification that applies to your organization.

Contractors consisting of one (1) person must have current certification as:

- ☐ Certified Rehabilitation Counselor (CRC) by the Commission of Rehabilitation Counselor Certification (CRCC)
- ☐ Accredited in Community Employment Services: Job Development by CARF; **OR**
- ☐ Accredited in Vocational Service Provision by RSAS; **OR**
- ☐ Certified as a Mental Health Clubhouse by the Department of Health; **OR**
- ☐ Certification from the International Center for Clubhouse Development (ICCD); **OR**
- ☐ Certified Employment Support Professional (CESP) by the Employment Support Professional Certification Council (ESPCC); **OR**
- ☐ ACRE Approved Certificate of Achievement in Employment Services (Basic).

Contractors consisting of more than one person must be:

- ☐ Accredited in Community Employment Services: Job Development by CARF; **OR**
- ☐ Accredited in Vocational Service Provision by RSAS; **OR**
- ☐ Licensed as a Behavioral Health Agency by the Department of Health; **OR**
- ☐ Certified as a Mental Health Clubhouse by the Department of Health; **OR**
- ☐ Certification from the International Center for Clubhouse Development (ICCD).

Intensive Training Services, Job Retention Services, Youth Extended Services

All services below require the same qualifications. Mark the services your organization will provide.

☐ **Intensive Training Services***

☐ **Job Retention Services***

☐ **Youth Extended Services***

Mark the accreditation / certification that applies to your organization.

Contractors consisting of one (1) person must have current certification as:

- ☐ Certified Rehabilitation Counselor (CRC) by the Commission of Rehabilitation Counselor Certification (CRCC); **OR**
- ☐ Accredited in Community Employment Services: Employment Supports by CARF; **OR**
- ☐ Accredited in Vocational Service Provision by RSAS; **OR**
- ☐ Certified as a Mental Health Clubhouse by the Department of Health; **OR**
- ☐ Certification from the International Center for Clubhouse Development (ICCD); **OR**
- ☐ Certified Employment Support Professional (CESP) by the Employment Support Professional Certification Council (ESPCC); **OR**
- ☐ ACRE Approved Certificate of Achievement in Employment Services Basic).

Contractors consisting of more than one person must be:

- ☐ Accredited in Community Employment Services: Employment Supports by CARF; **OR**
- ☐ Accredited in Vocational Service Provision by RSAS; **OR**
- ☐ Licensed as a Behavioral Health Agency by the Department of Health; **OR**
- ☐ Certified as a Mental Health Clubhouse by the Department of Health; **OR**
- ☐ Certification from the International Center for Clubhouse Development (ICCD).

Off-Site Psychosocial Services, Non-Supported and Supported

Both services listed below require the same qualifications. Mark the services your organization will provide.

☐ **Off-Site Psycho-Social Services – Non-Supported Employment**

☐ **Off-Site Psycho-Social Services – Supported Employment**

Qualification requirement applies to ALL, including first time contractors.

Each staff person in your organization that will provide Off-Site Psycho-Social Services must meet one of the following qualifications below or be directly supervised by an employee with one of the qualification listed below.

- ☐ Certified Rehabilitation Counselor (CRC) by the Commission of Rehabilitation Counselor Certification (CRCC).
- ☐ Mental Health Credentialing by Washington State Department of Health. One of the following credentials are acceptable:
  - ☐ Mental Health Counselor Associate License.
  - ☐ Mental Health Counselor Associate Temporary Practice Permit.
  - ☐ Mental Health Counselor Certificate.
  - ☐ Mental Health Counselor License.
  - ☐ Mental Health Counselor Temporary Practice Permit.

List Individuals here and attach proof of credential. If more space is needed, please add additional page.

First Name	Last Name	Credential and Date Attained

Pre-Employment Transition Services

All services listed below require the same qualifications. Mark the services your organization will provide.

- ☐ **Work Based Learning Experience (WBLE)***
- ☐ **Workplace Readiness Training (WRT)***
- ☐ **Informational Interviews***
- ☐ **Job Shadows***

Mark the accreditation / certification that applies to your organization.

Contractors consisting of one (1) person must have current certification as:

- ☐ Certified as a Vocational Evaluator (CVE) maintained by the Commission of Rehabilitation Counselor Certification (CRCC); **OR**
- ☐ Certified Rehabilitation Counselor (CRC) by the Commission of Rehabilitation Counselor Certification (CRCC) and have successfully completed three graduate level courses from an accredited college or university in vocational evaluation, standardized assessment, psychological testing and measurement, or any combination of the above mentioned coursework; **OR**
  - ** **This option requires both a copy of your current CRCC certificate and original college or university transcript indicating your successful completion of all required graduate course work.**
- ☐ Accredited in Employment Planning Services by CARF; **OR**
- ☐ Accredited in Vocational Service Provision by RSAS; **OR**
- ☐ Certified as a Mental Health Clubhouse by the Department of Health; **OR**
- ☐ Certification from the International Center for Clubhouse Development (ICCD).

Contractors consisting of more than one person must be:

- ☐ Accredited in Employment Planning Services by CARF; **OR**
- ☐ Accredited in Vocational Service Provision by RSAS; **OR**
- ☐ Licensed as Behavioral Health Agency by the Department of Health; **OR**
- ☐ Certified as a Mental Health Clubhouse by the Department of Health; **OR**
- ☐ Certification from the International Center for Clubhouse Development (ICCD).

CONTRACTOR'S SIGNATURE	DATE

PRINTED NAME	TITLE

Washington State Department of Social & Health Services
Transforming lives

DIVISION OF VOCATIONAL REHABILITATION (DVR)

Independent Living (IL) Services and Qualifications

CONTRACTOR'S NAME AS REGISTERED WITH THE IRS	CONTRACTOR DBA (IF ANY) FOR THIS CONTRACT

Contractor Instructions: Check all boxes that apply.

1. Select the counties in which your company intends to provide services.
2. Only check those boxes for services your organization will provide.
3. Use this document to reference the qualifications needed for each staff member providing the selected service.
4. Submit copies of transcripts and resumes of all staff that will provide services, showing they meet the educational and experience requirements.
5. Use Exhibit K to list all new staff and services for which you are seeking approval and update current staff who are already approved to provide services.

County Served by CRP Contractor

Please check only those counties your organization is able to serve.

☐ **Statewide**	☐ Cowlitz	☐ Jefferson	☐ Okanogan	☐ Spokane
☐ Adams	☐ Douglas	☐ King	☐ Pacific	☐ Stevens
☐ Asotin	☐ Ferry	☐ Kitsap	☐ Pend Oreille	☐ Thurston
☐ Benton	☐ Franklin	☐ Kittitas	☐ Pierce	☐ Wahkiakum
☐ Chelan	☐ Garfield	☐ Klickitat	☐ San Juan	☐ Walla Walla
☐ Clallam	☐ Grant	☐ Lewis	☐ Skagit	☐ Whatcom
☐ Clark	☐ Grays Harbor	☐ Lincoln	☐ Skamania	☐ Whitman
☐ Columbia	☐ Island	☐ Mason	☐ Snohomish	☐ Yakima

☐ **IL Evaluations:**

All providers of IL Evaluations must have one (1) year experience performing individual evaluations and writing reports regarding individuals' cognitive, psycho / social, life skills and interpersonal abilities, either directly or under supervision and sign-off authority of a person who meets the Washington DVR qualifications for IL Evaluation.

AND

A Bachelor's degree in human or social services (counseling, vocational rehabilitation, social work, education, psychology, occupational / physical therapy, etc.) from an accredited college or university **and the following**:

- Two (2) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

OR

A Bachelor's degree, in any field, from an accredited college or university, **and the following**:

- Three (3) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

OR

Ninety (90) quarter or sixty (60) semester hours of human or social services coursework (counseling, vocational rehabilitation, social work, education, psychology, occupational / physical therapy, etc.) from an accredited college or university, **and the following**:

- Four (4) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

OR

A high school diploma or GED, **and the following**:

- Six (6) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

IL Services

All services listed below require the same qualifications. Mark the services your organization will provide:

☐ **IL Work-related Systems Access related to barriers to employment**

☐ **IL Skills Training Related to Barriers to Employment**

☐ **IL Pre-ETS Self-Advocacy Training**

A Bachelor's degree, in any field, from an accredited college or university, **and the following**:

- One (1) year Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

OR

Ninety (90) quarter or sixty (60) semester hours of coursework, in any field, from an accredited college or university, **and the following**:

- Two (2) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

OR

A high school diploma or GED, **and the following**:

- Four (4) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

CONTRACTOR'S SIGNATURE	DATE

CONTRACTOR'S PRINTED NAME	CONTRACTOR'S TITLE

Exhibit K

Washington State Department of Social & Health Services
Transforming lives

DIVISION OF VOCATIONAL REHABILITATION
INDEPENDENT LIVING SERVICES

Contractor Employee(s) to Provide IL Services and Service(s) Approved

ORGANIZATION'S LEGAL NAME	ORGANIZATION'S LEGAL NAME

Use additional copies of this form, if needed, to list current or new employees and the services they are approved or request to provide.

List existing employees <u>currently</u> approved by DVR to provide IL services and what services they are approved to provide.

Employees approved through the current contract do **<u>not</u>** need to resubmit current resume and educational transcripts.

FIRST NAME	LAST NAME	IL EVALUATIONS	IL SKILLS TRAINING	IL WORK-RELATED SYSTEMS ACCESS
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

List <u>new employees</u> to be reviewed and approved to provide IL services and mark the services you request them to provide.

Please include: 1) a current resume; and 2) official educational transcripts for each new employee to be reviewed. **Review requirements listed on Exhibit J.**

FIRST NAME	LAST NAME	IL EVALUATIONS	IL SKILLS TRAINING	IL WORK-RELATED SYSTEMS ACCESS
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

Please note: A signed contract does not automatically approve the Contractor or Contractor's staff to perform IL Services. The Contractor or Contractor's staff (IL Providers) cannot provide any of the above services until official approved by authorized DVR staff.

CONTRACTOR'S SIGNATURE	DATE	CONTRACTOR'S PRINTED NAME
		CONTRACTOR'S TITLE