2013-2014 Service Agreement Signature Form
Department of Workforce Development-Division of Vocational Rehabilitation

Tax ID/FEIN/SSN# _____

Provider Contact Person: _____
Last Name-Please Print

_____
Middle Initial

_____
First Name

Provider Name & Address: _____
Name-Please Print

_____
Street

_____
City

_____
State

Contact Person E-Mail Address: _____

Contact Person Phone: _____

This designated person will receive all DVR service agreement related correspondence. Please provide updated information if this designated persons contact information changes. Failure to do so may result in an inability for DVR to remain in contact or for important information to be missed. DVR is not responsible for misdirected or lost correspondence as a result of failure to update this information.

Provider Website: _____

WDA(s) Served:

_____WDA 1	_____WDA 5	_____WDA 9
_____WDA 2	_____WDA 6	_____WDA 10
_____WDA 3	_____WDA 7	_____WDA 11
_____WDA 4	_____WDA 8	

Counties Served:

☐ Adams	☐ Douglas	☐ Kewaunee	☐ Outagamie	☐ Shawano
☐ Ashland	☐ Dunn	☐ La Crosse	☐ Ozaukee	☐ Sheboygan
☐ Barron	☐ Eau Claire	☐ Lafayette	☐ Pepin	☐ Taylor
☐ Bayfield	☐ Florence	☐ Langlade	☐ Pierce	☐ Trempealeau
☐ Brown	☐ Fond du Lac	☐ Lincoln	☐ Polk	☐ Vernon
☐ Buffalo	☐ Forest	☐ Manitowoc	☐ Portage	☐ Vilas
☐ Burnett	☐ Grant	☐ Marathon	☐ Price	☐ Walworth
☐ Calumet	☐ Green	☐ Marinette	☐ Racine	☐ Washburn
☐ Chippewa	☐ Green Lake	☐ Marquette	☐ Richland	☐ Washington
☐ Clark	☐ Iowa	☐ Menominee	☐ Rock	☐ Waukesha
☐ Columbia	☐ Iron	☐ Milwaukee	☐ Rusk	☐ Waupaca
☐ Crawford	☐ Jackson	☐ Monroe	☐ St Croix	☐ Waushara
☐ Dane	☐ Jefferson	☐ Oconto	☐ Sauk	☐ Winnebago
☐ Dodge	☐ Juneau	☐ Oneida	☐ Sawyer	☐ Wood
☐ Door	☐ Kenosha			

Communities Served: (Please list)

_____

_____

_____

Rehabilitation Service Programs Provided :

_____**Benefits Analysis Services**

_____**Internship/Temporary Work**

_____**Job Coaching Services (Other Than Supported Employment)**

_____**Job Preparation, Development and Placement Services**

_____**Supported Employment**

_____**Vocational Evaluation Services**

Managed Care Organizations-Contract for Service _____No _____Yes

- ☐ Care Wisconsin First
- ☐ Comm. Care of Central WI
- ☐ Community Care
- ☐ Comm. Health Partnership
- ☐ iCare
- ☐ Lakeland Care District
- ☐ Milwaukee County Department of Family Care
- ☐ NorthernBridges
- ☐ Southwest Family Care Alliance
- ☐ Western Wisconsin Cares

Total Number of agency staff :_____
(ALL staff-Not just those who work with DVR)

Agreement Period: **Begin:_____** **End: June 30, 2014**

1. This Agreement is entered into by and between the State of Wisconsin, Department of Workforce Development, Division of Vocational Rehabilitation (DVR), and the above-named Provider upon the completed signature of the DVR's authorized representative.

2. Whereby the Division of Vocational Rehabilitation agrees to direct the purchase and the Provider agrees to furnish to authorized DVR consumers the specified rehabilitation services in compliance with the service program technical specifications (Attachment #7) and the current DVR statewide fee schedule during the Agreement period indicated above.

3. The Provider agrees that services will commence within two weeks of receipt of DVR purchase order (authorization).

4. Provider certifies that by signing this Agreement, assigned staff are qualified to provide these services as required in the technical specifications.

5. Are there sub-contracted agencies under this Agreement? **Yes___ No___**

   If **Yes**, the Provider must complete Form #3 (Reference Attachment #11, Item #9 of this Agreement) and complete an additional : Certification Regarding Debarment, Suspension & Other Responsibility Matters, Certification Regarding Lobbying, Certification Regarding Drug-Free Workplace Requirements.

6. The DVR must be assured that agencies completing Agreements with DVR meet performance outcomes and providing equitable and quality services to all DVR consumers. This assurance also applies to any agencies you have a sub-contract with. DVR will review performance and outcomes and require appropriate action as needed.

7. In signing this Agreement, the Provider also certifies that it has not, either directly or indirectly, entered into any agreement or participated in any collusion or otherwise taken any action in restraint of free competition. The Provider agrees to provide the services, meet the program requirements and accepts the terms and conditions set forth in this Agreement, and that all documents are deemed to be a part of this Agreement.
   Including:

Individual Documents (Effective July 1, 2013):

Service Agreement Signature Page Form 1
Service Provider Location Form 2
Service Provider Personnel List Form 3
Service Provider Subcontractor Form 4
Agreement for Services (Attachment 1)
Agreement Standard Terms and Conditions (Attachment 2)
Instructions for Certification Regarding Debarment, Suspension and other Responsibility Matters (Attachment 3)
Certification Regarding Debarment, Suspension & Other Responsibility Matters (Attachment 4)
Certification Regarding Lobbying (Attachment 5)
Certification Regarding Drug-Free Workplace Requirements (Attachment 6)
Technical Specifications (Attachment 7):

- Benefits Analysis Services
- Internship/Temporary Work
- Job Coaching -- Other Than Supported Employment
- Job Preparation, Development & Placement Services
- Supported Employment
- Vocational Evaluation Services

Statewide Service Fee Structure / Fiscal Year 2011-2012 (Attachment 8)
Service Provider Sample Invoice (Attachment 9)
Criminal Background Check Policy (Attachment 10)
Certification of Criminal Background Check (Attachment 11)
Undue Hardship Policy (Attachment 12)

8. Now, therefore, in consideration of the mutual undertakings and agreements hereinafter set forth and the Chapter 47 of the Wisconsin Statutes the DVR and Provider agree with this Agreement as follows.

_____ _____
Signature – Provider Authorized Representative Date

_____ _____
Signature – Deputy Administrator Date
Division of Vocational Rehabilitation

Service Provider Narrative Section

Please provide information about your agency that you wish to share with DVR Consumers. This information will be used in addition to other details about your agency to assist DVR Consumers when selecting a provider.

Please limit each area to 1000 characters or less.

Years in Business: _____

Mission Statement:

_____
_____
_____
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Provider Professional Affiliations:

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Areas of Expertise:

_____
_____
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About the Provider Agency:

Professional Credentials:

Special Projects of Pilots: