|  |  |
| --- | --- |
| Texas Workforce Solutions logo | **Texas Workforce Commission****Vocational Rehabilitation Services****Goods and Equipment Part A:****Parent Company Information**  |
| * For response to an Electronic State Business Daily (EBSD) posting, follow the instructions in the ESBD posting,  otherwise submit updated forms to the Quality Assurance Specialist for VR (Q) or Regional Program Support Specialist (RPSS).
* Follow instructions on the form and in the TWC VR Standards for Providers.
* Type all information on form using a computer and get all required signatures.
* Complete all sections of the form. Record “N/A” (not applicable) if a question does not apply.
* Keep a copy of your submitted form with attachments and supporting documentation for your records.
 |
| Reason for Submission    |
| **Date of submission:**       |
| [ ]  Application package | **Solicitation ID:**       |
| [ ]  Update of information due to change in information on file. |
| [ ]  Other Specify:       |
| Parent Company Information    |
| **Parent company**: The business that is requesting or has been granted the bilateral contract with TWC to provide services on behalf of VR customers.     |
| **Parent company’s legal name**:        |
| **Parent company’s “doing business as” (DBA) name**:       |
| **Provide at least one of the following**:  Employer Identification Number (EIN): (9 digits, issued by IRS):      Last four digits of the sole proprietor’s Social Security Number:       |
| **Street address:**      |
| **City:**      | **County:**      | **State:**      | **ZIP code:**      |
| **Mailing address:** (if different from physical address)       |
| **City:**      | **County:**      | **State:**      | **ZIP code:**      |
| **Remittance address:** (if different from mailing and/or physical address)       |
| **City:**      | **County:**      | **State:**      | **ZIP code:**      |
| **Describe your principal line of business. Include a brief description of the types of products and services your business provides.**      |
| **Email address, if any**:      |
| **Web address** (if applicable):      |
| **List the name of each location the parent company will operate.**      |
| **List any current contracts the entity has with TWC Vocational Rehabilitation:**      **[ ]** No contract related to Vocational Rehabilitation has been granted to this parent company. |
| Parent Company Management Team   |
| **Legally authorized representative**: Person who is authorized to sign contracts and official documents for the parent company.    |
| **Last name**:      | **First name**:      |
| **Title**:       |
| **Phone number**: (   )       | **Alternate phone number**: (   )       |
| **Fax number**:(   )       | **Email address**:      |
| **Point of contact** The person appointed by the legally authorized representative as the primary contact for routine TWC communication  and is responsible for meeting all TWC VR Standards for Providers manual and contract requirements.  If the legally authorized representative is serving as the point of contact, they must complete this section.   |
| **Point of contact last name**:      | **Point of contact first name**:      |
| **Title**:       |
| **Phone number**: (   )       | **Alternate phone number**: (   )       |
| **Fax number**:(   )       | **Email address**:      |
| Authorized Representative Acknowledgments and Signature   |
| I, the legally authorized representative, have been named by the parent company and have the authority to certify acknowledgement:  * the information provided in this form is complete and accurate;
* the application includes the following forms:
* VR1020, W9 and Direct Deposit Form;
* VR1305, Child Support Certification Form;
* VR3443, Standards for Providers Certification;
* VR3444, Conflict of Interest Certification;
* VR3440A, Goods and Equipment Part A, Parent Company Information;
* VR3440B, Goods and Equipment Part B, Local Business Location Information; and
* VR3437, Hearing Aids and Accessories Certification or VR3438, Vehicle Modification Certification, or  VR3439, Durable Medical Equipment Certification.
* the business must keep all forms listed above up to date with TWC-VR submitting to the assigned Quality Assurance Specialist (Q) or Regional Program Support Specialist (RPSS);
* the applicant must be in compliance with all the terms in the Electronic State Business Daily Agency posting notice, TWC VR Standards for Provider Manual, and/or contract, if awarded.
 |
| **Authorized Representative’s typed name**:      | **Handwritten signature**:**X**   | **Date**:      |
| Agency Use Only   |
| **Comments**:      |
| **Name and initials of each reviewer(s) of the application. Date each entry.**      |