OVR

(Rev. 04/2025)

Vendor Application Form

Kentucky Office of Vocational Rehabilitation

Kentucky Career Center
Vocational Rehabilitation

Thank you for your interest in applying to be a vendor with the Kentucky Office of Vocational Rehabilitation (OVR). OVR commits to assist Kentuckians with disabilities to achieve suitable employment and independence.

OVR accepts and reviews Vendor Applications on a rolling basis and does not guarantee approval or any specific number of referrals.

OVR will only consider applications that follow the criteria outlined in the Vendor Manual. If approved, applicants must follow the standards established by federal and state laws, national certification boards, applicable licensure boards, and OVR. To begin the process, complete and submit the information below.

Section A | Business Information

Legal Business Name		
Doing Business As (DBA) *(if applicable)*		
Business Office Address		
City	**State**	**Zip Code**
Address Where Services Provided		
City	**State**	**Zip Code**
Business Website URL *(if applicable)*		

Kentucky counties Vendor will serve (list all counties in alphabetical order)

Is this business registered with the Kentucky Secretary of State?

Business Contact Information

Contact Person Name	Title
Phone number *(999-999-9999)*	**Fax Number** *(999-999-9999)*
Email Address	

Tax Information

Federal Taxpayer/Employer Identification Number *(FEIN)*	
Tax Status	**If other, please specify**

Service Type (select all that apply)

- ☐ Assistive Technology
- ☐ Audiology
- ☐ Child Care
- ☐ CRP Services
- ☐ Chiropractic Services
- ☐ Dental Services
- ☐ Dietician Services
- ☐ Driver Rehab Program
- ☐ Hospitals (in & out patient)
- ☐ Interpreting Services
- ☐ Job Coaching
- ☐ Life Skills Coaching

- ☐ Medical Services
- ☐ Mental Health Counseling
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Orientation & Mobility
- ☐ Orthotics & Prosthetics
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Post-Secondary Education
- ☐ Pre-Employment Transition Services
- ☐ Property Modifications
- ☐ Retail/Wholesale
- ☐ Speech Language Education
- ☐ Support Service Provider
- ☐ Transportation
- ☐ Tutoring Services
- ☐ Vehicle Modifications
- ☐ Other Services (not listed)

If you selected Medical Services, please specify

If you selected Other Services (not listed), please specify

Service Providers and Credentials

Please list the name(s) and credential(s) of any employee who will provide services on behalf of this business. Attach additional sheets if necessary. Vendors are required to submit proof of credentials upon application and renewal.

Employee 1

Name	**Degree**

Background Check *(if yes, date completed)*	**Certificate/Licensure Type**

Certificate/Licensure Number	**Expiration Date** *(mm/dd/yyyy)*

Email Address

Employee 2

Name	**Degree**

Background Check *(if yes, date completed)*	**Certificate/Licensure Type**

Certificate/Licensure Number	**Expiration Date** *(mm/dd/yyyy)*

Email Address

Employee 3

Name	**Degree**

Background Check *(if yes, date completed)*	**Certificate/Licensure Type**

Certificate/Licensure Number	**Expiration Date** *(mm/dd/yyyy)*

Email Address

If you're applying as a Community Rehabilitation Program (CRP), fill out Section B. If you're applying as a Support Service Provider, proceed to Section C. If you're not applying for either, go to Section D.

Section B | Community Rehabilitation Programs

Type of service/outcome applying for
(select the appropriate service(s) and indicate the number served last year):

Community Rehabilitation Program Services	Number Served Last Year
☐ Adjustment Services	_____
☐ Comprehensive Vocational Assessment	_____
☐ Comprehensive Vocational Evaluation	_____
☐ Employment & Retention	_____
☐ Pre-Vocational Services	_____
☐ Supported Employment (Customized)	_____
☐ Supported Employment (Placement & Support)	_____
☐ Supported Employment (Traditional)	_____
☐ Transportation Services	_____
☐ Other: _____	_____

Business Information

Please indicate the population you wish to serve
(select all that apply)

☐ Individual Placement & Support (IPS)
☐ Michelle P.
☐ Supported Community Living (SCL)
☐ All Others

Hours of Operation

Describe your organization's admissions criteria for receiving services
Business Accreditations
Other Services/Comments

Supported Employment Services

If you are applying for Supported Employment services, complete the section below, otherwise **skip to Section D**.

Answer the following questions in narrative format. Please be as detailed as possible in your answers. Attach additional pages (such as descriptions of funding) as necessary.

Describe your organization's mission and why you desire to provide SE services

How many individuals do you currently serve who work in the community?
(Please describe how you provide support for these individuals, both on and off the job site)

Describe in general terms the population(s) you plan to serve.
(If you restrict services to a particular disability population due to funding or for other reasons, please explain)

Describe how you plan to address/assure integration at the job site
(This is a key feature of Supported Employment)

How will you ensure consumer satisfaction with your services and supports?

How will you customize, and fund extended, ongoing support services? *(Be specific about the funding sources you plan to use)*

Section C | Support Service Providers

Complete this section only if you are applying as a Support Service Provider, otherwise skip to **Section D**.

Video Phone/TTY Number *(999-999-9999)*

Types of services you will provide *(select all that apply)*		
☐ Certified Deaf Interpreter	☐ Deaf Interpreter	☐ Deaf-Blind Interpreter

Communication & Skills

Are you a licensed interpreter by the Kentucky Board of Interpreters for the Deaf and Hard of Hearing?

What kind of interpreting experience do you have?

How would you describe your signing skills?

How many years have you been signing?

Are you experienced in the use of Tactile Signing? *(If yes, please specify Right-handed, Left-handed, or both; and number of years' experience)*

Have you had Support Service Provider training?	If yes, when was your last training?

What kind of Support Service Provider experiences have you had? *(i.e., guiding, food shopping, read mail, etc.).* **Attach additional sheets if necessary:**

Deaf-Blind Services

Select all services that you can provide to Deaf-Blind persons:

- ☐ American Sign Language
- ☐ Braille
- ☐ Cued Speech
- ☐ Finger Spelling
- ☐ FM Loop
- ☐ Haptic Signals
- ☐ Manually Coded English
- ☐ Oral Interpreting
- ☐ Pidgen Signed English
- ☐ Print on Palm
- ☐ Pro Tactile
- ☐ Tactile Signing Use
- ☐ Voice Interpreting
- ☐ Working with Developmentally Disabled Deaf-Blind
- ☐ Working with hard of hearing
- ☐ Other *(please specify)* _____

Section D | Applicant's Acknowledgement & Signature

By signing and submitting this application, vendor acknowledges:

- ☐ I have read and understood the Vendor Manual. If this application is accepted, I agree to comply with all requirements outlined in the Vendor Manual.
- ☐ I have attached all required documentation as described in the Vendor Manual and this application. I understand that failure to submit the necessary documentation or provide false or misleading information will result in the denial of this application.
- ☐ I shall not provide any services without first receiving a preauthorization. The vendor also understands they shall not bill any consumer if preauthorization was not obtained for the service.
- ☐ I verify that I am authorized to sign this document on behalf of the business named herein.

Applicant's Signature _____ Date (mm/dd/yyyy) _____

Printed Name _____ Title _____