DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
EMPLOYMENT SPECIALIST APPLICATION

Provider Information

PROVIDER NAME:	Steps Foundation, Inc		
FEDERAL TAX ID:	84-4017417	PROVIDER NUMBER:	407-279-0713
PROVIDER CONTACT:	Abigail Ellis	PHONE NUMBER:	407-279-0713
SERVICES ES WILL PROVIDE:	☑ EMPLOYMENT SERVICES	☐ SUPPORTED EMPLOYMENT SERVICES	☐ OJT

Employee Information

FIRST NAME		MI		LAST NAME	
MAILING ADDRESS					
CITY		STATE		ZIP CODE	
EMAIL ADDRESS:					

Post-Secondary Education

NAME OF SCHOOL	CITY, STATE	CREDIT HOURS EARNED		MAJOR/MINOR COURSE OF STUDY	TYPE OF DEGREE EARNED
		QTR	SEM		

Qualifications for Certification

Employees who will provide direct services must meet one of the following qualifications

1. ☐ Four years' experience or employment in a public vocational rehabilitation program; experience in job placement, job coaching, or counseling; or other related experience working with persons with disabilities. OR

2. ☐ A Master's Degree in a related field such as rehabilitation, counseling, social work, psychology, education, human resources, business administration, or economics, from an accredited college or university, and six month's experience as described above. OR

3. ☐ A Bachelor's Degree in a related field such as rehabilitation, counseling, social work, psychology, education, human resources, business administration, or economics, from an accredited college or university, and one year's experience as described above. OR

4. ☐ An Associate's Degree from an accredited college or university, or a Bachelor's or Master's Degree in an unrelated field, and two years' experience as described above.

All employees who will provide Supported Employment Services must also have a training certificate in Supported Employment from a state or nationally recognized Supported Employment Program.
Please provide copy(ies) of the following, if applicable:

- Degree(s)
- Training Certificate(s)

Employment History

Employment History must support the option chosen above. Reference checks may be conducted to verify this information. List those duties consistent with above qualifications under DESCRIPTION OF WORK PERFORMED. If more space is needed, please attach a resume.

EMPLOYER				
ADDRESS				
PHONE NUMBER				
JOB TITLE				
DATES EMPLOYED (MM/YYYY TO MM/YYYY):	FROM		TO	
DESCRIPTION OF WORK PERFORMED:				
YOUR NAME IF DIFFERENT FROM EMPLOYMENT				
EMPLOYER				
ADDRESS				
PHONE NUMBER				
JOB TITLE				
DATES EMPLOYED (MM/YYYY TO MM/YYYY):	FROM		TO	
DESCRIPTION OF WORK PERFORMED:				
YOUR NAME IF DIFFERENT FROM EMPLOYMENT				
EMPLOYER				
ADDRESS				
PHONE NUMBER				
JOB TITLE				
DATES EMPLOYED (MM/YYYY TO MM/YYYY):	FROM		TO	

DESCRIPTION OF WORK PERFORMED:				
YOUR NAME IF DIFFERENT FROM EMPLOYMENT				
EMPLOYER				
ADDRESS				
PHONE NUMBER				
JOB TITLE				
DATES EMPLOYED (MM/YYYY TO MM/YYYY):	FROM		TO	
DESCRIPTION OF WORK PERFORMED:				
YOUR NAME IF DIFFERENT FROM EMPLOYMENT				
EMPLOYER				
ADDRESS				
PHONE NUMBER				
JOB TITLE				
DATES EMPLOYED (MM/YYYY TO MM/YYYY):	FROM		TO	
DESCRIPTION OF WORK PERFORMED:				
YOUR NAME IF DIFFERENT FROM EMPLOYMENT				
EMPLOYER				
ADDRESS				
PHONE NUMBER				
JOB TITLE				

DATES EMPLOYED (MM/YYYY TO MM/YYYY):	FROM		TO	
DESCRIPTION OF WORK PERFORMED:				
YOUR NAME IF DIFFERENT FROM EMPLOYMENT				

Volunteer Work

Please enter any volunteer work you've performed in the areas of; job placement, job coaching, counseling or working with persons with disabilities. Include organization's name, and dates (mm/yyyy) of volunteer service.

Transportation

Will you be transporting VR clients?

☐ Yes

☑ No

If you will be transporting VR Customers, please provide the following:

☐ Valid Driver's License

☐ Valid Vehicle Registration

☐ Valid Automobile Insurance with minimum coverage 50,000/100,000 unless the Provider's Insurance

Coverage includes Automobile Liability which covers any Automobile. Please provide a copy of the Automobile Declaration page (not the whole policy).

Certification	
I hereby certify that, to the best of my knowledge, the above information is correct. Omissions, falsifications, misstatements, or misrepresentations above may determine me unqualified to provide services to Customers of Vocational Rehabilitation under the above Provider's Manual. I consent to the release of my employment history from any of the above mentioned employers to Vocational Rehabilitation.	
Signature:	
☐ I hereby certify that I am a subcontractor or independent contractor of the above Provider ***and I have attached the employment agreement between myself and the Provider.*** Failure to provide this information will result in the Provider being in violation of the Employment Services Manual held with Vocational Rehabilitation. ☐ I hereby certify that I am NOT a subcontractor or independent contractor of the above Provider.	
Signature:	
I hereby certify that I've reviewed the Employment Specialist Training presentations on Services and Overview, and completed the VR New Employment Specialist Training Quiz. I've received a score of _____. This score will be independently verified by Vocational Rehabilitation.	
Signature:	