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| Texas Workforce Solutions logo | **Texas Workforce Commission****Vocational Rehabilitation Services****Hospital Facility Information**  |
| **Instructions**:  For response to an Electronic State Business Daily (EBSD) posting, follow the instructions in the ESBD posting.  All sections must be completed at application.  * Type all information on form using a computer and get all required handwritten 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:**       | **Solicitation ID:**       |
| [ ]  Application package[ ]  Update of information due to change in information on file. For example, qualifications change.[ ]  Other: Specify:       |
| **Hospital System Information**  |
| **Hospital System**: The business that is requesting or has been granted the bilateral contract with TWC to provide services on behalf of VR customers.   |
| **Hospital System’s legal name:**        | **Hospital System’s “doing business as” (DBA) name:**       |
| **Physical address:**      |
| **City:**      | **County:**      | **State:**      | **ZIP code:**      |
| **Mailing address:** (if different from physical address)       |
| **City:**      | **County:**      | **State:**      | **ZIP code:**      |
| **Email address, if any**:      |
| **Web address** (if applicable):      |
| **Provide the following**: Medicare Number:       | NPI Number:       |
| **Primary Contact for Contract Purposes**  |
| **Last name:**      | **First name:**      |
| **Title:**      |
| **Direct Phone number:**(   )       | **Alternate phone number:**(   )       |
| **Fax number:**(   )       | **Email address:**      |
| **Primary Contact for Billing Purposes** |
| **Last name:**       | **First name:**       |
| **Title:**       |
| **Direct Phone number:**(   )       | **Alternate phone number:**(   )       |
| **Fax number:**(   )       | **Email address:**      |
| **Hospital Location(s)** (Submit a VR3118 for **each** hospital location) |
| **Hospital’s legal name:**       | **Hospital’s “doing business as” (DBA) name:**       |
| **Physical address:**      |
| **City:**      | **County:**      | **State:**      | **ZIP code:**      |
| **Phone number:**(   )       | **Fax number:**(   )       |
| **Provide the following**: Medicare Number:       | NPI Number:       |
| **Available Services** |
| **Check all that apply:****[ ]** Hospital Services: [ ] Inpatient Service [ ]  Outpatient Services**[ ]** Implantable Device:**[ ]** Implanted [ ]  Embedded [ ]  Inserted [ ]  Otherwise [ ]  Related equipment necessary to operate, program and recharge the implantable**[ ]** Medical Records**[ ]** Robotic Surgery |
| **TWC Acknowledgment and Signatures**  |
| This acknowledgment is applicable to, and shall be considered active for, the following purposes: * Processing of the respondent’s application;
* Execution of the initial award, if applicable;
* Continuation of the contract life through subsequent execution of renewals and/or amendments and/or  updating information on file with TWC as applicable.

**I, the legally authorized representative, have been named by the entity and have the authority to certify:**  * the entity has the ability to provide Hospital/Medical services in Texas;
* the information provided in this form is complete and accurate, and
* the legal entity is in compliance with all the terms in the Electronic State Business Daily (ESBD) Agency Posting notice, and/or contract if awarded.
 |
| **Legally authorized representative’s printed name:**      | **Title:**      |
| **Legally authorized representative’s handwritten signature:****X**   | **Date:**      |
| **Agency Use Only**  |
| **Comments, if any:**      |
| **Reviewers of the Form** |
| **Date** | **Printed Name** | **Title** | **Signature** | **Initials** |
|       |       |       |       |       |
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