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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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