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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Proprietary School Training Information** | | | | | | | | | | | | |
| **Provider Information** | | | | | | | | | | | | | | | |
| Legal name: | | | | | DBA name: | | | | | | | | | | |
| **Location** | | | | | | | | | | | | | | | |
| Street address: | | | | | | | | | | | | | | | |
| City: | | | | | | | | | State: | | | | | ZIP code: | |
| Telephone number:  (   ) | | | FAX number:  (   ) | | | | | | | Tax identification number (9 digits): | | | | | |
| **Billing Address (if different)** | | | | | | | | | | | | | | | |
| Street address: | | | | | | | | | | | | | | | |
| City: | | | | | State: | | | | | | | | ZIP code: | | |
| Telephone number:  (   ) | | | | FAX number:  (   ) | | | | | | | | | | | |
| **School Ownership Information** | | | | | | | | | | | | | | | |
| Enter X to select one of the following and complete the requested information: | | | | | | | | | | | | | | | |
| Sole proprietor | | Owner’s name: | | | | | | | | | | Owner’s SSN: | | | |
| Partnership | | First partner’s name: | | | | | | | | | | First partner’s SSN or EIN: | | | |
|  | | Second partner’s name: | | | | | | | | | | Second partner’s SSN or EIN: | | | |
| Limited partnership | | | | | File number: | | | | | | | | | | |
| Texas corporation | | | | | Charter number: | | | | | | | | | | |
| Professional association | | | | | Charter number: | | | | | | | | | | |
| Professional corporation | | | | | Charter number: | | | | | | | | | | |
| Out-of-state corporation | | | | |  | | | | | | | | | | |
| Government | | | | |  | | | | | | | | | | |
| Financial institution | | | | |  | | | | | | | | | | |
| State agency or university | | | | |  | | | | | | | | | | |
| **Historically Underutilized Business (HUB)** | | | | | | | | | | | | | | | |
| Are you HUB-certified with the Texas Comptroller of Public Accounts (CPA)? | | | | | | | | | | | | | | | Yes    No |
| Are you interested in becoming HUB-certified? | | | | | | | | | | | | | | | Yes    No |
| **School and Course Identification** | | | | | | | | | | | | | | | |
| Complete this page for each approved course. | | | | | | | | | | | | | | | |
| School name: | | | | | | | | | | | Tax ID number: | | | | |
| Course title: | | | | | | | | | | | Course number: | | | | |
| Prerequisite for admission: | | | | | | | | | | | | | | | |
| **Provider Catalog Course Information** | | | | | | | | | | | | | | | |
| Provide a copy of your current catalog to the TWC-VR address below. | | | | | | | | | | | | | | | |
| Total required hours needed to complete the course: | | | | | | | | | | | | | | | |
| Daily course hours are from:       to | | | | | | | | Number of days per week: | | | | | | | |
| Does your school require advance payment of tuition?    Yes    No  If “no,” explain tuition payment options: | | | | | | | | | | | | | | | |
| Financial aid programs available through the school (for example, PELL Grant, Veterans Program, Scholarship): | | | | | | | | | | | | | | | |
| Job placement percentage rate for this course:      % | | | | | | | | | | | | | | | |
| **Course Fees** | | | | | | | | | | | | | | | |
| Tuition | $ | | | | | | | | | | | | | | |
| Registration | $ | | | | | | | | | | | | | | |
| Supplies/Tools | $ | | | | | | | | | | | | | | |
| Books | $ | | | | | | | | | | | | | | |
| \* Other Fees | $ | | | | | | | | | | | | | | |
| **Total** | $ | | | | | | | | | | | | | | |
| \* **Itemize Other Fees** | | | | | | | | | | | | | | | |
|  | | | | | | |  | | | | | | | | |
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| **Certification of Approved Courses** | | | | | | | | | | | | | | | |
| You must provide a copy of the certificate of approval from the regulating state agency, federal board, or other regulating entities given that responsibility. An approved course list, if applicable, must also accompany this certificate before TWC-VR can enter your school information into the provider system. | | | | | | | | | | | | | | | |
| **Billing Agreement** | | | | | | | | | | | | | | | |
| I understand that the Vocational Rehabilitation Services is to be billed, and will pay for services in accordance with my usual billing procedures. | | | | | | | | | | | | | | | |
| Signature of director:  **X** | | | | | | Date: | | | | | | | | | |
| **Mail or Fax This Form To:**  TWC VR Program Operations – Data Maintenance  101 E 15th St  Rm 506T  Austin, TX 78778-0001  (512) 936-3768 (fax) | | | | | | | | | | | | | | | |