

# VOCATIONAL REHABILITATION VENDOR APPLICATION (K.A.R. 51-24-4)

K-WC-R 93-10 (11-16)

## Type of Application (please check):

- Original application (new applicant)  
 Change application  
 Renewal application

Individuals, firms or corporations proposing to qualify as a vendor must:

- Carefully review this application before completing
- Provide all information requested in this application
- Agree to and abide by all requirements contained within
- Sign the application
- Obtain a vendor number from the Division of Workers Compensation prior to accepting referrals, if this is an original application (new applicant)
- Submit an updated application as changes occur which may affect vendor's standing to become or remain qualified
- Submit a renewal application when determined necessary by the rehabilitation administrator

## Qualifications and Duties of a Vendor:

It is agreed that:

- (a) An office as defined in 51.24.3 (c) shall be maintained in the state of Kansas or in the metropolitan Kansas City area, staffed with personnel capable of responding to written or phone inquiries regarding cases referred to that vendor.
- (b) The addresses and phone numbers of the offices within and outside the state of Kansas from which vocational rehabilitation services will be performed for cases under the Kansas Workers Compensation Act **are attached to this application.**
- (c) A listing of each person employed to perform services as a medical manager, counselor, evaluator or job placement specialist for cases referred to that vendor, and an indication of each person's discipline, **is attached to this application.**
- (d) This vendor will employ or contract with one or more persons qualified to perform work as a medical manager, counselor, evaluator or job placement specialist as necessary to carry out the purpose of the referral **(if contracting these services, identify source).**
- (e) This vendor will be responsible for the appropriateness and timeliness of service delivery by each medical manager, counselor, evaluator and job placement specialist employed or under contract to carry out the purpose of the referral.
- (f) This vendor wants to be included in the list of vendors qualified and requesting to receive referrals from employers or the Director of Workers Compensation.
- (g) This vendor will report, in a form prescribed by the Director, to the vocational rehabilitation administrator each referral received from an employer or insurance carrier and the date of the referral.
- (h) This vendor will report upon the status of each evaluation and/or plan 30 days after the referral, and report upon the status of the evaluation or plan as requested by the rehabilitation administrator. These reports shall be in a form prescribed by the Director.
- (i) This vendor will provide copies of all vocational assessments, plans, plan amendments and progress reports to all parties involved, including attorneys for the claimant and respondent if it is a litigated case.
- (j) This vendor will provide objective and impartial assessments of the injured worker's need for rehabilitation services.
- (k) This vendor acknowledges that the authorization by the Director to provide vocational rehabilitation services pursuant to the Kansas Workers Compensation Act and regulations may be suspended or revoked for failure to comply with regulations adopted by the Director.
- (l) This vendor will adhere to the fee schedule as set forth by the Kansas Division of Workers Compensation.

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**As an official representative of the company, I acknowledge that**

\_\_\_\_\_  
*Company name*

**has reviewed the standards of conduct for vocational rehabilitation vendors and vocational rehabilitation professionals, and agrees to be accountable under K.A.R. 51-24-1 thru 51-24-10 and all provisions of the Kansas Workers Compensation Act.**

\_\_\_\_\_  
*Signature (representative/owner)*

\_\_\_\_\_  
*Date of application*

\_\_\_\_\_  
*Title*

**Vendor Information:**

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Owner: \_\_\_\_\_ Contact person: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Email: \_\_\_\_\_

Website address to be displayed on the Division's list of **Qualified Vocational Rehabilitation Providers**  
(<http://www.dol.ks.gov/workcomp/qvrlist.aspx>):

**Please attach information on additional offices in Kansas or the Kansas City Metro area.**

\*NOTE: Protecting claimants' identity is important to us. Please be advised that: (1) email communication is not a secure method of communication; (2) any email that is sent between you and this agency may be copied and held by various computers it passes through as it is transmitted; (3) persons not participating in the communication between you and KDOL may intercept the communication by improperly accessing your computer or this agency's computer or even some computer unconnected to either of us that this email passes through. If you do not want to communicate with KDOL through email, please call KDOL or mail your communication to KDOL, instead of using email.

**For Agency Use Only**

Date approved: \_\_\_\_\_

Date not approved: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_