



DEPARTMENT OF ADMINISTRATIVE SERVICES QUALIFIED REHABILITATION FACILITY APPLICATION

ORGANIZATION INFORMATION

1. The information provided is from the fiscal year ending _____ (mm/dd/yy).
2. Principal Name of Legal Entity: _____
3. Principal Mailing Address: _____
4. DBA and Mailing Address (*Only provide DBAs pertaining to the QRF Program*): _____

5. How is the organization certified/accredited as a Community Rehabilitation Program¹: _____

6. Federal ID Number: _____
7. Check this box if you are a **new applicant**. Enclosed is a copy of the Internal Revenue Services 501(c)3 letter or proof the organization is recognized by this state as a nonprofit.
8. Executive Director: _____ Phone No. _____
9. Executive Director Email Address: _____ Fax No. _____
10. List Board Members and contact information. (*Use additional pages as required*)

Office	Name	Business Address	Phone
President/Chairperson			
Vice President/Chairperson			
Secretary			
Treasurer			
Member			
Member			
Member			
Member			
Member			
Member			
Member			
Member			
Member			
Member			
Member			
Member			

¹ A Community Rehabilitation Program is a nonprofit activity center or rehabilitation facility for individuals with disabilities approved through the Department of Human Services; Office of Vocational Rehabilitation Services, Addictions & Mental Health and Seniors and People with Disabilities.

**QRF Product and Service
Contact Information**
(Use additional pages as required)

Name the contact person for each product or service identified on the "Procurement List".

Name	Product(s)/Service(s)	Phone Number	Email Address

EMPLOYEE INFORMATION

Provide the number of individuals with documented disability employed by your organization through the QRF Program by eligibility source. Use one primary source per individual.

Qualifying Documentation	Number of Employees
a. DHS Seniors and People with Disabilities (SPD)	
b. Commission for the Blind	
c. DHS Office of Vocational Rehabilitation Services (VRD)	
d. Certification that the employee is legally deaf and is disabled as defined in OAR 125-055-0005	
e. Certification that the employee is eligible for SSI or SSD	
f. Competitive Employment Statement signed by a physician or other Accredited Vocational Consultant stating that the employee is disabled as defined in OAR 125-055-0005	
g. Total number of individuals with disabilities employed by this organization. (This is the sum of line a through line f)	

**Calculation and Reporting
Direct Labor² Ratio**

Labor Description	Hours
a. Direct labor hours worked by employees with qualifying disabilities.	
b. Direct labor hours worked by employees without qualifying disabilities.	
c. Direct labor hours worked by all employees. (This is the sum of line a and line b)	
d. Indirect labor hours worked by all employees.	
e. Total hours worked by all employees in the corporation. (This is the sum of line c and line d)	

² "Direct labor" means all work required for the manufacture, preparation, processing and packing of products produced by a QRF and all work performed in the rendition of services by a QRF, but does not include supervision, administration or shipping. "Direct labor also does not include client-type services provided by a QRF to Disabled Individuals served by the QRF, such as job training and therapeutic services. OAR 125-055-0035(4)(a)

The individual signing below on behalf of the organization certifies and affirms the information supplied is correct and this organization:

- 1) is a nonprofit activity center or rehabilitation facility organized for individuals with disabilities, that complies with any applicable occupational health and safety standards required by the laws of the United States or of this state and during the fiscal year employs individuals with qualifying disabilities for not less than 75 percent of the direct labor hours; *and*
- 2) understands and agrees that as a condition of acceptance in the QRF program and subsequent listing in the QRF Procurement List, this organization shall comply with the applicable requirements set forth in Oregon Revised Statute (ORS) 279.835-850 and Oregon Administrative Rule (OAR) 125-055-0005-0045; *and*
- 3) understands and agrees that the intentional submission of false or misleading information may result in immediate disqualification from participation in this program.

Authorized Signature: _____

Title: _____ Date: _____

Mail application to: QRF COORDINATOR
 State Procurement Office
 Department of Administrative Services
 1225 Ferry Street SE, U140
 Salem, Oregon 97301-4285

FOR INTERNAL USE ONLY

Date received: _____

Information verified through: _____

Comments: _____

Signature of Approving Official

Date approved: _____



State Procurement Office
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