



121 North Cedar Street Centralia, WA 98531 360.438.3646 voice / text
application26@rsasnet.org

APPLICATION FOR ACCREDITATION

Provider Information

Provider Name : _____

Provider Executive Director / CEO / Owner: _____

Postal Address: _____

Postal City, State, Zip _____

Physical Address: _____

Physical City, State, Zip _____

Website: _____

Contact Name: _____

Contact Position: _____

Contact Phone: _____

Contact Cell Phone: _____

Contact Email: _____

Current Vocational Service Status (if new provider, skip to Service Delivery Information)

Is your firm currently certified by a federal agency, state agency, county agency, private pay or any other funding sources to provide vocational services ? _____

Federal Funding Source: _____

Contact Name: _____ Phone: _____ Email: _____

State Funding Source: _____

Contact Name: _____ Phone: _____ Email: _____

Local / School District Funding Source: _____

Contact Name: _____ Phone: _____ Email: _____

Private Funding Sources: _____

Contact Name: _____ Phone: _____ Email: _____

Date of initial certification(s) _____ Date certification(s) expires _____

Previous / Current Accreditation

Has your firm been accredited by another organization? _____

If yes, what organization: _____

Date of expiration _____

Indicate services your organization has provided to funding sources in past 12 months:

Evaluation/Assessment _____ Work Training _____ Job Retention _____

Job Coaching _____ Job Placement _____ Supported Employment _____

Independent Living Services _____ Transition Services _____ Other _____

If Other, name Service(s) _____

What is the average daily population of all participants your firm serves? _____

How many vocational services participants are served in the average month _____

Does your firm provide paid employment as a rehabilitation service? _____

Service Delivery Information

Type(s) of service you will be delivering:

Evaluation/Assessment _____ Work Training _____ Job Retention _____

Job Coaching _____ Job Placement _____ Supported Employment _____

Independent Living Services _____ Transition Services _____ Other _____

If Other, name Service(s) _____

State of Idaho Department of Health & Welfare region(s) your organization

will be performing services in: _____

Location(s) that you will be performing services from: _____

Legal, Insurance Information (not required for application, is required for accreditation)

Legal Type of Organization: _____

Date of Incorporation of Organization: _____

Professional Liability Insurance Carrier: _____

Professional Liability Insurance Policy Number: _____

Effective Date of Policy: _____ Expiration Date of Policy: _____

**For each direct service staff to be providing vocational services,
please complete the below qualification sheets**

RSAS Washington Vocational Provider Staff Qualification Sheet	RSAS Standard B-4a & B-4b	Funding Reference IDAPA 47.01.01 & 47.01.02	Date Completed [Redacted]
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Name [Redacted]	Date of Birth [Redacted]
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Date of Completed Criminal History Background Check [Redacted]
Date of Expiration of Current First Aid / CPR Certification [Redacted]

Total Hours of Vocational Services Training completed within first 6 months of employment or vocational position) [Redacted]

Date Initial 40 hours of vocational services training including all training topics was completed [Redacted]

Current Vocational Services Position(s)	Date of Hire	Date End	# of Months Services Performed*				# 90 Day Plcmnts
			WE	JSD	P&F	CJC	

Previous Vocational Services Position(s)	Organization	Date of Hire	Date End	WE	JSD	P&F	CJC	Plcmnts

Previous Social Services Position(s)	Organization	Date of Hire	Date End

*** Services Performed**

WE – Facility or Community Based Work Evaluation

JSD – Job Site Development

P&F – Placement and Follow Along

CJC – Community Supported Employment Job Coaching

90 day Plcmnts – # of placements resulting in employment retained for 90 Days or more

Name _____

1. **What is the primary purpose of the study?**

Vocational Services Training Record

Vocational Services Training Topics Key (for this and subsequent pages)

Note: Trainings must include training in each topic (though each topic is not required to be in each training)

Put a X in Training Topic box for each Topic was covered in training

- i. Behavior technology, especially in positive behavior support
- ii. Instructional technique
- iii. Strategies for dealing with aberrant or maladaptive behavior
- iv. Integration / normalization
- v. Functional impact of disabilities, particularly developmental disabilities and mental illness
- vi. Strategies for remediation and accommodation
- vii. Ethics and confidentiality
- viii. The development of measurable objectives
- ix. Overview of assistive technology

Vocational Services Trainings

Total Required Training Hours this page

Use additional pages if necessary

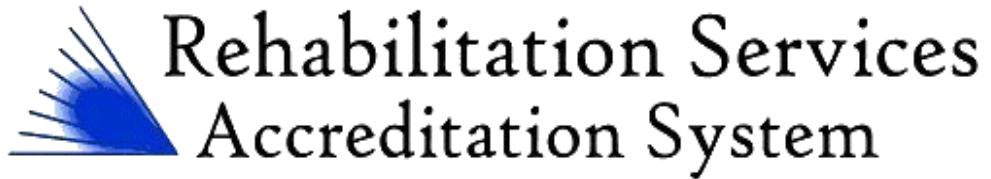
100

Name _____

Vocational Services Training

Total Required Training Hours this page

Total Required Training Hours all pages



AFFIRMATION STATEMENT

I affirm that all the information submitted in this Application and Staff Qualification Sheet(s) is/are complete and accurate:

Signature of Executive Director / CEO / Owner/ Administrator

Date



FINANCIAL AGREEMENT

This Financial Agreement is between _____ (hereafter referred to as Service Provider) and Rehabilitation Services Accreditation System, Inc. (hereafter referred to as RSAS) for vocational service provision in Washington Department of Social & Health Services Region _____ .

Below is the list of possible applicable fees relative to transactions between the Service Provider and RSAS. While this may not be a complete list of possible fees, it is typical of possible service provider fees. Any other fee costs will be based on costs to RSAS for the service rendered or expense incurred.

Initial Accreditation Fee	\$ 1075.00	Initial Accreditation
Reaccreditation Fee	\$ 1000.00	Accreditation of Provider Currently Accredited
Consultation + expenses	\$ 500.00 /day	Contracted Consultation between RSAS and Provider
Cancellation of Accreditation Review Fee	\$ 500.00	Cancellation of Confirmed Accreditation Review
Late Fee (typically the 1 st of each month)	\$ 35.00	Fee for Accounts Past Due At Billing Date
NSF Fee	\$ 50.00	Non Sufficient Funds (bounced check)
Wire Transfer Fee	\$ 50.00	Fee for Receiving Wire Transfer
Reasonable collection, attorney and court fees for any account 90 days past due.		

The Service Provider agrees to submit documentation showing all revenues received for performance of vocational services from County agencies, State agencies, Medicaid, and any funding organizations or individuals, initially and on an annual basis when notified by RSAS. If appropriate revenue documentation is not submitted at time of application or annually thereafter (by 12/31/26 this year) , the maximum monthly fee of \$470.00 fee per month will be charged until the Financial Agreement is completed and returned to RSAS.

Based upon the previous 12 months applicable revenue of \$ _____ (per the attached **Provider Revenue By Month** form), the Service Provider agrees to pay a monthly fee of \$ _____ (per the included **Costs of Accreditation** sheet) to RSAS beginning the month following application, to be due and payable by the last day of each month. This payment will be required until such time as either party gives the other 30 days written notice of termination.

Non payment of fees for a period of 60 days may result in termination of award of accreditation status.

Signature of Service Provider Executive Director / CEO/Administrator/Owner

Date

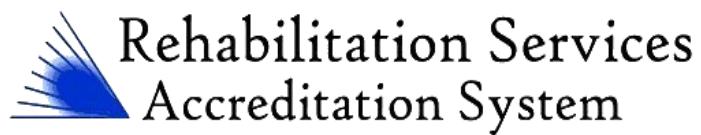
Thomas Craven

Date

Chief Executive Officer RSAS

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COST OF ACCREDITATION

Rehabilitation Services Accreditation System (RSAS) assesses a \$1075.00 Initial Accreditation Fee or a \$1000.00 Accreditation Renewal Fee to be paid prior to a scheduled review, which includes all of the materials and expenses needed to complete the review.

The Monthly Fee will be re-evaluated annually during our Annual Update process in December.

The new fee will be billed January 1, 2026 or the first day of the month following the signing of the Agreement and every month thereafter until expiration of the current Award of Accreditation Status or termination of the Award.

Monthly fees are based upon the total revenue received from the County Vocational Service agencies, State Vocational Rehabilitation agencies, Medicaid, and/or any funding organizations or individuals for the provision of vocational services during the preceding 12 months prior to application or renewal.

The Monthly Fee is calculated using the TOTAL revenue amount calculated in the attached Provider Revenue By Month sheet and referencing the Monthly Fee corresponding to that TOTAL revenue amount indicated on the Monthly Fee Schedule on the attached page.

The monthly fee schedule for 2026 is as follows on the next page.

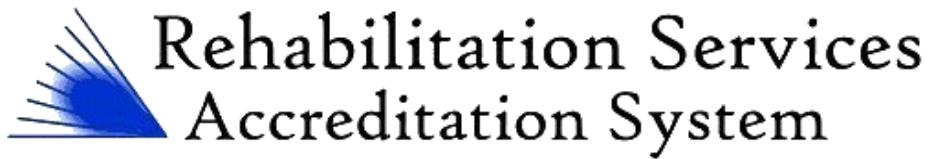
If documentation is not submitted at the time of application or annual review as notified by the previous RSAS Provider Update, the Service Provider will be charged \$470.00 (Full Fee) per month until documentation is received.

2026 Monthly Fee Schedule

Previous month	12	Revenue	Monthly Fee	Previous month	12	Revenue	Monthly Fee
\$0.00		\$3,499.00	\$95.00	\$133,000.00		\$136,499.00	\$285.00
\$3,500.00		\$6,999.00	\$100.00	\$136,500.00		\$139,999.00	\$290.00
\$7,000.00		\$10,499.00	\$105.00	\$140,000.00		\$143,499.00	\$295.00
\$10,500.00		\$13,999.00	\$110.00	\$143,500.00		\$146,999.00	\$300.00
\$14,000.00		\$17,499.00	\$115.00	\$147,000.00		\$150,499.00	\$305.00
\$17,500.00		\$20,999.00	\$120.00	\$150,500.00		\$153,999.00	\$310.00
\$21,000.00		\$24,499.00	\$125.00	\$154,000.00		\$157,499.00	\$315.00
\$24,500.00		\$27,999.00	\$130.00	\$157,500.00		\$160,999.00	\$320.00
\$28,000.00		\$31,499.00	\$135.00	\$161,000.00		\$164,499.00	\$325.00
\$31,500.00		\$34,999.00	\$140.00	\$164,500.00		\$167,999.00	\$330.00
\$35,000.00		\$38,499.00	\$145.00	\$168,000.00		\$171,499.00	\$335.00
\$38,500.00		\$41,999.00	\$150.00	\$171,500.00		\$174,999.00	\$340.00
\$42,000.00		\$45,499.00	\$155.00	\$175,000.00		\$178,499.00	\$345.00
\$45,500.00		\$48,999.00	\$160.00	\$178,500.00		\$181,999.00	\$350.00
\$49,000.00		\$52,499.00	\$165.00	\$182,000.00		\$185,499.00	\$355.00
\$52,500.00		\$55,999.00	\$170.00	\$185,500.00		\$188,999.00	\$360.00
\$56,000.00		\$59,499.00	\$175.00	\$189,000.00		\$192,499.00	\$365.00
\$59,500.00		\$62,999.00	\$180.00	\$192,500.00		\$195,999.00	\$370.00
\$63,000.00		\$66,499.00	\$185.00	\$196,000.00		\$199,499.00	\$375.00
\$66,500.00		\$69,999.00	\$190.00	\$199,500.00		\$202,999.00	\$380.00
\$70,000.00		\$73,499.00	\$195.00	\$203,000.00		\$206,499.00	\$385.00
\$73,500.00		\$76,999.00	\$200.00	\$206,500.00		\$209,999.00	\$390.00
\$77,000.00		\$80,499.00	\$205.00	\$210,000.00		\$213,499.00	\$395.00
\$80,500.00		\$83,999.00	\$210.00	\$213,500.00		\$216,999.00	\$400.00
\$84,000.00		\$87,499.00	\$215.00	\$217,000.00		\$220,499.00	\$405.00
\$87,500.00		\$90,999.00	\$220.00	\$220,500.00		\$223,999.00	\$410.00
\$91,000.00		\$94,499.00	\$225.00	\$224,000.00		\$227,499.00	\$415.00
\$94,500.00		\$97,999.00	\$230.00	\$227,500.00		\$230,999.00	\$420.00
\$98,000.00		\$101,499.00	\$235.00	\$231,000.00		\$234,499.00	\$425.00
\$101,500.00		\$104,999.00	\$240.00	\$234,500.00		\$237,999.00	\$430.00
\$105,000.00		\$108,499.00	\$245.00	\$238,000.00		\$241,499.00	\$435.00
\$108,500.00		\$111,999.00	\$250.00	\$241,500.00		\$244,999.00	\$440.00
\$112,000.00		\$115,499.00	\$255.00	\$245,000.00		\$248,499.00	\$445.00
\$115,500.00		\$118,999.00	\$260.00	\$248,500.00		\$251,999.00	\$450.00
\$119,000.00		\$122,499.00	\$265.00	\$252,000.00		\$255,499.00	\$455.00
\$122,500.00		\$125,999.00	\$270.00	\$255,500.00		\$258,999.00	\$460.00
\$126,000.00		\$129,499.00	\$275.00	\$259,000.00		\$262,499.00	\$465.00
\$129,500.00		\$132,999.00	\$280.00	\$262,500.00	and above		\$470.00

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Washington Provider Revenue By Month

Return With Financial Agreement

Provider Name _____

Washington Department of Social & Health Services Region _____

January 202_____

February 202_____

March 202_____

April 202_____

May 202_____

June 202_____

July 202_____

August 202_____

September 202_____

October 202_____

November 202_____

December 202_____

TOTAL _____

I affirm the above information to be accurate and correct:

Signature of Executive Director / CEO/Administrator/Owner

Date