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| Texas Workforce Solutions logo | **Texas Workforce Commission****Vocational Rehabilitation Services****ILS-OIB Customer Services Progress Report**    |
| **Independent Living Services for Older Individuals who are Blind (ILS-OIB)****Customer Information** |
| **Customer name:**      | Case ID:      | Service authorization number:       |
| **ILS-OIB worker name**:       |
| **Independent Living Skills (ILS) Provider:**      | **Beginning date of service:**      | **Ending date of service:**      |
| **Select the services provided:**  |
| [ ]  Application Assessment  |
| [ ]  IL Skills Training Services  |
| [ ]  Final IL Skills training services report  |
| **Progress Report**  |
| **A narrative report detailing the services provided during the reporting period including:** * **identification of the customer's needs, strengths, and limitations for independent living;**
* **measurable goals, objectives, and timelines;**
* **progress made toward the customer’s goals;**
* **the number of hours the customer participated in training;**
* **the provider's observations, comments, and recommendations; and**
* **specific references to the services requested by the customer's ILS-OIB worker.**
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| **Provider Signatures**  |
| **Independent Living Services Provider Signature (Required for all providers)** |
| **By signing below, I, the Independent Living Services Provider, certify that:*** the above dates, times, and services are accurate;
* I personally facilitated all training, meeting all outcomes required for payment and documented the service, as prescribed in the VR-SFP and service authorization;
* Verification of the customer’s satisfaction and service delivery obtained as stated above;
* I maintain the staff qualifications required for an Assistive Technology Trainer as described in the VR‑SFP or Service Authorization; and
* I signed my signature and entered the date below.
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| **Provider typed name**:      | **Signature:** (See VR-SFP 3 on Signatures**X** | **Date signed:**      |
| **Director Credentials and Signature**  |
| **By signing below, I, the Director, certify that:** * I ensure that the services were provided by qualified staff, met all outcomes required for payment, and services were documented, as prescribed in the VR-SFP and service authorization;
* I maintain UNTWISE Director credential, as prescribed in VR-SFP;
* I signed my signature and entered the date below.
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| **Typed or printed name**:      | **Signature:** (See VR-SFP 3 on Signatures)**X** | **Date Signed**:      |
| **Select all that apply:** [ ]  UNTWISE Credentialed with ID:       [ ]  VR3490-Waiver Proof Attached |
| **VRS Use Only**  |
| If any question below is answered no or if the report or supporting documentation is missing or incomplete, return the invoice to the provider with the VR3460. Make a case note to document the results of the review and the date VR3460 was sent to provider, when applicable.     |
| **Technical Review to Verify Provider Qualifications****(Completed by any VR staff such as RA, CSC, VR Counselor)**  |
| **Director’s Credential:**  |
| **UNTWISE website or attached VR3490 verifies, for the dates of service, the director listed above:** [ ]  maintained or waived the UNTWISE Director Credential [ ]  did not hold a valid UNTWISE Director Credential |
| **Verification of Service Delivery**  |
| **Technical Review (completed by any VR staff such as RA, CSC, VR Counselor)**  |
| Verified that the report is accurately completed per form instructions | [ ]  Yes [ ]  No |
| Verified that the service(s) was provided within service date of SA and as stated in the VR Standards for Providers and/or the SA | [ ]  Yes [ ]  No |
| When applicable, verify a copy of an approved VR3472 is attached to the report? | [ ] NA  | [ ]  Yes [ ]  No |
| Verified that the assessment on Independent Living and Communication Skills was completed with customer. | [ ]  Yes [ ]  No |
| Verified that attendance was recorded and includes the total number of hours the customer participated in services  | [ ]  Yes [ ]  No |

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| Verified that the appropriate fee(s) was invoiced. | [ ]  Yes [ ]  No |

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| **Printed name of VR staff member making verification:**  |

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| 1.        | Date:       | 2.        | Date:       |

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| **VR Counselor Review**  |
| Verified that all necessary accommodations, compensatory techniques, and special needs were provided as necessary, for the customer to successfully participate in the services.   | [ ]  Yes [ ]  No |
| Verified that customer’s performance, skills, and needs were assessed, and results summarized for the reporting period.   | [ ]  Yes [ ]  No |
| Verified that goals and objectives are measurable and established for all skills to be addressed.   | [ ]  Yes [ ]  No |
| Verified that a projected timeline to include training hours has been established for each goal.   | [ ]  Yes [ ]  No |

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| **By typing or printing your name, the VRC verifies:** Verified the completion of the technical review,  * services provided met the customer’s individual needs,
* services provided met specifications in the VR-SFP and on the SA, and
* customer’s or legally authorized representative’s satisfaction with services received.
 |
| [ ]  **Approve to pay invoice** [ ]  **Do not approve to pay invoice** |
| **VR Counselor**:        | **Date:**       |