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| **Texas Workforce Solutions logo** | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Comprehensive Assessment**  **for ILS-OIB Program** | | | | |
| **General Information** | | | | | | |
| **Customer:** | | | **Assessment completed by (if completed by a vendor):** | | | |
| **Assessment beginning date:** | | | **Assessment ending date:** | | | |
| **Independent Living and Communication Skills** | | | | | | |
| **Assess all the following areas in terms of current training needs using the following codes:**  **Y – yes, training needed**  **N – no, training not needed** | | | | | | |
| **Assessment Area** | | | | **Code** | | |
| * Preparing meals and maintaining kitchen safety | | | |  | | |
| * Measuring and pouring liquids and dry ingredients | | | |  | | |
| * Using appliances in the home | | | |  | | |
| * Eating skills | | | |  | | |
| * Performing household chores | | | |  | | |
| * Sewing and crafts | | | |  | | |
| * Providing dependent care (children, spouse, other family member, etc.) | | | |  | | |
| * Personal grooming | | | |  | | |
| * Dressing (clothing and shoe identification, laundry skills, etc.) | | | |  | | |
| * Accessing printed materials | | | |  | | |
| * Writing and calendar skills | | | |  | | |
| * Using the telephone | | | |  | | |
| * Time telling | | | |  | | |
| * Identifying money | | | |  | | |
| * Managing finances | | | |  | | |
| * Organizing and labeling | | | |  | | |
| * Using braille | | | |  | | |
| **Does the customer have a computer?**  Yes  No | | | | | | |
| **Does the customer need information on a computer issue?**  Yes  No  **If yes, what information is needed?** | | | | | | |
| **Does the customer need to be assessed for a magnifier or closed-circuit TV?**  Yes  No | | | | | | |
| **Does the customer need a low-vision evaluation?**  Yes  No | | | | | | |
| **Comments, if any:** | | | | | | |
| **Managing Secondary Disabilities** | | | | | | |
| **List secondary disabilities:** | | | | | | |
| **Does the customer have a hearing loss?**  Yes  No | | | | | | |
| **Does the customer need a deafblind evaluation?**  Yes  No | | | | | | |
| **Does the customer need a hearing evaluation and/or hearing aids?**  Yes  No | | | | | | |
| **Does the customer need diabetes education?**  Yes  No | | | | | | |
| **Assess all the following areas in terms of current training needs using the following codes:**  **Y – yes, training needed**  **N – no, training not needed** | | | | | | |
| **Assessment Area** | | | | **Code** | | |
| * Managing diabetes (blood sugar levels, insulin administration, medications, meals, etc.) | | | |  | | |
| * Managing other health conditions (high blood pressure, congestive heart failure, etc.) | | | |  | | |
| * Managing medications | | | |  | | |
| **Comments:** | | | | | | |
| **Travel and Transportation** | | | | | | |
| **Assess all the following areas in terms of current training needs using the following codes:**  **Y – yes, training needed**  **N – no, training not needed** | | | | | | |
| **Assessment Area** | | | | **Code** | | |
| * Mobility in and around the home | | | |  | | |
| * Detecting steps or drop-offs | | | |  | | |
| * Maintaining balance when walking | | | |  | | |
| * Using public or private transportation | | | |  | | |
| * Traveling outside the home | | | |  | | |
| **What are the customer’s goals for travel-related training and orientation and mobility (O&M) training?** | | | | | | |
| **Is an O&M evaluation recommended?**  Yes  No | | | | | | |
| **Does the customer want to participate in O&M training?**  Yes  No | | | | | | |
| **Comments, if any:** | | | | | | |
| **Support System** | | | | | | |
| **Who provides the customer’s primary (natural) support system?** | | | | | | |
| **What community resources does the customer already use?** | | | | | | |
| **Are any other referrals needed?**  Yes  No  **If yes, list the referrals:** | | | | | | |
| **Quality of Life** | | | | | | |
| **Does the customer participate in leisure, volunteer, or recreation activities?**  Yes  No | | | | | | |
| **Would the customer like to be more active?**  Yes  No  **If yes, how?** | | | | | | |
| **What training would improve the customer’s quality of life?** | | | | | | |
| **Adjustment to Blindness** | | | | | | |
| **Is the customer coping with his or her vision loss?**  Yes  No | | | | | | |
| **Is the customer ready or motivated to participate in services?**  Yes  No | | | | | | |
| **Does the customer advocate for himself or herself and express needs?**  Yes  No | | | | | | |
| **Is the customer using adaptive techniques?**  Yes  No  **If so, what adaptations are being used?** | | | | | | |
| **Is the customer at risk of going to a more dependent living environment (for example, an assisted living facility or a nursing home) without the provision of IL services?**  Yes  No | | | | | | |
| **Comments, if any:** | | | | | | |
| **Summary of Recommendations and Justification for Equipment** | | | | | | |
| **Make additional comments here, and list any additional services, equipment, or supplies that the customer needs:** | | | | | | |
| **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. | | | | | |
| **Typed or printed 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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| **Director Typed or Printed name**: | **Director Signature:**  (See VR-SFP 3 on Signatures)  **X** | **Date Signed**: |

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| **Select all that apply:**  UNTWISE Credentialed with ID:        VR3490-Waiver Proof Attached |

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| **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 |

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| Verified that the assessment on Independent Living and Communication Skills was completed with customer. | Yes  No |

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| Verified that the appropriate fee(s) was invoiced. | | | | Yes  No |
| **Printed name of VR staff member making verification:** | | | | |
| 1. | Date: | 2. | Date: | |
| **VR Counselor Review** | | | | |
| Verified the trainer recorded the specific training services he or she provided to the customer and documented the customer’s progress he or she observed on this form. | | | | Yes  No |

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| Verified that there was discussion with customer on managing secondary disabilities. | Yes  No |
| Verified that Travel and Transportation activities were assessed with customer including customer’s goals for travel-related training. | Yes  No |
| Verified that customer has a natural support system and is familiar with other community resources. | Yes  No |
| Verified that there was discussion regarding customer’s leisure, volunteer, and/or recreation activities. | Yes  No |
| Verified that customer’s adjustment to blindness was addressed. | Yes  No |
| Verified that additional services, equipment, or supplies were discussed (if appropriate). | 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 satisfaction with services received. | |
| **Approve to pay invoice**  **Do not approve to pay invoice** | |
| VR Counselor: | Date: |