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| **Texas Workforce Solutions  Logo** | | | | | | | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Vocational Adjustment Training  Specialized Evaluation** | | | | | | | | | | | | | | | | |
| **General Information** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Customer name:** | | | | | | | | | | | | | | | | **VR case ID:** | | | | | | | | | |
| **Service authorization number (s)**: | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Training facilitated**: (Check all that apply)  In a group setting (maximum of six customers for each trainer)  In an individual setting (one trainer to one customer)  A combination of group and individual settings  In-person training (with the staff and customer(s) at the same physical location)  Remote training (using a computer-based training platform that allows for face-to-face and/or real time interaction)  A combination of in person and remote training | | | | | | | | | | | | | | | | | | | | | | | | | |
| **If training is facilitated in a group setting, record the instructors, and record the VRS case IDs of all customers who participated in the group training session(s).**  **Note:**   * The provider must ensure, a VR3472, Contracted Service Modification Request for Work Readiness has been approved by the VR director prior to the class, for every customer in a group when the ratio is greater than 1 trainer to 6 customers. * Sign-in sheet for each class must identify the instructor(s) and may be requested to verify class ratio. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Instructors:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | | | | | 2. | | | | | | | | | | | | | | 3. | | | | | | |
| **Customers:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | | | | | 2. | | | | | | | | | | | | | | 3. | | | | | | |
| 4. | | | | | 5. | | | | | | | | | | | | | | 6. | | | | | | |
| 7. | | | | | 8. | | | | | | | | | | | | | | 9. | | | | | | |
| 10. | | | | | 11. | | | | | | | | | | | | | | 12. | | | | | | |
| **Training instructional approaches used in the delivery of the curriculum to meet the customer’s learning styles and preferences** (Mark all that apply.): | | | | | | | | | | | | | | | | | | | | | | | | | |
| Discussions | | | | PowerPoint presentations | | | | | | | | | Inquiry-based instructions | | | | | | | | | | | | |
| Hands-on experiments | | | | Project and problem-based learning | | | | | | | | | Computer-aided instructions | | | | | | | | | | | | |
| Others: Describe: | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | | 2. | | | | | | | | 3. | | | | | 4. | | | | | | | | 5. | | |
| 6. | | 7. | | | | | | | | 8. | | | | | 9. | | | | | | | | 10. | | |
| **Attendance** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Instructions:**   * For each week of the training, enter the date (mm/dd/yy) of Monday through Sunday in the date column. * For each day of the week, record the number of hour(s) the customer participated in the training. * If customer is absent from the training, record an “A” for the day missed. * Notify the counselor immediately when the customer is absent. * Total the number of hours that the customer attended the evaluation. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Week** | **Date** (Mon-Sun) | | **Monday** | | | | **Tuesday** | | | | **Wednesday** | | | **Thursday** | | | | **Friday** | | | | **Saturday** | | **Sunday** | |
| 1 |  | |  | | | |  | | | |  | | |  | | | |  | | | |  | |  | |
| 2 |  | |  | | | |  | | | |  | | |  | | | |  | | | |  | |  | |
| 3 |  | |  | | | |  | | | |  | | |  | | | |  | | | |  | |  | |
| 4 |  | |  | | | |  | | | |  | | |  | | | |  | | | |  | |  | |
| 5 |  | |  | | | |  | | | |  | | |  | | | |  | | | |  | |  | |
| 6 |  | |  | | | |  | | | |  | | |  | | | |  | | | |  | |  | |
| **Total number of hours the customer participated in the evaluation**: | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Areas to be Evaluated** (based on referral) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Balancing life and work  Career exploration  Child care management  Community resources  Conflict resolution  Daily living skills  Other: | | | | | | | | Decision making  Disability awareness  Effective communication  Financial management  Goal setting  Grooming and hygiene  Other: | | | | | | | | | | | | Household management  Independent living  Interpersonal communication  Leadership  Stress management  Other:  Other: | | | | | |
| **Evaluation Summary** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Rate the customer’s performance:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ability to learn | | | | | | Excellent | | | | | | Very Good | | | | | Good | | | | Marginal | | | | Poor |
| Accuracy of work | | | | | | Excellent | | | | | | Very Good | | | | | Good | | | | Marginal | | | | Poor |
| Accepts assistance | | | | | | Excellent | | | | | | Very Good | | | | | Good | | | | Marginal | | | | Poor |
| [Adaptability](https://www.southeastern.edu/admin/hr/ee_and_mngr_info/manager_information/ppr_comments.html#adapt) | | | | | | Excellent | | | | | | Very Good | | | | | Good | | | | Marginal | | | | Poor |
| Appearance and hygiene | | | | | | Excellent | | | | | | Very Good | | | | | Good | | | | Marginal | | | | Poor |
| Attendance | | | | | | Excellent | | | | | | Very Good | | | | | Good | | | | Marginal | | | | Poor |
| Communication | | | | | | Excellent | | | | | | Very Good | | | | | Good | | | | Marginal | | | | Poor |
| Cooperativeness | | | | | | Excellent | | | | | | Very Good | | | | | Good | | | | Marginal | | | | Poor |
| Initiative | | | | | | Excellent | | | | | | Very Good | | | | | Good | | | | Marginal | | | | Poor |
| Motivation | | | | | | Excellent | | | | | | Very Good | | | | | Good | | | | Marginal | | | | Poor |
| Safety practices | | | | | | Excellent | | | | | | Very Good | | | | | Good | | | | Marginal | | | | Poor |
| Timeliness | | | | | | Excellent | | | | | | Very Good | | | | | Good | | | | Marginal | | | | Poor |
| **Describe the customer’s ability and willingness to perform skills and tasks for each area identified in the referral including all problematic issues or concerns that emerge. Address all items identified in the referral.** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Describe accommodations, compensatory techniques, and special training needs required by the customer.** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Evaluations Results:**  No training recommended  Training recommended  **When training is recommended, the VR3135B, VAT Specialized Training Plan completed and attached.** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Additional comments, if any:** | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **Customer Signatures** | | | | | | |
| **Verification of the customer’s satisfaction and service delivery obtained by:**  Handwritten signature  Digital signature (See VR-SFP 3 on Signatures)  By sending a copy of the document returned with a scanned signature  Unable to obtain signature, describe attempts:  Email verification, per VR-SFP 3 (must be attached) | | | | | | |
| By signing below, I, the customer, agree with the information recorded within the report above.  If you are not satisfied, do not sign. Contact your VR counselor. | | | | | | |
| **Customer’s signature:**  **X** | | | | | | **Date Signed:** |
| **Provider Signatures** | | | | | | |
| **Type of Provider:**  Traditional-bilateral contractor  Transition Educator  Non-traditional | | | | | | |
| **Premiums to be invoiced**:  None  Autism  Blind and Visually Impaired  Brain Injury  Deaf  other, specify: | | | | | | |
| **Vocational Adjustment Trainer** | | | | | | |
| **By signing below, I 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 a Vocational Adjustment Trainer as described in the VR‑SFP or Service Authorization; and * I signed my signature and entered the date below. | | | | | | |
| **Typed or printed name of instructor 1**: | | | **Signature:** (See VR-SFP 3 on Signatures)  **X** | | | **Date Signed**: |
| **Select all that apply:**  UNTWISE Credentialed with ID:        VR3490-Waiver Proof Attached  Transition Educator  Non-traditional  RID/BEI/SLIPI with Number:       or  proof attached | | | | | | |
| **Typed or printed name of instructor 2**: | | | **Signature:** (See VR-SFP 3 on Signatures)  **X** | | | **Date Signed**: |
| **Select all that apply:**  UNTWISE Credentialed with ID:        VR3490-Waiver Proof Attached  Transition Educator  Non-traditional  RID/BEI/SLIPI with Number:       or  proof attached | | | | | | |
| **Typed or printed name of instructor 3**: | | | **Signature:** (See VR-SFP 3 on Signatures)  **X** | | | **Date Signed**: |
| **Select all that apply:**  UNTWISE Credentialed with ID:        VR3490-Waiver Proof Attached  Transition Educator  Non-traditional  RID/BEI/SLIPI with Number:       or  proof attached | | | | | | |
| **Director** (only required for Traditional-Bilateral Contractors) | | | | | | |
| **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. | | | | | | |
| **Director Typed or Printed name**: | | **Director 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) | | | | | | |
| **When Vocational Adjustment Trainer is a Transition Educator or Non-Traditional provider, skip this section.** | | | | | | |
| **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 | | | | | | |
| **Vocational Adjustment Trainer’s Credential:** | | | | | | |
| UNTWISE website or attached VR3490 verifies, for the dates of service, the **Vocational Adjustment Trainer** listed above:  maintained or waived the required UNTWISE Credential  did **not** holda valid UNTWISE Credential | | | | | | |
| **UNTWISE Endorsements:** | | | | | | |
| UNTWISE website verifies, for the dates of service, the Vocational Adjustment Trainer listed above maintained the following endorsement:  None  Autism  Blind and Visually Impaired  Brain Injury  other, specify: | | | | | | |
| **Qualifications Related to Deaf Premium:** | | | | | | |
| Attached documentation verifies, for the dates of service, the Vocational Adjustment Trainer listed above maintained one of the following:  not applicable/no attachment  BEI  RID  SLIPI | | | | | | |
| **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 the training was provided in the environment(s) (in person, remotely or combination) indicated on the referral form. | | | | | | Yes  No |
| Verified the trainer‑to‑customer ratio was adhered to as described in the VR-SFP | | | | | | Yes  No |
| Verify that the VR3135B, VAT Specialized Training Plan is attached when the evaluation recommends training. | | | | | | Yes  No |
| Verified the customer’s satisfaction with the training through signature on the form and/or by VR staff member contact with customer | | | | | | Yes  No |
| Verified that the appropriate fee(s) was invoiced | | | | | | Yes  No |
| **Print staff member(s) names who completed technical review and/or verified the UNTWISE Credentials:** | | | | | | |
| 1. | Date: | | | 2. | | Date: |
| **VR Counselor Review** | | | | | | |
| Verified the customer received necessary accommodations, supplies and resources; various instructional approaches were used; and the customer has the ability to use compensatory techniques to increase ability to perform task and skills | | | | | | Yes  No |
| Verified that the vocational adjustment trainer used and documented on the form the  various instructional approaches to meet the customer’s learning styles and preferences | | | | | | Yes  No |
| Verified that the vocational adjustment trainer provided all supplies and resources necessary for the customer  to participate in the training through signature on form or by VR staff member contact with customer | | | | | | Yes  No |
| **By typing or printing your name, the VRC verifies:**   * 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:** |