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| Texas Workforce Solutions logo | | | | | Texas Workforce Commission **Vocational Rehabilitation Services** Supportive Residential Services Progress Report | | | | | | | | | | | | | |
| **Instructions** | | | | | | | | | | | | | | | | | | |
| Follow the instructions below when completing this form:   * Refer to the contract for additional details; * Complete the form electronically, answering all questions; * Before faxing, emailing encrypted, or mailing to the provider, review this form to ensure that all questions have been answered. | | | | | | | | | | | | | | | | | | |
| **Report Reporting Period** | | | | | | | | | | | | | | | | | | |
| **Start Date:** | | | | | | | | | **End Date:** | | | | | | | | | |
| **Customer’s Identification Information** | | | | | | | | | | | | | | | | | | |
| **Customer’s name:** | | | | | | | | | | | | | | | | | | |
| **Case ID:** | | | | | | | | | | | | | **Date of birth:** | | | | | |
| **Case Manager Contact Information** | | | | | | | | | | | | | | | | | | |
| **Case Manager name:** | | | | | | | | | | | | | | | | | | |
| **Contact number:** (   ) | | | | | | | | **Email address:** | | | | | | | | | | |
| **Additional Information Turned in with Report** | | | | | | | | | | | | | | | | | | |
| **Check all included with the report.** | | | | | | | | | | | | | | | | | | |
| Treatment Plan | | | Facility Documentation | | | | | | | | Other: | | | | | | | |
| **Customer and Specialist Contacts for Reporting Period** | | | | | | | | | | | | | | | | | | |
| **Instructions:**   * For each week enter the date (mm/dd/yy) of Monday through Sunday in the date column. * For each day of the week, record the contact made with the customer using the following key:   (C=Chemical Dependency Counseling, E=Chemical Dependency Education, LS=Life skills training, R=Relapse Prevention Education, or O=Other)   * If the category “other” used below, describe the type of contact in the field below * If the customer is absent from a schedule activity, record an “A”. | | | | | | | | | | | | | | | | | | |
| **Week** | **Start Date** (Mon-Sun) | **Monday** | | **Tuesday** | | **Wednesday** | | | | **Thursday** | | | | **Friday** | **Saturday** | | **Sunday** | |
| 1 |  |  | |  | |  | | | |  | | | |  |  | |  | |
| 2 |  |  | |  | |  | | | |  | | | |  |  | |  | |
| 3 |  |  | |  | |  | | | |  | | | |  |  | |  | |
| 4 |  |  | |  | |  | | | |  | | | |  |  | |  | |
| 5 |  |  | |  | |  | | | |  | | | |  |  | |  | |
| 6 |  |  | |  | |  | | | |  | | | |  |  | |  | |
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| 8 |  |  | |  | |  | | | |  | | | |  |  | |  | |
| If any “other” entered above, describe: | | | | | | | | | | | | | | | | | | |
| **Report of Treatment Services** | | | | | | | | | | | | | | | | | | |
| **Instructions:**  Record information for each Chemical Dependency Counseling, Chemical Dependency Education, Life skills training, Relapse Prevention Education, or Other session(s) held during the Reporting Period. | | | | | | | | | | | | | | | | | | |
| **Date:**       **Length of time the Customer attended the event**:  **Type of Event, check one:**   Chemical Dependency Counseling Chemical Dependency Education  Life Skills  Relapse Prevention Education  Other  **Briefly describe and evaluate each session including the purpose/goals of the session, the customer’s skills/performance and/or problematic issues or concerns:** | | | | | | | | | | | | | | | | | | |
| **Date:**       **Length of time the Customer attended the event**:  **Type of Event, check one:**  Chemical Dependency Counseling  Chemical Dependency Education  Life Skills  Relapse Prevention Education  Other  **Briefly describe and evaluate each session including the purpose/goals of the session, the customer’s skills/performance and/or problematic issues or concerns:** | | | | | | | | | | | | | | | | | | |
| **Date:**       **Length of time the Customer attended the event**:  **Type of Event, check one:**  Chemical Dependency Counseling  Chemical Dependency Education  Life Skills  Relapse Prevention Education  Other  **Briefly describe and evaluate each session including the purpose/goals of the session, the customer’s skills/performance and/or problematic issues or concerns:** | | | | | | | | | | | | | | | | | | |
| **Date:**       **Length of time the Customer attended the event**:  **Type of Event, check one:**  Chemical Dependency Counseling  Chemical Dependency Education  Life Skills  Relapse Prevention Education  Other  **Briefly describe and evaluate each session including the purpose/goals of the session, the customer’s skills/performance and/or problematic issues or concerns:** | | | | | | | | | | | | | | | | | | |
| **Date:**       **Length of time the Customer attended the event**:  **Type of Event, check one:**  Chemical Dependency Counseling  Chemical Dependency Education  Life Skills  Relapse Prevention Education  Other  **Briefly describe and evaluate each session including the purpose/goals of the session, the customer’s skills/performance and/or problematic issues or concerns:** | | | | | | | | | | | | | | | | | | |
| **Date:**       **Length of time the Customer attended the event**:  **Type of Event, check one:**  Chemical Dependency Counseling  Chemical Dependency Education  Life Skills  Relapse Prevention Education  Other  **Briefly describe and evaluate each session including the purpose/goals of the session, the customer’s skills/performance and/or problematic issues or concerns:** | | | | | | | | | | | | | | | | | | |
| **Date:**       **Length of time the Customer attended the event**:  **Type of Event, check one:**  Chemical Dependency Counseling  Chemical Dependency Education  Life Skills  Relapse Prevention Education  Other  **Briefly describe and evaluate each session including the purpose/goals of the session, the customer’s skills/performance and/or problematic issues or concerns:** | | | | | | | | | | | | | | | | | | |
| **Date:**       **Length of time the Customer attended the event**:  **Type of Event, check one:**  Chemical Dependency Counseling  Chemical Dependency Education  Life Skills  Relapse Prevention Education  Other  **Briefly describe and evaluate each session including the purpose/goals of the session, the customer’s skills/performance and/or problematic issues or concerns:** | | | | | | | | | | | | | | | | | | |
| **Customer’s Performance-Evaluation of Soft Skills** | | | | | | | | | | | | | | | | | | |
| **Instructions:** Rate the Customer’s Soft Skills below by checking the appropriate performance level. | | | | | | | | | | | | | | | | | | |
| **Soft Skill** | | | | | | | **Excellent**: meets expectations | | | | | **Fair**: meets expectations most of the time | | | | **Poor**:does not meet expectations | | **Not applicable**: not addressed |
| Ability to learn | | | | | | |  | | | | |  | | | |  | |  |
| Accuracy and quality of work | | | | | | |  | | | | |  | | | |  | |  |
| Accepts supervision | | | | | | |  | | | | |  | | | |  | |  |
| [Adaptability](https://www.southeastern.edu/admin/hr/ee_and_mngr_info/manager_information/ppr_comments.html#adapt) | | | | | | |  | | | | |  | | | |  | |  |
| Admits mistakes | | | | | | |  | | | | |  | | | |  | |  |
| Appearance, dress, and hygiene | | | | | | |  | | | | |  | | | |  | |  |
| Asks for help and clarification as needed | | | | | | |  | | | | |  | | | |  | |  |
| Attendance | | | | | | |  | | | | |  | | | |  | |  |
| Communication | | | | | | |  | | | | |  | | | |  | |  |
| Cooperativeness | | | | | | |  | | | | |  | | | |  | |  |
| Dependability | | | | | | |  | | | | |  | | | |  | |  |
| Handles stress | | | | | | |  | | | | |  | | | |  | |  |
| Initiative | | | | | | |  | | | | |  | | | |  | |  |
| Listens and pays attention | | | | | | |  | | | | |  | | | |  | |  |
| Motivation | | | | | | |  | | | | |  | | | |  | |  |
| Maintains eye contact | | | | | | |  | | | | |  | | | |  | |  |
| Refrains from unnecessary social interactions | | | | | | |  | | | | |  | | | |  | |  |
| Relations with authority figures | | | | | | |  | | | | |  | | | |  | |  |
| Relations with peers | | | | | | |  | | | | |  | | | |  | |  |
| Respects the rights and privacy of others | | | | | | |  | | | | |  | | | |  | |  |
| Timeliness and deadline achievement | | | | | | |  | | | | |  | | | |  | |  |
| The customer has abstained from any controlled substances and maintaining medication.    Yes  No  **If no, explain:** | | | | | | | | | | | | | | | | | | |
| The customer continues to follow residential rules.  Yes  No  **If no, explain:** | | | | | | | | | | | | | | | | | | |
| **Additional comments on soft skills, if any:** | | | | | | | | | | | | | | | | | | |
| **Additional Comments** | | | | | | | | | | | | | | | | | | |
| Enter 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: | | | | | |
| 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** | | | | | |
| **Case Manager** | | | | | |
| **By signing below, I, the Case Manager, certify that**:   * the above dates, times, and services are accurate; * services provided meet the requirements as outlined in 25 TAC 448; * persons providing services documented the information on the form for the customer represented on this form; * The customer’s signature on this form was obtained on the date stated in the date field of the form; * I signed my signature and the date below; and * Staff maintains qualifications as stated in 25 TAC 488, the Standards, or Service Authorization for the services provided and   documented on this form. | | | | | |
| **Typed or Printed name**: | **Signature:**  (See VR-SFP 3 on Signatures)  **X** | | | | **Date Signed**: |
| **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 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 |
| Verify the customer was actively in the facility and did not have any unexcused or excused absences | | | | | Yes  No |
| Verified the customer's attendance in at least the six hours of required treatment services each week was recorded | | | | | 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 services were provided in accordance with [25 TAC §448.903](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=448&rl=903). | | | | | Yes  No |
| Verified goals and objectives identified in the treatment plan were addressed and progress documented on the VR3384, Supportive Residential Services Progress Report | | | | | 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: |