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| Texas Workforce Solutions logo | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Customer Orientation Checklist**  **for VR Service Providers** | | | | |
| **Instructions**: Complete one form per customer and file in their case file. | | | | | |
| **Customer Name:** | | | **Case ID:** | | |
| **Orientation was conducted:**  In-person  Remotely | | | | | |
| **Checklist** | | | | | |
| As the following content is covered with the customer, check the box to the right. | | | | | |
| **Overview of services:** | | | | |  |
| * Description of the individual services to be provided, | | | | |  |
| * How services will be conducted (In-person and/or Remotely), | | | | |  |
| * Orientating the customer to the physical space where services are provided, if applicable. | | | | |  |
|  | | | | | Covered |
| **Expectations:** | | | | |  |
| * Attendance and tardiness, | | | | |  |
| * Customer participation, | | | | |  |
| * Rules, | | | | |  |
| * Appropriate behaviors, and | | | | |  |
| * Health and Safety (e.g. orientating to the physical space where services are provided if applicable). | | | | |  |
|  | | | | | Covered |
| **Behaviors that could lead to service termination:** | | | | |  |
| * Dangerous behaviors towards oneself or others, | | | | |  |
| * Serious or continual infraction of the provider’s rule, | | | | |  |
| * Frequent unexcused absences and tardiness, | | | | |  |
| * Lack of cooperation, and | | | | |  |
| * Disrespectful behavior. | | | | |  |
|  | | | | | Covered |
| **Customer Rights and Resources:** | | | | |  |
| * How to report complaints about a contractor to TWC-VR at 1-800-628-5115. | | | | |  |
| * Explained the purpose of the [Client Assistance Program (CAP) In Texas - Disability Rights](https://www.disabilityrightstx.org/en/handout/client-assistance-program-cap-in-texas/) | | | | |  |
| * Provided the phone number for CAP – 1-800-252-9108 | | | | |  |
|  | | | | | Covered |
| **Signature** | | | | | |
| **By signing below, I certify that I guided the customer through an orientation that detailed the above information.** | | | | | |
| **Provider Staff Member Printed Name:** | | **Provider Staff Member Title:** | | **Date:** | |
| **Provider Staff Member Signature:**  **X** | | | | | |
| **Once completed, file this form in the provider’s customer case file. It is recommended that a copy of this form also be given to the customer for their records.** | | | | | |