



Texas Workforce Commission
Vocational Rehabilitation Services
**Supported Self-Employment Concept
Development**

General Instructions

The Concept Development Worksheet must be completed as follows:

- Type responses using a computer.
- Answer all questions. If a question or section does not apply, enter "Not Applicable" and explain why.
- Answers must be written in a narrative format in clear, positive, descriptive English with minimal bullet points.
- The narrative summaries must indicate how and when the information was collected. For example, by discussion with the customer's business team, from the customer, or by observation of the customer performing the skills necessary to achieve the outcome.

Customer Information

Customer's name:

VRS customer number:

Service Requested

Concept Development – Supported Self-Employment Only

Step 1: Describe the Industry

Product or Service

Describe the product or service to be considered as a result from the discovery process

Financial Considerations

What are the business's sales projections?

How much net profit might be achieved in the first year?

What are critical factors to reach the sales projections?

List anticipated start-up costs and on-going monthly expenses:

What is the break-even point, where the business owner be able to cover their own expenses?

Step 3: Identify Financial Resources Available to the Customer

Identify the proposed and known availability of financial resources available to the customer in the following table.

| Financial and Benefits Resource | Amount | In-Kind (\$ Value of Resource) | Description of Resource |
|--|---------------|---|--------------------------------|
| Customer's | | | |
| Home and Property Equity | | | |
| Savings | | | |
| SSDI Benefits | | | |
| SSI Benefits | | | |
| Trust Fund | | | |
| Wages | | | |
| Customer's Family | | | |
| Home and Property Equity | | | |
| Loan | | | |
| Savings | | | |
| Trust Fund | | | |
| Other | | | |
| Bank or Credit Union Loan | | | |
| VRS | | | |
| Individual Development Account | | | |
| Private Investors | | | |
| Small Business Administration (SBA) Loan | | | |
| WIOA | | | |
| PASS | | | |
| Family Self-Sufficiency Program | | | |

Step 4: Identify Prospective Business Owner Considerations

Does this business idea match the ideal work conditions and goals of the customer?

How much time can the customer invest in operating the business?

What tasks are necessary to produce the product or service?

Does the customer have, or can he or she acquire a portion or all skills needed to perform the production of goods or services, sales of goods or services, and management activities of the business?

Does the customer have, can he or she afford, or can other resources be identified to provide the business and personal supports necessary for the customer to be a successful business owner?

How much money can the customer access or invest?

How will this business affect the customer's family?

Additional information and/or comments:

Outside Services and Supports

Instructions: In the table below, record any anticipated supports needed to maintain self-employment once the business has been started and once VRS has closed the case. Record the potential provider to provide each support and potential resources for any associated costs.

| Extended Services and Supports Needed | Frequency of Support Needs | Potential Provider and Contact Information | Identified Resource to Provide or Sponsor Supports |
|--|----------------------------|---|--|
| Examples: | | | |
| Job coaching for new job duties identified | As identified | Employment Network Provider—Susie Provider (000) 000-0000 | Social Security sponsored |
| Bookkeeping | Weekly | Karen’s Bookkeeping Service (000) 000-0000 | Will be a small business expense |
| Medication management | Monthly | MHMR home visits, Karen Case manager (000) 000-0000 | MH General Fund sponsored |
| Assistance with day-to-day business responsibilities such as work schedule and routine work duties | Daily | Natural supports of the family: Mom—Jen, jencustomermom@email.com | in-kind service of family members |
| Transportation to and from work provided by cab driver | According to work schedule | PASS Plan—Provider to write PASS Plan needs to be found | Social Security sponsored |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| Additional comments: | | | |

| Recommendations | | |
|---|--|----------------------------|
| CBTAC or VR counselor completes this section: | | |
| Proceed with Feasibility Study Yes No | | |
| If no, please provide comments below regarding decision: | | |
| Signatures | | |
| Customer Signature | | |
| 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, certify that I received the service as recorded within the report above. If you are not satisfied with the service, contact your VR counselor. | | |
| Customer's signature X | Date: | |
| Customer's legally authorized representative's signature, if any: X | Date: | |
| Provider Qualifications | | |
| If the customer required assistance from a CBTAC, the following information is required. | | |
| Provider Qualifications | | |
| Type of Provider: Traditional-bilateral contractor Non-traditional | | |
| Traditional-bilateral contractor must complete the provider qualification section below. This section is not applicable to Non-traditional providers. | | |
| Qualifications | Proof of Qualification | Verified by TWS-VRS |
| CBTAC Certification | CBTAC certificate attached If no, <input type="checkbox"/> VR3490-Waiver Proof Attached | Yes No N/A |
| CBTAC signature | | |
| By signing below, I, the CBTAC, certify that: | | |
| <ul style="list-style-type: none"> • the above dates, times, and services are accurate; • I personally provided services recorded on this form and associated invoice; • I 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 the report below; and | | |
| I maintain the staff qualifications, including the CBTAC Certificate, required for a CBTAC, as described in Standards for Providers and/or Service Authorization. | | |
| CBTAC typed name: | CBTAC signature: X | Date: |

If unable to verify the credentials, complete the following:

- Enter the date a **copy** of the submitted invoice, report and VR3460 was sent to provider to notify the staff did not meet the qualification as defined in the Standards for Providers and/or SA.

Date:

- Enter the date a case note was made to document the return of invoice and required form(s)

Date:

Director Credentials and Signature

Required for Traditional-Bilateral Contractors

By signing below, I, the Director, certify that:

- I signed the report below; and
- I ensure that the staff meets the qualifications and met the requirements in the Standards for Providers when delivering the service and;

I maintain the staff qualifications, including the UNTWISE credential, required for a Director, as described in Standards for Providers and/or Service Authorization.

| Qualifications | Proof of Qualification | Verified by TWS-VRS |
|-------------------------------|--|---------------------|
| Specify UNTWISE Credential: | UNTWISE Credential Number: If no, <input type="checkbox"/> VR3490-Waiver Proof Attached | Yes No N/A |
| Director's typed name: | Director's signature (see VR-SFP 3 on Signatures): X | Date: |

If unable to verify the credentials, complete the following:

- Enter the date a **copy** of the submitted invoice, report and VR3460 was sent to provider to notify the staff did not meet the qualification as defined in the Standards for Providers and/or SA.

Date:

- Enter the date a case note was made to document the return of invoice and required form(s)

Date:

| | |
|---|--|
| Date Form Submitted by Provider: | Date Form Received by TWS-VRS Office: |
|---|--|

VRS Use Only

| | | |
|---|---|-------|
| <input type="checkbox"/> Reviewed and provided feedback. Note method of feedback (such as email or RHW): _____ | State program specialist's initials: | Date: |
| <input type="checkbox"/> Reviewed and provided feedback. Note method of feedback (such as email or RHW): _____ | Regional program specialist's initials: | Date: |
| Approved Sent back to the counselor with feedback. | VR manager or supervisor's initials: | Date: |

| | | |
|--|-----------------------|-------|
| Note method of feedback (such as email or RHW): _____ | | |
| Approved Sent back to the provider (if applicable)with feedback. Note method of feedback (such as email or RHW): _____ | Counselor's initials: | Date: |
| Comments: | | |