TEXAS
WORKFORCE SOLUTIONS

Texas Workforce Commission
Vocational Rehabilitation Services
Autism Service Premium Report

Purpose

The purpose of the **Autism Service Premium Report** is to document how the provider is removing the barriers **directly related to the customer's Autism Spectrum Disorder (ASD)** that are impeding their ability to obtain and maintain employment.

Instructions

1. In order to receive payment for the premium, the **Autism Service Report must be submitted** with the invoice for the following:
   1) Bundled Job Placement: Benchmarks A-C
   2) Non-Bundled Job Placement: Interviewing Training and/or Employment Data Sheet, Application, and Résumé Training
   3) Career Planning Assessment (CPA)
   4) Supported Employment Services
   5) Job Skills Training
2. **Rate the customer's level of support** needed in all 5 categories at the **initial evaluation** of the customer; using the same form, **monitor and report progress** throughout the designated time frames and lastly, rate the level of support achieved by job placement in **the final column**.

General Information

Name of Customer:	Customer ID:	Report Completed by:	Date Submitted:

Employment Service: Bundled Job Placement   Career Planning Assessment   Supported Employment
Non-Bundled Job Placement   Job Skills Training

Type of Report: Initial Report   Progress Report   Final Report

Category 1: Social and Communication Deficits

Social and Communication Deficits Requires:	Initial	Progress Report					Final
	Date:	Date:	Date:	Date:	Date:	Date:	Date:
1 = no support needed	1	1	1	1	1	1	1
2 = monthly support	2	2	2	2	2	2	2
3 = weekly support	3	3	3	3	3	3	3
4 = daily support	4	4	4	4	4	4	4
5 = hourly support	5	5	5	5	5	5	5

Due to the level of support needed, what services, strategies and or supports will be provided?

Category 2: Obsessive, Restrictive Interests, Repetitive Behaviors, Resistance to Change

Obsessive, Restrictive, Repetitive, Resistance to Change Requires:	Initial	Progress Report					Final
	Date:	Date:	Date:	Date:	Date:	Date:	Date:
1 = no support needed	1	1	1	1	1	1	1
2 = monthly support	2	2	2	2	2	2	2
3 = weekly support	3	3	3	3	3	3	3
4 = daily support	4	4	4	4	4	4	4
5 = hourly support	5	5	5	5	5	5	5

Due to the level of support needed, what services, strategies and or supports will be provided?

Category 3: Sensory Abnormalities

Sensory Abnormalities Requires:	Initial	Progress Report					Final
	Date:	Date:	Date:	Date:	Date:	Date:	Date:
1 = no support needed	1	1	1	1	1	1	1
2 = monthly support	2	2	2	2	2	2	2
3 = weekly support	3	3	3	3	3	3	3
4 = daily support	4	4	4	4	4	4	4
5 = hourly support	5	5	5	5	5	5	5

Due to the level of support needed, what services, strategies and or supports will be provided?

Category 4: Level of Anxiety

Level of Anxiety Requires:	Initial	Progress Report					Final
	Date:	Date:	Date:	Date:	Date:	Date:	Date:
1 = no support needed	1	1	1	1	1	1	1
2 = monthly support	2	2	2	2	2	2	2
3 = weekly support	3	3	3	3	3	3	3
4 = daily support	4	4	4	4	4	4	4
5 = hourly support	5	5	5	5	5	5	5

Due to the level of support needed, what services, strategies and or supports will be provided?

Category 5: Co-Morbidities

Co-Morbidities Requires:	Initial	Progress Report					Final
	Date:	Date:	Date:	Date:	Date:	Date:	Date:
1 = no support needed	1	1	1	1	1	1	1
2 = monthly support	2	2	2	2	2	2	2
3 = weekly support	3	3	3	3	3	3	3
4 = daily support	4	4	4	4	4	4	4
5 = hourly support	5	5	5	5	5	5	5

Due to the level of support needed, what services, strategies and or supports will be provided?

Signature

Provider's Typed Name:	Provider's Signature (See VR-SFP 3. Documentation and Signatures): **X**

VRS Use Only—VRS Approval of the Report

VR Counselor Review

I verified that all 5 categories are completely filled out: **Yes or No**

I verified that the provider signed the report: **Yes or No**

I verified that the counselor reviewed and signed the report: **Yes or No**

VR Counselor's Name:	Date: