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| Texas Workforce Solutions logo | Texas Workforce Commission**Vocational Rehabilitation Services****Assistive Technology Evaluation** |
| **Instructions** |
| Submit to the customer’s counselor or case manager and employment assistance specialist (EAS)when the customer has completed the evaluation. Email is preferred.    **Note:** AT evaluations cannot be provided remotely.   |
| **General Information**  |
| **Facility:**       | **Customer first name:**       **Last initial:**       |
| **Evaluator:**       | **Vocational goal:**       |
| **Counselor name:**       | **Type of evaluation:**       |
| **VR caseload number:**       | **Date of evaluation:**       |
| **Service authorization number:**       | **Case ID number (CID):**       |
| Assistive Technology    |
| **Assistive technology evaluations must be completed using two competing products. List the specific assistive technology products you used to complete the evaluation (below):**    |
|       |
| **Interview Process—All Evaluations** |
| **Describe the customer’s work/school circumstances:** |
| **What is the customer’s current occupation including work-related tasks, or occupational goals?**      |
| **What work-related or personal changes does the customer anticipate may affect the customer’s position or job-related tasks and goals?**      |
| **Describe any samples of materials used by the customer at work or school you used for the evaluation.**      |
| **If the customer is a student, provide the information you collected about the following, or indicate the information was in the referral documentation the counselor or case manager sent to you:**  |
| **The customer’s academic plans:**      |
| **The customer’s degree program or course work:**      |
| **The current customer’s year of school and anticipated graduation date:**      |
| **Required or anticipated tasks, such as note taking, reading, etc.:**      |
| **An assessment of how the customer is currently handling required tasks:**      |
| **Description** (Select Yes, No, or Not Applicable) | **Yes** | **No** | **N/A** | **Comments** |
| **Enter the information you collected during the CCTV evaluation interview:** |
| Is color identification critical to the customer’s job performance?   | [ ]  | [ ]  | [ ]  |       |
| Does the customer use a computer on the job site or at home?   | [ ]  | [ ]  | [ ]  |       |
| **Enter the information you collected during the scanner evaluation interviews:** |
| Did you explain the reason for a scanner evaluation? Describe   | [ ]  | [ ]  | [ ]  |       |
| Did you ask if the customer is aware of other resources? Describe   | [ ]  | [ ]  | [ ]  |       |
| Will the customer enter scanned documents into the computer?   | [ ]  | [ ]  | [ ]  |       |
| Will the customer use the computer to manipulate scanned documents?   | [ ]  | [ ]  | [ ]  |       |
| Does the customer have any needs for computer access in terms of speech or Braille access?   | [ ]  | [ ]  | [ ]  |       |
| Does the customer have sample materials that need to be scanned?   | [ ]  | [ ]  | [ ]  |       |
| **Interview Process—Computer Applications** |
| Indicate how you addressed the following issues during interviews for screen magnification devices, refreshable braille PC screen access devices, and screen review systems:     |
| For a customer using a computer in his/her employment?   | Comments:       |
| The type of computer the customer is using?   | Comments:       |
| Any software?   | Comments:       |
| Any access equipment currently being used by the customer?   | Comments:       |
| Discussion regarding job tasks and performance expectations?   | Comments:       |
| **A determination of the customer’s skill level for:** |
| Typing speed?   | Comments:       |
| Accuracy?   | Comments:       |
| Keyboard familiarity?   | Comments:       |
| **For customer with previous computer experience:** |
| Type of computer?   | Comments:       |
| Software?   | Comments:       |
| When and where the customer gained the previous experience?   | Comments:       |
| Previous experience acquired before the loss of vision?   | Comments:       |
| **Describe any previous experience the customer has with:** |
| Computer access equipment?   | Comments:       |
| Video magnifiers or similar devices?   | Comments:       |
| Computer braille devices?   | Comments:       |
| Refreshable braille PC screen access devices?   | Comments:       |
| Synthesized speech devices?   | Comments:       |
| **Customer Performance** |
| 1. **Describe the customer’s keyboarding skills** (familiarity with the keyboard, typing speed (if assessed), ability to find keys by touch, etc.)**:**

      |
| 1. **Describe the physical environment during the evaluation, and any effect it had on the customer’s vision (lighting, glare, etc.):**

      |
| 1. **List or describe the sample materials the customer brought from home, work, or school, and used at the evaluation:**

      |
| 1. **Does the customer have any low vision aids?**

[ ]  Yes [ ]  No |
| 1. **Describe the extent to which the customer uses low-vision aids available to him or her:**

      N/A [ ]  |
| 1. **Describe any assistive techniques you saw the customer use to improve what he or she could see:**

      N/A [ ]  |
| 1. **If the customer is blind (no light perception or no functional vision), describe how the customer takes notes, reads, writes, and performs other daily living skills:**

      N/A [ ]  |
| 1. **If braille is the customer’s primary literacy medium, describe the customer’s braille reading speed:**

      N/A [ ]  |
| Customer Interview Process   |
| We discussed, and/or I verified, the following information at the customer interview:   |
| 1. **The customer and I discussed the goals of the evaluation:**   [ ]  Yes [ ]  No

**The goals of the evaluation were as follows:**       |
| 1. **I (the evaluator) conducted a private interview with the customer to review the customer’s background and other referral information, including the EAS report, provided by the counselor at referral.**  [ ]  Yes [ ]  No

**The following additional information was provided during the interview:**       [ ]  N/A |
| 1. **The customer verified the referral information is correct, or indicated where information was missing or incorrect:**

[ ]  Yes [ ]  No**The following missing information was added:**       [ ]  N/A**The following information was corrected:**      [ ]  N/A |
| 1. **The customer verified the referral information about the customer’s known functional limitations is correct:**   [ ]  Yes [ ]  No

**The following information regarding the customer’s known functional limitations was corrected:**       [ ]  N/A |
| 1. **The referral information described all the customer’s physical limitations, secondary disabilities, or conditions that might interfere with the customer’s evaluation or future training:**     [ ]  Yes [ ]  No

**The following additional physical limitations, secondary disabilities, or conditions that might interfere with the customer’s evaluation or future training were identified:**       [ ]  N/A |
| 1. **The customer and I discussed the evaluation, the evaluation equipment, and training recommendations:**   [ ]  Yes [ ]  No
 |
| 1. **I explained how the evaluation report is used by the counselor to help determine whether to purchase assistive technology, and if so, which technology to purchase.**     [ ]  Yes [ ]  No
 |
| 1. **I informed the customer that the counselor would determine whether to purchase equipment, and which equipment to purchase based on the report**:     [ ]  Yes [ ]  No
 |
| 1. **I summarized my interview findings with the customer:**   [ ]  Yes [ ]  No
 |
| 1. **I observed the customer’s ability to use and benefit from the equipment I recommended:**  [ ]  Yes [ ]  No
 |
| 1. **I gave the customer an opportunity to ask questions about the evaluation before, during, and after the evaluation:**

[ ]  Yes [ ]  No |
| 1. **The customer and I discussed the goals of the evaluation:**   [ ]  Yes [ ]  No

 **The goals of the evaluation were as follows:**       |
| **List any equipment problems that occurred during the evaluation.**  |
| 1. **Computer:**       [ ]  N/A
 |
| 1. **Monitor:**       [ ]  N/A
 |
| 1. **Printer:**       [ ]  N/A
 |
| 1. **Software:**       [ ]  N/A
 |
| 1. **Optical Character Reader (OCR) or scanner:**       [ ]  N/A
 |
| **Other:**       [ ]  N/A |
| **Service Limitations**  |
| [ ]  **I did not make any recommendations or discuss additional training time, equipment, or software upgrades with the customer or in the customer’s presence.** |
|  [ ]  **I did not show the customer any products not indicated on the Employment Assistance Services (EAS) Consultation Report.** |
|  [ ]  **I did not allow anyone to observe the customer’s evaluation without the customer’s expressed permission.** |
| **[ ]  I did not allow any observer to ask questions or make suggestions or comments during the evaluation process.** |
| **[ ]  I did not install programs or equipment on the customer’s computer system without prior written approval from the customer’s counselor or case manager.** |
|  [ ]  **I did not solicit training, consultation, or referrals from the customer.** |
| **Training Recommendations**  |
| **I recommend training on the following equipment:**      |
| **To Be Completed by Provider**  |
| **Services provided by (business name):**       | **Date:**       |
| **Report completed by (evaluator):**       | **Date:**        |

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| **Provider Signatures**  |
| Assistive Technology Trainer **Signature (Required for all providers)** |
| **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 an Assistive Technology Trainer as described in the VR‑SFP or Service Authorization; and
* I signed my signature and entered the date below.
 |
| **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 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)   |
| **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 |
| Verified the trainer recorded training dates, times, and services accurately on this form. | [ ]  Yes [ ]  No |
| Verified the trainer recorded signed the form. | [ ]  Yes [ ]  No |
| Verified that the appropriate fee(s) was invoiced. | [ ]  Yes [ ]  No |
| **Printed name of VR staff member making verification:**  |
| 1.        | Date:       | 2.        | Date:       |
| **VR Counselor Review**  |
| Verified the trainer recorded the specific training services he or she provided to the customer and documented the customer’s progress he or she observed on this form.  | [ ]  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:**       |