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| Texas Workforce Solutions logo | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **ILS-OIB Customer Services Progress Report** | | | | | | | |
| **Independent Living Services for Older Individuals who are Blind (ILS-OIB)**  **Customer Information** | | | | | | | | | | |
| **Customer name:** | | | | Case ID: | | Service authorization number: | | | | |
| **ILS-OIB worker name**: | | | | | | | | | | |
| **Independent Living Skills (ILS) Provider:** | | | | | **Beginning date of service:** | | | **Ending date of service:** | | |
| **Select the services provided:** | | | | | | | | | | |
| Application Assessment | | | | | | | | | | |
| IL Skills Training Services | | | | | | | | | | |
| Final IL Skills training services report | | | | | | | | | | |
| **Progress Report** | | | | | | | | | | |
| **A narrative report detailing the services provided during the reporting period including:**   * **identification of the customer's needs, strengths, and limitations for independent living;** * **measurable goals, objectives, and timelines;** * **progress made toward the customer’s goals;** * **the number of hours the customer participated in training;** * **the provider's observations, comments, and recommendations; and** * **specific references to the services requested by the customer's ILS-OIB worker.** | | | | | | | | | | |
| **Provider Signatures** | | | | | | | | | | |
| **Independent Living Services Provider Signature (Required for all providers)** | | | | | | | | | | |
| **By signing below, I, the Independent Living Services Provider, 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. | | | | | | | | | | |
| **Provider typed name**: | **Signature:** (See VR-SFP 3 on Signatures  **X** | | | | | | | | | **Date signed:** |
| **Director Credentials and Signature** | | | | | | | | | | |
| **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. | | | | | | | | | | |
| **Typed or printed name**: | | **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 that the assessment on Independent Living and Communication Skills was completed with customer. | | | | | | | | | Yes  No | |
| Verified that attendance was recorded and includes the total number of hours the customer participated in services | | | | | | | | | Yes  No | |

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| Verified that the appropriate fee(s) was invoiced. | Yes  No |

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| **Printed name of VR staff member making verification:** |

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| 1. | Date: | 2. | Date: |

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| **VR Counselor Review** | |
| Verified that all necessary accommodations, compensatory techniques, and special needs were provided as necessary, for the customer to successfully participate in the services. | Yes  No |
| Verified that customer’s performance, skills, and needs were assessed, and results summarized for the reporting period. | Yes  No |
| Verified that goals and objectives are measurable and established for all skills to be addressed. | Yes  No |
| Verified that a projected timeline to include training hours has been established for each goal. | Yes  No |

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| **By typing or printing your name, the VRC verifies:**  Verified the 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:** |