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| Texas Workforce Solutions logo | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Customer Services Report: Orientation & Mobility (O&M) Training** | | | | |
| **General Information** | | | | | |
| **Provider’s name:** | | | **Service authorization number:** | | |
| **Counselor’s / OIB Worker’s name:** | | | | | |
| **Customer’s name:** | | | **Customer’s Case ID:** | | |
| **Total training hours approved at assessment:**  **Total training hours provided to date:**  **Training hours provided this month:**  **Training hours requested for next service authorization:** | | | | | |
| **Training** | | | | | |
| For each of the skills area trained, include the date of lesson, location, hours and a brief description of the lesson provided. | | | | | |
| **Basic Cane Skills area** | **Date of lesson** | **Location** | | **Hours** | **Brief description** |
| Open palm grip |  |  | |  |  |
| Pencil grip |  |  | |  |  |
| Walking in step |  |  | |  |  |
| Touch and drag/two point touch |  |  | |  |  |
| Stairs |  |  | |  |  |
| Picking up dropped objects |  |  | |  |  |
| Cane storage (including vehicles) |  |  | |  |  |
| Seating |  |  | |  |  |
| Entering and exiting doors |  |  | |  |  |
| Introduction to sidewalk travel, driveways, and curb travel |  |  | |  |  |
| Other, please specify |  |  | |  |  |
| **Basic cane skills training hours recommended:** | | | | **Hours completed for the month.** | |
| **Indoor Skills Area** | **Date of lesson** | **Location** | | **Hours** | **Brief description** |
| Straight line travel |  |  | |  |  |
| Indoor numbering systems |  |  | |  |  |
| Orientation |  |  | |  |  |
| Problem solving |  |  | |  |  |
| Stairs, escalators, and elevators |  |  | |  |  |
| Locating objectives in unfamiliar places |  |  | |  |  |
| Finding intersecting hallways |  |  | |  |  |
| Soliciting information |  |  | |  |  |
| Malls, grocery sores, small shops,  bus and train stations, etc. |  |  | |  |  |
| Other, please specify |  |  | |  |  |
| **Indoor skills training hours recommended**: | | | | **Hours completed for the month:** | |
| **Outdoor Skills Area** | **Date of lesson** | **Location** | | **Hours** | **Brief description** |
| Address system |  |  | |  |  |
| Sun cues |  |  | |  |  |
| Traffic |  |  | |  |  |
| Orientation |  |  | |  |  |
| Problem solving |  |  | |  |  |
| Soliciting information |  |  | |  |  |
| Parking lots |  |  | |  |  |
| Transportation systems such as buses, paratransit, and communicating with drivers |  |  | |  |  |
| Other, please specify |  |  | |  |  |
| **Outdoor skills training hours recommended:** | | | | **Hours completed for the month:** | |
| **Intersection Skills area** | **Date of lesson** | **Location** | | **Hours** | **Brief description** |
| Approaching |  |  | |  |  |
| Analyzing |  |  | |  |  |
| Alignment |  |  | |  |  |
| Lights |  |  | |  |  |
| Nonlights |  |  | |  |  |
| Actuated |  |  | |  |  |
| Automatic |  |  | |  |  |
| Crossing |  |  | |  |  |
| Crowns |  |  | |  |  |
| Challenging traffic (heavy turn lanes, light traffic at busy intersections, night time) |  |  | |  |  |
| Correcting veering |  |  | |  |  |
| Other, please specify |  |  | |  |  |
| **Intersection skills training hours recommended:** | | | | **Hours completed for the month:** | |
| **Extra Skills Area** | **Date of lesson** | **Location** | | **Hours** | **Brief description** |
| College campus |  |  | |  |  |
| Rural travel |  |  | |  |  |
| Airport, train, and bus terminals |  |  | |  |  |
| Others as needed, please specify |  |  | |  |  |
| **Extra skills training hours recommended:** | | | | **Hours completed for the month:** | |
| **Additional Comments** | | | | | |
| Height of customer:  Height of cane used for training: | | | | | |
| Any additional comments or requests for support, if any. Include any travel aids customer uses or may benefit from using: | | | | | |
| **Certification** | | | | | |
| I certify that all lessons for VR or OIB customers were conducted per SFP 5.4.1: Orientation and Mobility Training Service Description.  Give exact dates of lessons that did not meet the standards, and attach a copy of the written approval sent by the customer’s counselor/OIB worker. | | | | | |

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| **Provider Signatures** | | | | | | | |
| **Orientation and Mobility Specialist 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 Orientation and Mobility Specialistas 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. | | | | | | | |
| **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/OIB Worker) | | | | | | | |
| **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 number of training hours provided in each training area. | | | | | | Yes  No | |
| Verified that group training was provided to a maximum of three customers. | | | | | | 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/OIB Worker Review** | | | | | | | |
| Verified that the detailed narrative of each skills area addressed during the reporting period and the training location for each lesson and a detailed explanation of anticipated training for the upcoming month is completed. | | | | | Yes  No | | |
| Verified that any deviation from assessment recommendations is explained. | | | | | Yes  No | | |
| Verified that a detailed narrative of cumulative progress is included if training is completed. | | | | | Yes  No | | |
| **By typing or printing your name, the VRC/OIB Worker 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 satisfaction with services received.   **Approve to pay invoice**  **Do not approve to pay invoice** | | | | | | | |
| **VR Counselor/OIB Worker:** | | | | | Date: | | |