



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.
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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 stores, small shops, bus and train stations, etc.				
Other, please specify				

Indoor skills training hours recommended:	Hours completed for the month:
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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:
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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.				
Provider Signatures				
Orientation and Mobility Specialist Signature (Required for all providers)				
By signing below, I certify that:				
<ul style="list-style-type: none"> • 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 Specialist 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)			Date signed:
	X			

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:
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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:
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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: