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| **Texas Workforce Solutions logo** | **Texas Workforce Commission****Vocational Rehabilitation Services****Comprehensive Assessment****for ILS-OIB Program**    |
| **General Information**  |
| **Customer:**      | **Assessment completed by (if completed by a vendor):**      |
| **Assessment beginning date:**      | **Assessment ending date:**      |
| **Independent Living and Communication Skills**   |
| **Assess all the following areas in terms of current training needs using the following codes:** **Y – yes, training needed** **N – no, training not needed**   |
| **Assessment Area** | **Code** |
| * Preparing meals and maintaining kitchen safety
 |       |
| * Measuring and pouring liquids and dry ingredients
 |       |
| * Using appliances in the home
 |       |
| * Eating skills
 |       |
| * Performing household chores
 |       |
| * Sewing and crafts
 |       |
| * Providing dependent care (children, spouse, other family member, etc.)
 |       |
| * Personal grooming
 |       |
| * Dressing (clothing and shoe identification, laundry skills, etc.)
 |       |
| * Accessing printed materials
 |       |
| * Writing and calendar skills
 |       |
| * Using the telephone
 |       |
| * Time telling
 |       |
| * Identifying money
 |       |
| * Managing finances
 |       |
| * Organizing and labeling
 |       |
| * Using braille
 |       |
| **Does the customer have a computer?** [ ]  Yes [ ]  No |
| **Does the customer need information on a computer issue?** [ ]  Yes [ ]  No**If yes, what information is needed?**       |
| **Does the customer need to be assessed for a magnifier or closed-circuit TV?** [ ]  Yes [ ]  No |
| **Does the customer need a low-vision evaluation?** [ ]  Yes [ ]  No |
| **Comments, if any:**       |
| **Managing Secondary Disabilities**   |
| **List secondary disabilities:**      |
| **Does the customer have a hearing loss?** [ ]  Yes [ ]  No |
| **Does the customer need a deafblind evaluation?** [ ]  Yes [ ]  No |
| **Does the customer need a hearing evaluation and/or hearing aids?** [ ]  Yes [ ]  No |
| **Does the customer need diabetes education?** [ ]  Yes [ ]  No |
| **Assess all the following areas in terms of current training needs using the following codes:** **Y – yes, training needed** **N – no, training not needed**    |
| **Assessment Area** | **Code** |
| * Managing diabetes (blood sugar levels, insulin administration, medications, meals, etc.)
 |       |
| * Managing other health conditions (high blood pressure, congestive heart failure, etc.)
 |       |
| * Managing medications
 |       |
| **Comments:**      |
| **Travel and Transportation**   |
| **Assess all the following areas in terms of current training needs using the following codes:** **Y – yes, training needed** **N – no, training not needed**    |
| **Assessment Area** | **Code** |
| * Mobility in and around the home
 |       |
| * Detecting steps or drop-offs
 |       |
| * Maintaining balance when walking
 |       |
| * Using public or private transportation
 |       |
| * Traveling outside the home
 |       |
| **What are the customer’s goals for travel-related training and orientation and mobility (O&M) training?**      |
| **Is an O&M evaluation recommended?** [ ]  Yes [ ]  No |
| **Does the customer want to participate in O&M training?** [ ]  Yes [ ]  No |
| **Comments, if any:**      |
| **Support System**   |
| **Who provides the customer’s primary (natural) support system?**      |
| **What community resources does the customer already use?**      |
| **Are any other referrals needed?** [ ]  Yes [ ]  No**If yes, list the referrals:**        |
| **Quality of Life**   |
| **Does the customer participate in leisure, volunteer, or recreation activities?** [ ]  Yes [ ]  No |
| **Would the customer like to be more active?** [ ]  Yes [ ]  No**If yes, how?**       |
| **What training would improve the customer’s quality of life?**      |
| **Adjustment to Blindness**   |
| **Is the customer coping with his or her vision loss?** [ ]  Yes [ ]  No |
| **Is the customer ready or motivated to participate in services?** [ ]  Yes [ ]  No |
| **Does the customer advocate for himself or herself and express needs?** [ ]  Yes [ ]  No |
| **Is the customer using adaptive techniques?** [ ]  Yes [ ]  No**If so, what adaptations are being used?**       |
| **Is the customer at risk of going to a more dependent living environment (for example, an assisted living facility or a nursing home) without the provision of IL services?** [ ]  Yes [ ]  No |
| **Comments, if any:**       |
| **Summary of Recommendations and Justification for Equipment**  |
| **Make additional comments here, and list any additional services, equipment, or supplies that the customer needs:**       |
| **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.
 |
| **Typed or printed 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.
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| **Director Typed or Printed name**:      | **Director 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 |

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| **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 |

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| Verified that the assessment on Independent Living and Communication Skills was completed with customer. | [ ]  Yes [ ]  No |

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| 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 |

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| Verified that there was discussion with customer on managing secondary disabilities. | [ ]  Yes [ ]  No |
| Verified that Travel and Transportation activities were assessed with customer including customer’s goals for travel-related training. | [ ]  Yes [ ]  No |
| Verified that customer has a natural support system and is familiar with other community resources. | [ ]  Yes [ ]  No |
| Verified that there was discussion regarding customer’s leisure, volunteer, and/or recreation activities. | [ ]  Yes [ ]  No |
| Verified that customer’s adjustment to blindness was addressed. | [ ]  Yes [ ]  No |
| Verified that additional services, equipment, or supplies were discussed (if appropriate). | [ ]  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 satisfaction with services received.
 |
| [ ]  **Approve to pay invoice** [ ]  **Do not approve to pay invoice** |
| VR Counselor:        | Date:       |