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| **Texas Workforce Solutions logo** | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Vocational Training Specialized Training Plan** | | | | | |
| **General Information** | | | | | | |
| **Customer name:** | | | **VRS case ID:** | | | |
| **Service authorization number(s):** | | | **Date training plan created or updated:** | | | |
| **Training Plan** | | | | | | |
| **Area(s) to be addressed in goals and objectives:** | | | | | | |
| Balancing life and work  Career exploration  Child care management  Community resources  Conflict resolution  Daily living skills  Other: | Decision making  Disability awareness  Effective communication  Financial management  Goal setting  Grooming and hygiene  Other: | | | Household management  Independent living  Interpersonal communication  Leadership  Stress management  Other:  Other: | | |
| **Goal 1:** | | | | | | |
| **Objectives:** | | **Date Set:** | | | **Projected Achievement Date:** | **Date Achieved:** |
| **A:** | |  | | |  |  |
| **B**: | |  | | |  |  |
| **C**: | |  | | |  |  |
| **Activities and interventions:** | | | | | | |
| **Description of abilities at entrance of training:** | | | | | | |
| **Goal 2:** | | | | | | |
| **Objectives:** | | **Date Set:** | | | **Projected Achievement Date:** | **Date Achieved:** |
| **A:** | |  | | |  |  |
| **B**: | |  | | |  |  |
| **C**: | |  | | |  |  |
| **Activities and Interventions:** | |  | | |  |  |
| **Description of abilities at entrance of program:** | | | | | | |
| **Goal 3:** | | | | | | |
| **Objectives:** | | **Date Set:** | | | **Projected Achievement Date:** | **Date Achieved:** |
| **A:** | |  | | |  |  |
| **B**: | |  | | |  |  |
| **C**: | |  | | |  |  |
| **Activities and Interventions:** | | | | | | |
| **Description of abilities at entrance of program:** | | | | | | |
| **Goal 4:** | | | | | | |
| **Objectives:** | | **Date Set:** | | | **Projected Achievement Date:** | **Date Achieved:** |
| **A:** | |  | | |  |  |
| **B**: | |  | | |  |  |
| **C**: | |  | | |  |  |
| **Activities and Interventions:** | | | | | | |
| **Description of abilities at entrance of program:** | | | | | | |
| **Goal 5:** | | | | | | |
| **Objectives:** | | **Date Set:** | | | **Projected Achievement Date:** | **Date Achieved:** |
| **A:** | |  | | |  |  |
| **B**: | |  | | |  |  |
| **C**: | |  | | |  |  |
| **Activities and Interventions:** | | | | | | |
| **Description of abilities at entrance of program:** | | | | | | |
| **Recommendations** | | | | | | |
| **Number of VAT hours requested:****Week 1:**       **Week 2:**       **Week 3:**       **Week 4:**  **Grand of total of hours for month**  **Justification for VAT hours:** | | | | | | |
| VR3135A or VR3136 completed and attached:  **Yes**  **No** | | | | | | |
| **Additional Comments** | | | | | | |
| **Additional comments, if any:** | | | | | | |

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| **Customer Signatures** | | |
| **Verification of the customer’s satisfaction and service delivery obtained by:**  Handwritten signature  Digital signature (See VR-SFP 3 on Signatures)  By sending a copy of the document returned with a scanned signature  Unable to obtain signature, describe attempts:  Email verification, per VR-SFP 3 (must be attached) | | |
| By signing below, I, the customer, agree with the information recorded within the report above.  If you are not satisfied, do not sign. Contact your VR counselor. | | |
| **Customer’s signature:**  **X** | | **Date Signed:** |
| **Provider Signatures** | | |
| **Type of Provider:**  Traditional-bilateral contractor  Transition Educator  Non-traditional | | |
| **Premiums to be invoiced**:  None  Autism  Blind and Visually Impaired  Brain Injury  Deaf  other, specify: | | |
| **Vocational Adjustment 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 a Personal Social Adjustment Trainer and/or Work Adjustment Trainer as described in the VR‑SFP or Service Authorization; and * I signed my signature and entered the date below. | | |
| **Vocational Adjustment Trainer 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  Transition Educator  Non-traditional  RID/BEI/SLIPI with Number:       or  proof attached | | |

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| **TWC Vocational Counselor Signature** | | |
| **By signing below, I, the VR Counselor, agree with the goals and objectives in the above Training Plan.** | | |
| **VR Counselor typed name**: | **VR Counselor signature:**  **X** | **Date:** |