TEXAS WORKFORCE SOLUTIONS

Texas Workforce Commission
Vocational Rehabilitation Services

Supportive Residential Services Progress Report

Instructions

Follow the instructions below when completing this form:

- Refer to the contract for additional details;
- Complete the form electronically, answering all questions;
- Before faxing, emailing encrypted, or mailing to the provider, review this form to ensure that all questions have been answered.

Report Reporting Period

Start Date:	**End Date:**

Customer's Identification Information

Customer's name:	
Case ID:	**Date of birth:**

Case Manager Contact Information

Case Manager name:	
Contact number: ( )	**Email address:**

Additional Information Turned in with Report

Check all included with the report.

☐ Treatment Plan ☐ Facility Documentation ☐ Other:

Customer and Specialist Contacts for Reporting Period

Instructions:

- For each week enter the date (mm/dd/yy) of Monday through Sunday in the date column.
- For each day of the week, record the contact made with the customer using the following key: (C=Chemical Dependency Counseling, E=Chemical Dependency Education, LS=Life skills training, R=Relapse Prevention Education, or O=Other)
- If the category "other" used below, describe the type of contact in the field below
- If the customer is absent from a schedule activity, record an "A".

Week	Start Date (Mon-Sun)	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1								
2								
3								
4								
5								
6								
7								
8								

If any "other" entered above, describe:

Report of Treatment Services

Instructions:
Record information for each Chemical Dependency Counseling, Chemical Dependency Education, Life skills training, Relapse Prevention Education, or Other session(s) held during the Reporting Period.

Date: **Length of time the Customer attended the event**:

Type of Event, check one: ○ Chemical Dependency Counseling ○ Chemical Dependency Education ○ Life Skills ○ Relapse Prevention Education ○ Other

Briefly describe and evaluate each session including the purpose/goals of the session, the customer's skills/performance and/or problematic issues or concerns:

Date: **Length of time the Customer attended the event**:

Type of Event, check one: ○ Chemical Dependency Counseling ○ Chemical Dependency Education ○ Life Skills ○ Relapse Prevention Education ○ Other

Briefly describe and evaluate each session including the purpose/goals of the session, the customer's skills/performance and/or problematic issues or concerns:

Date: **Length of time the Customer attended the event**:

Type of Event, check one: ○ Chemical Dependency Counseling ○ Chemical Dependency Education ○ Life Skills ○ Relapse Prevention Education ○ Other

Briefly describe and evaluate each session including the purpose/goals of the session, the customer's skills/performance and/or problematic issues or concerns:

Date: **Length of time the Customer attended the event**:

Type of Event, check one: ○ Chemical Dependency Counseling ○ Chemical Dependency Education ○ Life Skills ○ Relapse Prevention Education ○ Other

Briefly describe and evaluate each session including the purpose/goals of the session, the customer's skills/performance and/or problematic issues or concerns:

Date: **Length of time the Customer attended the event**:

Type of Event, check one: ○ Chemical Dependency Counseling ○ Chemical Dependency Education ○ Life Skills ○ Relapse Prevention Education ○ Other

Briefly describe and evaluate each session including the purpose/goals of the session, the customer's skills/performance and/or problematic issues or concerns:

Date: **Length of time the Customer attended the event**:

Type of Event, check one: ○ Chemical Dependency Counseling ○ Chemical Dependency Education ○ Life Skills ○ Relapse Prevention Education ○ Other

Briefly describe and evaluate each session including the purpose/goals of the session, the customer's skills/performance and/or problematic issues or concerns:

Date: **Length of time the Customer attended the event**:

Type of Event, check one: ◯ Chemical Dependency Counseling ◯ Chemical Dependency Education ◯ Life Skills ◯ Relapse Prevention Education ◯ Other

Briefly describe and evaluate each session including the purpose/goals of the session, the customer's skills/performance and/or problematic issues or concerns:

Date: **Length of time the Customer attended the event**:

Type of Event, check one: ◯ Chemical Dependency Counseling ◯ Chemical Dependency Education ◯ Life Skills ◯ Relapse Prevention Education ◯ Other

Briefly describe and evaluate each session including the purpose/goals of the session, the customer's skills/performance and/or problematic issues or concerns:

Customer's Performance-Evaluation of Soft Skills

Instructions: Rate the Customer's Soft Skills below by checking the appropriate performance level.

Soft Skill	**Excellent**: meets expectations	**Fair**: meets expectations most of the time	**Poor**: does not meet expectations	**Not applicable**: not addressed
Ability to learn	◯	◯	◯	◯
Accuracy and quality of work	◯	◯	◯	◯
Accepts supervision	◯	◯	◯	◯
Adaptability	◯	◯	◯	◯
Admits mistakes	◯	◯	◯	◯
Appearance, dress, and hygiene	◯	◯	◯	◯
Asks for help and clarification as needed	◯	◯	◯	◯
Attendance	◯	◯	◯	◯
Communication	◯	◯	◯	◯
Cooperativeness	◯	◯	◯	◯
Dependability	◯	◯	◯	◯
Handles stress	◯	◯	◯	◯
Initiative	◯	◯	◯	◯
Listens and pays attention	◯	◯	◯	◯
Motivation	◯	◯	◯	◯
Maintains eye contact	◯	◯	◯	◯
Refrains from unnecessary social interactions	◯	◯	◯	◯
Relations with authority figures	◯	◯	◯	◯
Relations with peers	◯	◯	◯	◯
Respects the rights and privacy of others	◯	◯	◯	◯
Timeliness and deadline achievement	◯	◯	◯	◯

The customer has abstained from any controlled substances and maintaining medication. ◯Yes ◯No

If no, explain:

The customer continues to follow residential rules. ◯Yes ◯No

If no, explain:

Additional comments on soft skills, if any:

Additional Comments

Enter additional comments, if any:

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:

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:	**Date Signed:**
X	

Provider Signatures

Case Manager

By signing below, I, the Case Manager, certify that:

- the above dates, times, and services are accurate;
- services provided meet the requirements as outlined in 25 TAC 448;
- persons providing services documented the information on the form for the customer represented on this form;
- The customer's signature on this form was obtained on the date stated in the date field of the form;
- I signed my signature and the date below; and
- Staff maintains qualifications as stated in 25 TAC 488, the Standards, or Service Authorization for the services provided and documented on this form.

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.

Director Typed or Printed name:	**Director Signature:** (See VR-SFP 3 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
Verify the customer was actively in the facility and did not have any unexcused or excused absences		◯ Yes ◯ No
Verified the customer's attendance in at least the six hours of required treatment services each week was recorded		◯ Yes ◯ No
Verified that the appropriate fee(s) was invoiced		◯ Yes ◯ No

Print staff member(s) names who completed technical review and/or verified the UNTWISE Credentials:

1.	Date:	2.	Date:

VR Counselor Review

Verified services were provided in accordance with 25 TAC §448.903.	◯ Yes ◯ No
Verified goals and objectives identified in the treatment plan were addressed and progress documented on the VR3384, Supportive Residential Services Progress Report	◯ Yes ◯ No

By typing or printing your name, the VRC 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 or legally authorized representative's satisfaction with services received.

◯ **Approve to pay invoice** ◯ **Do not approve to pay invoice**

VR Counselor:	Date: