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| Texas Workforce Solutions logo | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Assistive Technology Training Report** | | |
| **Provider Information** | | | | | |
| **Provider:** | | | | | |
| **Address:** | | | | | |
| **City:** | | | | **State:** | **ZIP Code:** |
| **Telephone:** (   ) | | | | | |
| **Fax Number:** | | | | | |
| **Email Address:** | | | | | |
| **Trainer:** | | | | | |
| **Report Date:** | | | | | |
| **Customer Information** | | | | | |
| **Customer:** | | | | | |
| **Address:** | | | | | |
| **City:** | | | | **State:** | **ZIP Code:** |
| **Telephone:** (   ) | | | | | |
| **Service Authorization Number:** | | | | | |
| **Counselor Information** | | | | | |
| **Counselor:** | | | | | |
| **VR Office:** | | | | **VR Caseload Number:** | |
| **Address:** | | | | | |
| **City:** | | | | **State:** | **ZIP Code:** |
| **Telephone:** (   ) | | | | | |
| **Summary of Services Provided** | | | | | |
| **Date** | **Total Hours** | **Service Description** | | | |
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| **Training Facts** | | | | | |
| **Training facilitated**: (Check all that apply) Keyboarding Training cannot be provided remotely.  **In-person training** (with the staff and customer(s) at the same physical location)  **Remote training** (using a computer-based training platform that allows for face-to-face and/or real time interaction)  **A combination of in person and remote training** | | | | | |
| **Training Report Narrative** | | | | | |
| **Training Objectives:** | | | | | |
| **Equipment Used in This Training Session:** | | | | | |
| **Software Used in This Training Session:** | | | | | |
| **Software/Hardware Problems:** | | | | | |
| **Training Effectiveness:** | | | | | |

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| **Provider Signatures** | | | | | | | | |
| **Assistive Technology 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 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 3.11.1 Documentation and 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) | | | | | | | | |
| **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 training was provided as indicated on referral (in person, remotely). | | | | | | | Yes  No | |
| Verified training delivered without exceeding policy prescribed provider-to-customer ratio. | | | | | | | Yes  No | |
| Verified the trainer recorded signed the form. | | | | | | | 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 Review** | | | | | | | | |
| Verified training objectives and status of wheter objective met or not met. | | | | | | | Yes  No | |
| Verified there is a detailed narrative report of each training session that includes the customer’s performance, skills, time spent on each product and the customer’s progress towards objectives in the baseline assessement. | | | | | | | Yes  No | |
| Verified the AT trainer conducted the post-training assessment at conclusion of the training. | | | | | | | Yes  No | |
| 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 | |
| **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:** | | |