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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Texas Workforce Solutions logo | | | | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Work Experience Training Report** | | | | | | | |
| **General Instructions** | | | | | | | | | | | | | |
| Instructions:   * Complete one form for each staff person working with the customer. * The Work Experience Trainer completes the Work Experience Training Report and the signatures are collected after all Work Experience Training services have been provided. * Complete the form electronically (on the computer), making certain all questions are accuratelyand thoroughly answered and all applicable standards have been met before submitting by fax, encrypted email, or mailing with an invoice for payment. | | | | | | | | | | | | | |
| **Customer name:** | | | | | | | | **VRS case ID:** | | | | | |
| **Service authorization (SA) number:** | | | | | | | | | | | | | |
| **Customer’s Work Experience Site** | | | | | | | | | | | | | |
| **Company name:** | | | | | | | | | | | | | |
| **Street address (include suite number, if any):** | | | | | | | | | | | | | |
| **City:** | | | | | | | | **State:** | | | **ZIP code:** | | |
| **Contact person’s name:** | | | | | | | | **Contact person’s title:** | | | | | |
| **Contact person’s phone number:** | | | | | | | | **Contact person’s email:** | | | | | |
| **Work Experience Training Goals** | | | | | | | | | | | | | |
| **Instructions**: In the first column below, select the checkbox if the goal is identified for the customer. Transfer goals from the referral.   If the goal is selected for the customer, individualize the goal by entering “Potential Areas of Focus. ” If additional goals are identified, add them to the form. | | | | | | | | | | | | | |
| Yes | | 1. Evaluate and make recommendations for support and training needs, accommodations, adaptive equipment, and job aids to ensure safe and efficient performance by the customer at the work experience’s site. | | | | | | | | | | | |
| **Potential Areas of Focus:** | | | | | | | | | | | |
| Yes | | 1. Assist the customer in learning hard and soft skills necessary to meet the work experience site’s expectations. | | | | | | | | | | | |
| **Potential Areas of Focus**: | | | | | | | | | | | |
| Yes | | 1. Identify performance issues and implement a plan of action to improve performance of the customer. | | | | | | | | | | | |
| **Potential Areas of Focus:** | | | | | | | | | | | |
| Yes | | 1. Establish support and training needs, accommodations, aids necessary to remove barriers to ensure successful work experience for the customer and site. | | | | | | | | | | | |
| **Potential Areas of Focus:** | | | | | | | | | | | |
| Yes | | 1. Observe, monitor, and make recommendations related to the customer’s performance of tasks, use of aids and need for accommodations to remove barriers for successful engagement in the work experience for the customer. | | | | | | | | | | | |
| **Potential Areas of Focus:** | | | | | | | | | | | |
| Yes | | 1. The work experience trainer will gradually reduce the time spent with the customer at the work experience site, as the customer becomes better adjusted and more independent. | | | | | | | | | | | |
| **Potential Areas of Focus:** | | | | | | | | | | | |
| Yes | | 1. Additional goal(s): | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Training Facts** | | | | | | | | | | | | | |
| **Training facilitated:**  In a group setting (maximum of four customers for each trainer)  In an individual setting (one trainer to one customer)  A combination of group and individual settings  In person training  Remote training  **Note:** For remote service delivery, thefirst training session must be held in person, at or away from the jobsite, to evaluate the customer’s and employer’s training needs and to set-up necessary equipment and software to facilitate remote service delivery. | | | | | | | | | | | | | |
| **When training is facilitated in a group setting, record the VRS case IDs of all customers who participated in the group training session(s).** | | | | | | | | | | | | | |
| 1. | | | | | | | 2. | | | | | | |
| 3. | | | | | | | 4. | | | | | | |
| **Progress Log** | | | | | | | | | | | | | |
| **Instructions:**   * Indicate what setting(s) the training was provided. * When the training is provided in a group setting, record the other group member’s VRS case ID. * For each entry on the progress report, enter the date the service was provided; the start time and end time of session; the total time of session using quarter hour .25 increments (Note: .25 = 15 minutes,.50 = 30 minutes, .75 = 45 minutes, and 1.0 = 60 minutes. Use 0 for non-billable notation); the number of each goal addressed; the setting the training occurred; and record a narrative description of both the services provided by the Work Experience Trainer and the customer’s performance including progress towards goals. * Indicate total time for individual, group and all sessions provided. Add any additional comments as appropriate. | | | | | | | | | | | | | |
| **Date**  (xx-xx-xx) | **Time** (Start–End) (a.m.–p.m.) | | **Total time of session** | **Number of each goal addressed** | **Setting** | | | | **Describe the contact or service provided.** | | | | |
|  | to | |  |  | 1 to 1  Group  In person  Remote | | | |  | | | | |
|  | to | |  |  | 1 to 1  Group  In person  Remote | | | |  | | | | |
|  | to | |  |  | 1 to 1  Group  In person  Remote | | | |  | | | | |
|  | to | |  |  | 1 to 1  Group  In person  Remote | | | |  | | | | |
|  | to | |  |  | 1 to 1  Group  In person  Remote | | | |  | | | | |
|  | to | |  |  | 1 to 1  Group  In person  Remote | | | |  | | | | |
|  | to | |  |  | 1 to 1  Group  In person  Remote | | | |  | | | | |
|  | to | |  |  | 1 to 1  Group  In person  Remote | | | |  | | | | |
|  | to | |  |  | 1 to 1  Group  In person  Remote | | | |  | | | | |
|  | to | |  |  | 1 to 1  Group  In person  Remote | | | |  | | | | |
| **Total time for 1 to 1 session(s)**:       **Total time for Group session(s)**:  **Total time for All session(s) provided**: | | | | | | | | | | | | | |
| **Summary of Customer’s Performance Soft Skills** | | | | | | | | | | | | | |
| Gain information from the staff at the Work Experience site and from observations made related to the customer’s soft skills then rate the customer on the following criteria for the reporting period of the form.    **Sections Below Completed After Last Work Experience Training Session for the Reporting Period** | | | | | | | | | | | | | |
| **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](https://www.southeastern.edu/admin/hr/ee_and_mngr_info/manager_information/ppr_comments.html#adapt) | | | | | | | |  | |  | |  |  |
| Admits mistakes | | | | | | | |  | |  | |  |  |
| Appearance, dress, and hygiene | | | | | | | |  | |  | |  |  |
| Asks for help and clarification as needed | | | | | | | |  | |  | |  |  |
| Attendance | | | | | | | |  | |  | |  |  |
| Communication | | | | | | | |  | |  | |  |  |
| Cooperativeness | | | | | | | |  | |  | |  |  |
| Co-worker relations | | | | | | | |  | |  | |  |  |
| Dependability | | | | | | | |  | |  | |  |  |
| Handles stress | | | | | | | |  | |  | |  |  |
| Initiative | | | | | | | |  | |  | |  |  |
| Listens and pays attention | | | | | | | |  | |  | |  |  |
| Motivation | | | | | | | |  | |  | |  |  |
| Maintains eye contact | | | | | | | |  | |  | |  |  |
| Quantity of work | | | | | | | |  | |  | |  |  |
| Refrains from unnecessary social interactions | | | | | | | |  | |  | |  |  |
| Respects the rights and privacy of others | | | | | | | |  | |  | |  |  |
| Service to customers | | | | | | | |  | |  | |  |  |
| Timeliness and deadline achievement | | | | | | | |  | |  | |  |  |
| **Additional comments on soft skills, if any:** | | | | | | | | | | | | | |
| **Additional Comments** | | | | | | | | | | | | | |
| **Additional comments**: | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Customer Signature** | | | | | | | | |
| **Verification of the customer’s and/or customer’s authorized representative’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 or authorized representative, 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  Mileage  Blind  Brain Injury  other, specify: | | | | | | | | |
| **Work Experience Trainer** | | | | | | | | |
| **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 and/or customer’s authorized representative’s satisfaction and service delivery obtained as stated above; * I maintain the staff qualifications required for a Work Experience Traineras 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**: |
| **Select all that apply:**  UNTWISE Credentialed with ID:        VR3490-Waiver Proof Attached  Transition Educator  Non-traditional  RID/BEI/SLIPI with Number:       or  proof attached | | | | | | | | |
| **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 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) | | | | | | | | |
| **When Work Experience Trainer** **is a Transition Educator or Non-Traditional provider, skip this section.** | | | | | | | | |
| **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 | | | | | | | | |
| **Work Experience Trainer’s Credential:** | | | | | | | | |
| UNTWISE website or attached VR3490 verifies, for the dates of service, the Work Experience Trainerlisted above:  maintained or waived the required UNTWISE Credential  did **not** holda valid UNTWISE Credential | | | | | | | | |
| **UNTWISE Endorsements:** | | | | | | | | |
| UNTWISE website verifies, for the dates of service, the Work Experience Trainerlisted above maintained the following endorsement:  None  Autism  Blind and Visually Impaired  Brain Injury  other, specify: | | | | | | | | |
| **Qualifications Related to Deaf Premium:** | | | | | | | | |
| Attached documentation verifies, for the dates of service, the Work Experience Trainerlisted above maintained one of the following:  not applicable/no attachment  BEI  RID  SLIPI | | | | | | | | |
| **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 | | | |
| When applicable, verify when services provided in group setting, no more than 4 customers per trainer. | | | | | NA  Yes  No | | | |
| Verified the customer’s satisfaction with the training through signature on the form and/or by VR staff member contact with customer | | | | | | | 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 the customer received necessary accommodations, supplies and resources; various instructional approaches were used; and the customer has the ability to use compensatory techniques to increase ability to perform task and skills | | | | | | | Yes  No | |
| Verified the form indicates the work experience trainer provided training based on goals and focus areas on the VR1600, Work Experience Services Referral, service authorization. | | | | | | | Yes  No | |
| Verified the form contains narrative descriptions of the services provided by Work Experience Trainer and the customer’s performance including progress towards goals. | | | | | | | Yes  No | |
| Verified the hours have decreased, as identified in goal, as the customer becomes better adjusted, more independent and no longer needs training supports. | | | | NA  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: |