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| Texas Workforce Solutions logo | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Contracted Service Modification Request Blind and Visually Impaired Services** | | | | | | |
| **Instructions:**  A VR3472, Contracted Service Modification Request must be utilized and submitted in accordance with the following process:   1. the VR counselor will complete the VR3472; 2. prior to submitting, the VR counselor verifies the customer and provider agree with the modification; 3. the VR counselor will sign the VR3472 and obtain the provider’s legal authorized representative’s signature; 4. the VR counselor must enter a case note in ReHabWorks for the customer that explains and justifies the need for the modification including the content to questions asked within the form;   5. after the above steps are completed, VR counselor will send the VR3472 to the [vrs.program.contract.approval@twc.texas.gov](mailto:vrs.program.contract.approval@twc.texas.gov) mailbox for approval using the naming convention in the subject line of the email: **Region#\_3472\_provider’s name** **or customer’s case id;**  6. the VR Standards Team or Subject Matter Expert will conduct a case review and coordinate the approval of the VR3472 obtaining VR Director signature;  7. VR standards team will ensure the final approved or not approved VR3472 is returned to VR counselor and will copy the Regional Quality Assurance Specialist or Regional Program Support Specialist;   1. the VR counselor will send the VR3472 to the provider and will file it in the customer paper file; and 2. providers will submit a copy of the approved VR3472 with applicable invoices.   **Note:** Update the customer’s IPE when necessary, after VR3472 is approved. | | | | | | | |
| **Contractor Information** | | | | | | | |
| **TWC contract number:** | | **Texas Identification Number (TIN):** | | | | | |
| **Legal name:** | | **Doing Business As (DBA) name:** | | | | | |
| **Director name:** | | | | | | | |
| **Director’s email:** | | **Director’s phone number:**  (   )    - | | | | | |
| **Customer Identification Information** | | | | | | | |
| **First name:** | | | **Last name:** | | | | |
| **VRS case ID:** | | | **City:** | | | | |
| **Services to be Modified** | | | | | | | |
| **Identify VR-SFP Chapter and service(s) involved in the Contracted Service Modification request.**  [Chapter 5: Orientation and Mobility Services](https://www.twc.texas.gov/standards-manual/vr-sfp-chapter-05)  Orientation and Mobility Assessment Orientation and Mobility Training  [Chapter 7: Diabetes Self-Management Education Services](https://www.twc.texas.gov/standards-manual/vr-sfp-chapter-07)  Assessment of Diabetes Self-Management Diabetes Skills Training  Post-Training Assessment  [Chapter 9: Assistive Technology for Sight Related Disabilities](https://www.twc.texas.gov/standards-manual/vr-sfp-chapter-09)  Assistive Technology Evaluations  Baseline Assessments  Assistive Technology Training  [Chapter 10: Independent Living Services for Older Individuals who are Blind](https://www.twc.texas.gov/standards-manual/vr-sfp-chapter-10)  Independent Living Skills Training | | | | | | | |
| **Requested Change in VR-SFP** | | | | | | | |
| **Requested change in the VR-SFP to meet the customer’s individual needs and circumstances.**    The service(s) (identified above) are to be conducted remotely, following VR-SFP 3.4.8 Remote Service Delivery, when the VR-SFP states the service must be provided in person with the staff and customer at the same location.  Orientation and Mobility Training is conducted for greater than 6 hours or less than 2 hours per day as required in VR-SFP 5.4.1  Orientation and Mobility Training is conducted with customer using non-ridged cane VR-SFP 5.4.2.3 Travel Aides  Diabetes Self-management Assessment that exceeds the 2 hours requirement. VR-SFP 7.3.2  Assistive Technology Training that deviates from the approved curriculum. VR-SFP 9.5.2.1    Other, service definition, process and procedures or outcomes required for payment prescribed in the VR-SFP needs to be changed to meet the customer’s individual needs and circumstances   * List the specific section of the VR-SFP needs to be changed: | | | | | | | |
| **Description and Justification for Contracted Service Modification** | | | | | | | |
| The following information needs to be documented in the customer’s ReHabWorks case notes.  State office will conduct a case review to determine if case notes support information below. | | | | | | | |
| **Describe the customer’s disability as identified in ReHabWorks.** | | | | | | | |
| **Describe in detail how the services will be provided to meet the customer’s individual needs and circumstances to achieve their IPE goal(s).**    **Note:** All remote services must be conducted following the VR-SFP 3.4.8 Remote Service Delivery | | | | | | | |
| **Describe the resources the customer has to engage in the remote service and how the customer’s abilities have been evaluated to ensure they can benefit from Remote Service Delivery.**  Examples: Has smartphone or tablet, able to use facetime or zoom independently  **Note:** When Diabetes Management or Assistive Technology or Independent Living Services are being requested to be provided remotely, following the VR-SFP 3.4.8 Remote Service Delivery.  Not purchasing Diabetes Management or Assistive Technology or Independent Living Services remotely | | | | | | | |
| **VR Counselor Acknowledgment** | | | | | | | |
| By typing my name below, I have verified the information on the request is accurate.  **Yes, the required ReHabWorks case note has been entered.** | | | | | | | |
| **VR counselor’s Typed Name:** | | | | **Region #:** | | | **Date:** |
| **Entity’s Legal Authorized Representative Signature** | | | | | | | |
| A legally authorized representative is the person who is authorized to sign contracts and other official documents for the entity. | | | | | | | |
| By signing below, I, the entity’s legally authorized representative, acknowledge agreement with the information contained in the Contracted Service Modification form. (See VR-SFP 3 on Signatures) | | | | | | | |
| **Entity’s Legally Authorized Representative typed or printed name:** | | | | | | | |
| **Entity’s legally authorized representative’s digital or handwritten signature:** | | | | | | | |
| **X** | | | | | **Date:** | | |
| **VR Division Director Review and Signature** | | | | | | | |
| By signing my name below, I am providing my approval or denial of the contract modification request as indicated: | | | | | | | |
| Approve request above  Deny request above | | | | | | | |
| **VR Division Director typed or signed name:**  **X** | | | | | | **Date:** | |
| **Additional Comments** | | | | | | | |
| **When needed add additional comments, date, and initial each entry:** | | | | | | | |
| **State Office Use Only** | | | | | | | |
| ReHabWorks Case and Contracted Service Modification Request reviewed  Comment, if any: | | | | | | | |