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| Texas Workforce Solutions logo | | | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Autism Spectrum Disorder (ASD) Supports Plan** | | | | | | |
| **Purpose** | | | | | | | | | | | |
| **Autism Spectrum Disorder (ASD) Supports:**   * is only for customers diagnosed with autism or displaying characteristics of autism, * intended to identify and address skill deficits **directly related** **to the customer’s autism**. | | | | | | | | | | | |
| **Instructions** | | | | | | | | | | | |
| * Billable time for the ASD Support Plan is **not to exceed 5 hours** and may include, but is not limited, to the following: consultation with the counselor, initial meeting with customer/guardian, email, phone correspondence with related parties, brief needs assessment to identify skills and completion of plan * Provider is **not required to identify 5 skills**, but more than 5 is not recommended * Once plan is completed, provider must review it with counselor and customer. | | | | | | | | | | | |
| **Customer Information** | | | | | | | | | | | |
| **Name of Customer** | | | | **Customer ID** | | | | **Age** | | **Reported Disability** | |
| **Name of Referring Counselor** | | | | **Date of Referral** | | | | **Date Report Submitted** | | **Date Report will be Reviewed** | |
| **Provider Information** | | | | | | | | | | | |
| **Name of Provider** | | | | **Vendor Number** | | | | **Phone Number** | | **Email** | |
| **Name of Referring Counselor** | | | | **Date of Referral** | | | | **Date Report Submitted** | | **Date Report will be Reviewed** | |
| **List individuals (ex. customer, family/guardian, friends, counselor and/or other professionals) interviewed, contacted or records** **reviewed to complete the plan**: | | | | | | | | | | | |
| **Important Note to Provider:** Are you providing job skills training services? If yes, then provider **must ensure** there is not a duplication of services by clearly documenting **identified skills are outside the role  of a job skills trainer**. If not, plan will not be accepted by the counselor and any submitted invoice will not be paid until changes are made. | | | | | | | | | | | |
| **Criteria to Use When Choosing Skills to Target in Plan** | | | | | | | | | | | |
| The following criteria must be true for each identified skill included in this plan. Check each box to verify that all identified skill/s meet criteria:  Skill is directly related to the customer’s autism and outside the role of job skills trainer,  Skill falls within 1 or more of the diagnostic characteristics of autism divided into 5 categories,  Skill will present an eminent or a significant employment risk if not addressed,  Skill is essential for performance of job tasks,  Skill can be mastered in a relatively short period of time in either a group or individual setting,  Skill must be able to be demonstrated in an employment setting. | | | | | | | | | | | |
| **Making Identified Skill/s Measurable** | | | | | | | | | | | |
| Each skill must be measurable. A skill is measurable when it clearly describes **how the customer will demonstrate mastery.**  **For example**:  **Skill #1:** “Joe will recognize when he is becoming anxious and use 1 of out 3 strategies to calm down”  **Skill #2:** “When Joe does not know the answer to a question asked by a customer, Joe will say, “I don’t know the answer to that, but  the person in the red apron can help you” | | | | | | | | | | | |
| **Rating Identified Skill/s** | | | | | | | | | | | |
| Provider must use following scale to rate customer’s current skill level and determine the level customer must demonstrate in order for skill to be considered mastered. Progress will be documented in the VR1881, ASD Supports Time Log and Progress Report . | | | | | | | | | | | |
| **At all times = (100%)** | | | Provider has observed the customer correcting demonstrating the skill 10 out of 10 times | | | | | | | | |
| **Almost always = (90%)** | | | Provider has observed the customer correcting demonstrating the skill 9 out of 10 times | | | | | | | | |
| **Most of the time = (80%)** | | | Provider has observed the customer correcting demonstrating the skill 8 out of 10 times | | | | | | | | |
| **On average = (70%)** | | | Provider has observed the customer correcting demonstrating the skill 7 out of 10 times | | | | | | | | |
| **Rarely or never = (60% or less)** | | | Provider has observed the customer correcting demonstrating the skill 6 or less out of 10 times | | | | | | | | |
| **Identified Skill/s Targeted for This Plan** | | | | | | | | | | | |
| **Skill #1:** | | **Addresses category/s:**  Communication/Social  Sensory  Level of anxiety  Obsesses, restrictive interests  Co-morbidity | | | | | **Current Skill Level:**  At all times (100%)  Almost always (90%)  Most of the time (80%)  On average (70%)  Rarely or never (60% or less) | | **Mastery Skill Level**  At all times (100%)  Almost always (90%)  Most of the time (80%)  On average (70%)  Rarely or never (60% or less) | | |
| **To address skill: what services, strategies and or supports will be provided?** | | | | | | | | | | | |
| **Skill #2:** | **Addresses category/s:**  Communication/Social  Sensory  Level of anxiety  Obsesses, restrictive interests  Co-morbidity | | | | | | **Current Skill Level:**  At all times (100%)  Almost always (90%)  Most of the time (80%)  On average (70%)  Rarely or never (60% or less) | | **Mastery Skill Level**  At all times (100%)  Almost always (90%)  Most of the time (80%)  On average (70%)  Rarely or Never (60% or less) | | |
| **To address skill: what services, strategies and or supports will be provided?** | | | | | | | | | | | |
| **Skill #3:** | **Addresses category/s:**  Communication/Social  Sensory  Level of anxiety  Obsesses, restrictive interests  Co-morbidity | | | | | | **Current Skill Level:**  At all times (100%)  Almost always (90%)  Most of the time (80%)  On average (70%)  Rarely or never (60% or less) | | **Mastery Skill Level**  At all times (100%)  Almost always (90%)  Most of the time (80%)  On average (70%)  Rarely or never (60% or less) | | |
| **To address skill: what services, strategies and or supports will be provided?** | | | | | | | | | | | |
| **Skill #4:** | **Addresses category/s:**  Communication/Social  Sensory  Level of anxiety  Obsesses, restrictive interests  Co-morbidity | | | | | | **Current Skill Level:**  At all times (100%)  Almost always (90%)  Most of the time (80%)  On average (70%)  Rarely or never (60% or less) | | **Mastery Skill Level**  At all times (100%)  Almost always (90%)  Most of the time (80%)  On average (70%)  Rarely or never (60% or less) | | |
| **To address skill: what services, strategies and or supports will be provided?** | | | | | | | | | | | |
| **Skill #5:** | **Addresses category/s:**  Communication/Social  Sensory  Level of anxiety  Obsesses, restrictive interests  Co-morbidity | | | | | | **Current Skill Level:**  At all times (100%)  Almost always (90%)  Most of the time (80%)  On average (70%)  Rarely or never (60% or less) | | **Mastery Skill Level**  At all times (100%)  Almost always (90%)  Most of the time (80%)  On average (70%)  Rarely or never (60% or less) | | |
| **To address skill: what services, strategies and or supports will be provided?** | | | | | | | | | | | |
| **Hours Recommended** | | | | | | | | | | | |
| * Hours can be provided in any combination of individual and group recommended to achieve mastery of identified skill/s. * No more than 20 hours will be authorized at one time | | | | | | | | | | | |
| **Individual Supports** | | | | | | **Group Supports** | | | | | |
| **Projected number of weeks:**  **Projected hours per week:**  **Projected hours per day:** | | | | | | **Projected number of weeks:**  **Projected hours per week:**  **Projected hours per day:** | | | | | |
| **Signature** | | | | | | | | | | | |
| **ASD Supports Provider’s Name:** | | | | | | | | | | | |
| **ASD Supports Provider’s Signature:** | | | | | | | | | | | |
| **VR Use Only- Counselor’s Review** | | | | | | | | | | | |
| **Counselor’s Printed Name**: | | | | | | | | | | | |
| **Counselor’s Signature**: | | | | | | | | | | | |
| **VR Use Only—TWS-VR Approval of the Report** | | | | | | | | | | | |
| **I verified that identified skills are related to customer’s autism** | | | | | | | | | | | **Yes**  **No** |
| **I verified that identified skills are outside the role of a job skills trainer** | | | | | | | | | | | **Yes  No** |
| **I verified that no more than 5 hours were billed for ASD Support Plan** | | | | | | | | | | | **Yes  No** |
| **I verified that no more than 20 hours of supports were recommended** | | | | | | | | | | | **Yes  No** |
| **I verified that the provider signed the report** | | | | | | | | | | | **Yes  No** |
| **I verified that the counselor reviewed and signed the report** | | | | | | | | | | | **Yes  No** |