|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Texas Workforce Solutions logo | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Autism Service Premium Report** | | | | | | | | | | | | | | | | | | | | | | |
| **Purpose** | | | | | | | | | | | | | | | | | | | | | | | |
| The purpose of the **Autism Service Premium Report** is to document how the provider is removing the barriers **directly related to the customer’s Autism Spectrum Disorder (ASD)** that are impeding their ability to obtain and maintain employment. | | | | | | | | | | | | | | | | | | | | | | | |
| **Instructions** | | | | | | | | | | | | | | | | | | | | | | | |
| 1. In order to receive payment for the premium, the **Autism Service Report must be submitted** with the invoice for the following:    1. Bundled Job Placement: Benchmarks A-C    2. Non-Bundled Job Placement: Interviewing Training and/or Employment Data Sheet, Application, and Résumé Training    3. Career Planning Assessment (CPA)    4. Supported Employment Services    5. Job Skills Training 2. **Rate the customer’s level of support** needed in all 5 categories at the **initial evaluation** of the customer; using the same form, **monitor and report progress** throughout the designated time frames and lastly, rate the level of support achieved by job placement in **the final column**. | | | | | | | | | | | | | | | | | | | | | | | |
| **General Information** | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of Customer:** | | **Customer ID:** | | | | | | | **Report Completed by:** | | | | | | | | | | **Date Submitted:** | | | | |
| **Employment Service:** Bundled Job Placement Career Planning Assessment Supported Employment  Non-Bundled Job Placement  Job Skills Training | | | | | | | | | | | | | | | | | | | | | | | |
| **Type of Report**:  Initial Report Progress ReportFinal Report | | | | | | | | | | | | | | | | | | | | | | | |
| **Category 1: Social and Communication Deficits** | | | | | | | | | | | | | | | | | | | | | | | |
| **Social and Communication Deficits**  **Requires:** | | **Initial** | | **Progress Report** | | | | | | | | | | | | | | | | | | **Final** | |
| **Date:** | | **Date:** | | **Date:** | | | | | | **Date:** | | | **Date:** | | | **Date:** | | | | **Date:** | |
| **1 = no support needed**  **2 = monthly support**  **3 = weekly support**  **4 = daily support**  **5 = hourly support** | | **1**  **2**  **3**  **4**  **5** | | **1**  **2**  **3**  **4**  **5** | | **1**  **2**  **3**  **4**  **5** | | | | | | **1**  **2**  **3**  **4**  **5** | | | **1**  **2**  **3**  **4**  **5** | | | **1**  **2**  **3**  **4**  **5** | | | | **1**  **2**  **3**  **4**  **5** | |
| **Due to the level of support needed, what services, strategies and or supports will be provided?** | | | | | | | | | | | | | | | | | | | | | | | |
| **Category 2: Obsessive, Restrictive Interests, Repetitive Behaviors, Resistance to Change** | | | | | | | | | | | | | | | | | | | | | | | |
| **Obsessive, Restrictive, Repetitive, Resistance to Change Requires:** | | **Initial** | | **Progress Report** | | | | | | | | | | | | | | | | | **Final** | | |
| **Date:** | | **Date:** | | **Date:** | | | | **Date:** | | | **Date:** | | | | **Date:** | | | | **Date:** | | |
| **1 = no support needed**  **2 = monthly support**  **3 = weekly support**  **4 = daily support**  **5 = hourly support** | | **1**  **2**  **3**  **4**  **5** | | **1**  **2**  **3**  **4**  **5** | | **1**  **2**  **3**  **4**  **5** | | | | **1**  **2**  **3**  **4**  **5** | | | **1**  **2**  **3**  **4**  **5** | | | | **1**  **2**  **3**  **4**  **5** | | | | **1**  **2**  **3**  **4**  **5** | | |
| **Due to the level of support needed, what services, strategies and or supports will be provided?** | | | | | | | | | | | | | | | | | | | | | | | |
| **Category 3: Sensory Abnormalities** | | | | | | | | | | | | | | | | | | | | | | | |
| **Sensory Abnormalities Requires:** | | **Initial** | | **Progress Report** | | | | | | | | | | | | | | | | | **Final** | | |
| **Date:** | | **Date:** | | **Date:** | | | | **Date:** | | | **Date:** | | | | **Date:** | | | **Date:** | | | |
| **1 = no support needed**  **2 = monthly support**  **3 = weekly support**  **4 = daily support**  **5 = hourly support** | | **1**  **2**  **3**  **4**  **5** | | **1**  **2**  **3**  **4**  **5** | | **1**  **2**  **3**  **4**  **5** | | | | **1**  **2**  **3**  **4**  **5** | | | **1**  **2**  **3**  **4**  **5** | | | | **1**  **2**  **3**  **4**  **5** | | | **1**  **2**  **3**  **4**  **5** | | | |
| **Due to the level of support needed, what services, strategies and or supports will be provided?** | | | | | | | | | | | | | | | | | | | | | | | |
| **Category 4: Level of Anxiety** | | | | | | | | | | | | | | | | | | | | | | | |
| **Level of Anxiety Requires:** | | **Initial** | | **Progress Report** | | | | | | | | | | | | | | | | | **Final** | | |
| **Date:** | | **Date:** | | **Date:** | | | | **Date:** | | | **Date:** | | | | **Date:** | | | **Date:** | | | |
| **1 = no support needed**  **2 = monthly support**  **3 = weekly support**  **4 = daily support**  **5 = hourly support** | | **1**  **2**  **3**  **4**  **5** | | **1**  **2**  **3**  **4**  **5** | | **1**  **2**  **3**  **4**  **5** | | | | **1**  **2**  **3**  **4**  **5** | | | **1**  **2**  **3**  **4**  **5** | | | | **1**  **2**  **3**  **4**  **5** | | | **1**  **2**  **3**  **4**  **5** | | | |
| **Due to the level of support needed, what services, strategies and or supports will be provided?** | | | | | | | | | | | | | | | | | | | | | | | |
| **Category 5: Co-Morbidities** | | | | | | | | | | | | | | | | | | | | | | | |
| **Co-Morbidities Requires:** | | | **Initial** | | **Progress Report** | | | | | | | | | | | | | | | | | | **Final** |
| **Date:** | | **Date:** | | **Date:** | | | | **Date:** | | | **Date:** | | | **Date:** | | | | | | **Date:** |
| **1 = no support needed**  **2 = monthly support**  **3 = weekly support**  **4 = daily support**  **5 = hourly support** | | | **1**  **2**  **3**  **4**  **5** | | **1**  **2**  **3**  **4**  **5** | | **1**  **2**  **3**  **4**  **5** | | | | **1**  **2**  **3**  **4**  **5** | | | **1**  **2**  **3**  **4**  **5** | | | **1**  **2**  **3**  **4**  **5** | | | | | | **1**  **2**  **3**  **4**  **5** |
| **Due to the level of support needed, what services, strategies and or supports will be provided?** | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature** | | | | | | | | | | | | | | | | | | | | | | | |
| **Provider’s Typed Name:** | | | | | | | | **Provider’s Signature** (See VR-SFP 3. Documentation and Signatures) **:**  **X** | | | | | | | | | | | | | | | |
| **VRS Use Only—VRS Approval of the Report** | | | | | | | | | | | | | | | | | | | | | | | |
| **VR Counselor Review** | | | | | | | | | | | | | | | | | | | | | | | |
| I verified that all 5 categories are completely filled out**:**  **Yes or**  **No** | | | | | | | | | | | | | | | | | | | | | | | |
| I verified that the provider signed the report:  **Yes or  No** | | | | | | | | | | | | | | | | | | | | | | | |
| I verified that the counselor reviewed and signed the report:  **Yes or  No** | | | | | | | | | | | | | | | | | | | | | | | |
| **VR Counselor’s Name:** | | | | | | | | | | | | | | | | **Date:** | | | | | | | |