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| 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 Report**[ ]** Final 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:** |