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| Texas Workforce Solutions logo | **Texas Workforce Commission****Vocational Rehabilitation Services****Assistive Technology Training Report**   |
| **Provider Information**   |
| **Provider:**       |
| **Address:**       |
| **City:**       | **State:**       | **ZIP Code:**       |
| **Telephone:** (   )       |
| **Fax Number:**       |
| **Email Address:**       |
| **Trainer:**       |
| **Report Date:**       |
| **Customer Information**   |
| **Customer:**       |
| **Address:**       |
| **City:**       | **State:**       | **ZIP Code:**       |
| **Telephone:** (   )       |
| **Service Authorization Number:**       |
| **Counselor Information**   |
| **Counselor:**       |
| **VR Office:**        | **VR Caseload Number:**        |
| **Address:**        |
| **City:**       | **State:**       | **ZIP Code:**       |
| **Telephone:** (   )       |
| **Summary of Services Provided**   |
| **Date** | **Total Hours** | **Service Description** |
|       |       |       |
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| **Training Facts** |
| **Training facilitated**: (Check all that apply) Keyboarding Training cannot be provided remotely. [ ]  **In-person training** (with the staff and customer(s) at the same physical location)[ ]  **Remote training** (using a computer-based training platform that allows for face-to-face and/or real time interaction)[ ]  **A combination of in person and remote training** |
| **Training Report Narrative**   |
| **Training Objectives:**      |
| **Equipment Used in This Training Session:**      |
| **Software Used in This Training Session:**       |
| **Software/Hardware Problems:**      |
| **Training Effectiveness:**      |

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| **Provider Signatures**  |
| **Assistive Technology Trainer Signature (Required for all providers)** |
| **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 satisfaction and service delivery obtained as stated above;
* I maintain the staff qualifications required for an Assistive Technology Trainer as 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 3.11.1 Documentation and Signatures)**X** | **Date Signed**:      |
| **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.
 |
| **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 |
| **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)   |
| **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 |
| **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 |
| Verified the training was provided as indicated on referral (in person, remotely). | [ ]  Yes [ ]  No |
| Verified training delivered without exceeding policy prescribed provider-to-customer ratio. | [ ]  Yes [ ]  No |
| Verified the trainer recorded signed the form. | [ ]  Yes [ ]  No |
| Verified that the appropriate fee(s) was invoiced. | [ ]  Yes [ ]  No |
| **Printed name of VR staff member making verification:**  |
| 1.        | Date:       | 2.        | Date:       |
| **VR Counselor Review**  |
| Verified training objectives and status of wheter objective met or not met.  | [ ]  Yes [ ]  No |
| Verified there is a detailed narrative report of each training session that includes the customer’s performance, skills, time spent on each product and the customer’s progress towards objectives in the baseline assessement.   | [ ]  Yes [ ]  No |
| Verified the AT trainer conducted the post-training assessment at conclusion of the training. | [ ]  Yes [ ]  No |
| Verified the trainer recorded the specific training services he or she provided to the customer and documented the customer’s progress he or she observed on this form.  | [ ]  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:**       |