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| Texas Workforce Solutions Logo | | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Job Skills Training Progress Report** | | | | | |
| **General Instructions** | | | | | | | | | |
| **The Job Skills Trainer follows** **the instructions below when completing this form.**   * Complete the form electronically (on the computer) and answer all questions. * Complete one form for each staff person working with the customer for the report period. * Print the form, obtain signatures after the services are complete and submit. * Make certain that all standards are met before submitting this form with an invoice for payment.   **Note:** Before a Job Skill Trainer can provide Job Skills Training for Extended Services to “a youth with disability”, a [VR3472, Contracted Service Modification Request](https://twc.texas.gov/forms/index.html)   form must be approved by the Director of the VR Division. A new VR3472, must be  approved by the Director of the VR Division for every 200 hours of Job Skills Training authorized for the customer. | | | | | | | | | |
| **Demographic Information** | | | | | | | | | |
| **Customer’s name:** | | | | | | | **VRS case ID:** | | |
| **Service authorization (SA) number:** | | | | | | | | | |
| **Customer’s Job Site** | | | | | | | | | |
| **Company name:** | | | | | | | | | |
| **Street address (include suite number, if any):** | | | | | | | | | |
| **City:** | | | **State:** | | | **ZIP code:** | | | |
| **Contact person’s name:** | | | | | **Contact person’s title:** | | | | |
| **Contact person’s phone number:** | | | | | **Contact person’s email:** | | | | |
| **Job Skill Training Goals** | | | | | | | | | |
| **Instructions**: In the first column below, select the checkbox if the goal is identified for the customer transferring goals from the referral.   If the goal is selected for the customer, individualize the goal by entering a description.  If additional goals are identified, add them to the form. | | | | | | | | | |
| **Goals** | | | | | | | | |
|  | 1. Evaluate, make recommendations, establish supports, training needs, accommodations, adaptive equipment, and job aids, as necessary, to remove barriers for successful, safe and efficient job performance by the customer.   **Areas to be addressed:**  **Barriers to be removed:** | | | | | | | |
|  | 1. Assist the customer in learning hard skills necessary to meet the job expectations.   **Skills to be addressed:** | | | | | | | |
|  | 1. Assist the customer in identification and development of social skills necessary to meet performance expectations of position.   **Social skills to be addressed:** | | | | | | | |
|  | 1. Observe and monitor the customer’s performance reinforcing skills taught by job skills trainer or employer to ensure correct demonstration of skills and efficient job performance by the customer.   **Skills to be addressed:**  **Behaviors to be addressed:** | | | | | | | |
|  | 1. Identify performance and behavioral issues and implement a plan of action to improve job performance to the employer’s satisfaction.   **Potential performance issue(s):** | | | | | | | |
|  | 1. Observe and monitor the customer’s performance with use of compensatory techniques (adaptive equipment, job aids, supports, etc.) to manage barriers related to successful, safe, and efficient job performance by the customer.   **Barriers to be removed:**  **Compensatory techniques to be used:** | | | | | | | |
|  | 1. Teach skills necessary to arrange and/or use transportation resources to get to and/or from home to worksite.   **Skills to be addressed:**  **Transportation resource:** | | | | | | | |
|  | 1. The Job Skills Trainer will gradually reduce the time spent with the customer at the job site as the customer becomes better adjusted and more independent.   **Projected amount of time needed at referral:** | | | | | | | |
|  | 1. Additional goal. | | | | | | | |
|  | 1. Additional goal. | | | | | | | |
| **Training Facts** | | | | | | | | | |
| **Training facilitated:**  In a group setting (maximum of four customers for each trainer)  In an individual setting (one trainer to one customer)  A combination of group and individual settings  In person training  Remote training  **Note:** For remote service delivery, thefirst training session must be held in person, at or away from the jobsite, to evaluate the customer’s and employer’s training needs and to set-up necessary equipment and software to facilitate remote service delivery. | | | | | | | | | |
| **When training is facilitated in a group setting, record the VRS case IDs of all customers who participated in the group training session(s).** | | | | | | | | | |
| 1. | | 2. | | | 3. | | | 4. | |

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| **Progress Report** | | | | | | |
| **Instructions:**   * Indicate what setting(s) the training was provided. * When the training is provided in a group setting, record the other group member’s VRS case ID. * For each entry on the progress report, enter the date the service was provided; the start time and end time of session; the total time of session using quarter hour .25 increments (Note: .25 = 15 minutes,.50 = 30 minutes, .75 = 45 minutes, and 1.0 = 60 minutes. Use 0 for non-billable notation); the number of each goal addressed; the setting the training occurred; and record a narrative description of both the services provided by the Job SkillsTrainer and the customer’s performance including progress towards goals. * Indicate total time for individual, group and all sessions provided. Add any additional comments as appropriate. | | | | | | |
| **Date**  (xx-xx-xx) | **Time** (Start–End) (a.m.–p.m.) | **Total time of session** | **Number of each goal addressed** | **Setting** | | **Describe the contact or service provided.** |
|  | to |  |  | 1 to 1  Group  In person  Remote | |  |
|  | to |  |  | 1 to 1  Group  In person  Remote | |  |
|  | to |  |  | 1 to 1  Group  In person  Remote | |  |
|  | to |  |  | 1 to 1  Group  In person  Remote | |  |
|  | to |  |  | 1 to 1  Group  In person  Remote | |  |
|  | to |  |  | 1 to 1  Group  In person  Remote | |  |
|  | to |  |  | 1 to 1  Group  In person  Remote | |  |
|  | to |  |  | 1 to 1  Group  In person  Remote | |  |
|  | to |  |  | 1 to 1  Group  In person  Remote | |  |
|  | to |  |  | 1 to 1  Group  In person  Remote | |  |
| **Total time for:** 1 to 1 session(s): | | | | | Group session(s) | |
| All session(s) provided | | | | | | |

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| **Additional comments, if any**: |
| **Premiums** |
| I, the Job Skills Trainer, have been approved by service authorization to submit for the following premiums. Proof of qualifications must be provided below. |
| Autism Service Premium (VR1882 must be submitted simutanously with VR3315)  Yes  No |
| Deaf Service Premium  Yes  No |
| Brain Injury Premium  Yes  No |
| Other: Describe        Yes  No |

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| **Customer Signatures** | | | | |
| **Verification of the customer’s satisfaction and service delivery obtained by:**  Handwritten signature  Digital signature (See VR-SFP 3 on Signatures)  By sending a copy of the document returned with a scanned signature  Unable to obtain signature, describe attempts:  Email verification, per VR-SFP 3 (must be attached) | | | | |
| By signing below, I, the customer, agree with the information recorded within the report above.  If you are not satisfied, do not sign. Contact your VR counselor. | | | | |
| **Customer’s signature:**  **X** | | | | **Date Signed:** |
| **Provider Signatures** | | | | |
| **Type of Provider:**  Traditional-bilateral contractor  Transition Educator  Non-traditional | | | | |
| **Premiums to be invoiced**:  None  Autism  Blind and Visually Impaired  Brain Injury  Deaf  other, specify: | | | | |
| **Job Skills Trainer** | | | | |
| **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 a Job Skills Traineras 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 on Signatures)  **X** | | | **Date Signed**: |
| **Select all that apply:**  UNTWISE Credentialed with ID:        VR3490-Waiver Proof Attached  Transition Educator  Non-traditional  RID/BEI/SLIPI with Number:       or  proof attached | | | | |
| **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. | | | | |
| **Director Typed or Printed name**: | | **Director 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) | | | | |
| **When Job Skills Trainer** **is a Transition Educator or Non-Traditional provider, skip this section.** | | | | |
| **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 | | | | |
| **Job Skills Trainer’s Credential:** | | | | |
| UNTWISE website or attached VR3490 verifies, for the dates of service, the Job Skills Trainerlisted above:  maintained or waived the required UNTWISE Credential  did **not** holda valid UNTWISE Credential | | | | |
| **UNTWISE Endorsements:** | | | | |
| UNTWISE website verifies, for the dates of service, the Job Skills Trainerlisted above maintained the following endorsement:  None  Autism  Blind and Visually Impaired  Brain Injury  other, specify: | | | | |
| **Qualifications Related to Deaf Premium:** | | | | |
| Attached documentation verifies, for the dates of service, the Job Skills Trainerlisted above maintained one of the following:  not applicable/no attachment  BEI  RID  SLIPI | | | | |
| **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, verified a VR3472 has been approved for the Job Skills Training provided as Extended Supports for youth with disabilities | | | NA  Yes  No | |

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| When applicable, verify a copy of an approved VR3472 is attached to the report. | NA | Yes  No |
| Verifed the training was provided in person at or away from the jobsite, unless a VR3472 has been approved to allow remote trainiing. | NA  Yes  No | |

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| Verified the hours are recorded in .25 increments and are totaled on form correctly | | | Yes  No |
| Verified the customer received the minimum required hours of service and the trainer‑to‑customer ratio was adhered to  as described in the VR-SFP | | | Yes  No |
| Verified the customer’s satisfaction with the training through signature on the form and/or by VR staff member contact with customer | | | Yes  No |
| Verified that the appropriate fee(s) was invoiced | | | Yes  No |
| **Print staff member(s) names who completed technical review and/or verified the UNTWISE Credentials:** | | | |
| 1. | Date: | 2. | Date: |
| **VR Counselor Review** | | | |
| Verified the customer received necessary accommodations, supplies and resources; various instructional approaches were used; and the customer has the ability to use compensatory techniques to increase ability to perform task and skills | | | Yes  No |
| Verified the customer was trained and demonstrated knowledge of and ability to perform skills/tasks as required in the service description and outcomes required for payment | | | Yes  No |
| Verified the report contains a narrative description of the services provided by the job skills trainer and customer’s performance of skills related to the customer’s goals | | | Yes  No |
| Verified that the documentation indicates various instructional approaches were used to meet the customer’s learning styles and preferences while providing the training | | | Yes  No |
| Verified that the documentation indicates the Job Skills Trainer observed the customer to identify and solve potential problems related to the customer's employment success before the problem becomes an issue for the customer, employer, or coworkers | | | Yes  No |
| Verified that the documentation indicates the Job Skills Trainer monitored the customer's performance to ensure improvement in the customer's performance reducing training hours as the customer became better adjusted and more independent | | | Yes  No |
| Verified that the documentation indicates the Job Skills Trainer worked with the customer, employer, and VR staff members to establish support services, accommodations, compensatory techniques, and training necessary to remove barriers to ensure successful employment for the customer | | | Yes  No |
| Verified the goals and focus areas on the report match the goals and focus areas on the referral, service authorizations and/or written approval by VR counselor | | | 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: |