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| Texas Workforce Solutions logo | **Texas Workforce Commission****Vocational Rehabilitation Services****Customer Services Report: Orientation & Mobility (O&M) Training**  |
| **General Information**   |
| **Provider’s name:**       | **Service authorization number:**       |
| **Counselor’s / OIB Worker’s name:**       |
| **Customer’s name:**       | **Customer’s Case ID:**       |
| **Total training hours approved at assessment:**      **Total training hours provided to date:**      **Training hours provided this month:**      **Training hours requested for next service authorization:**       |
| **Training**   |
| For each of the skills area trained, include the date of lesson, location, hours and a brief description of the lesson provided.   |
| **Basic Cane Skills area**  | **Date of lesson** | **Location** | **Hours** | **Brief description** |
| Open palm grip |       |       |       |       |
| Pencil grip |       |       |       |       |
| Walking in step |       |       |       |       |
| Touch and drag/two point touch |       |       |       |       |
| Stairs |       |       |       |       |
| Picking up dropped objects |       |       |       |       |
| Cane storage (including vehicles) |       |       |       |       |
| Seating |       |       |       |       |
| Entering and exiting doors |       |       |       |       |
| Introduction to sidewalk travel, driveways, and curb travel |       |       |       |       |
| Other, please specify |       |       |       |       |
| **Basic cane skills training hours recommended:**      | **Hours completed for the month.**      |
| **Indoor Skills Area**  | **Date of lesson** | **Location** | **Hours** | **Brief description** |
| Straight line travel |       |       |       |       |
| Indoor numbering systems |       |       |       |       |
| Orientation |       |       |       |       |
| Problem solving |       |       |       |       |
| Stairs, escalators, and elevators |       |       |       |       |
| Locating objectives in unfamiliar places |       |       |       |       |
| Finding intersecting hallways |       |       |       |       |
| Soliciting information |       |       |       |       |
| Malls, grocery sores, small shops,bus and train stations, etc. |       |       |       |       |
| Other, please specify |       |       |       |       |
| **Indoor skills training hours recommended**:      | **Hours completed for the month:**      |
| **Outdoor Skills Area**  | **Date of lesson** | **Location** | **Hours** | **Brief description** |
| Address system |       |       |       |       |
| Sun cues |       |       |       |       |
| Traffic |       |       |       |       |
| Orientation |       |       |       |       |
| Problem solving |       |       |       |       |
| Soliciting information |       |       |       |       |
| Parking lots |       |       |       |       |
| Transportation systems such as buses, paratransit, and communicating with drivers |       |       |       |       |
| Other, please specify |       |       |       |       |
| **Outdoor skills training hours recommended:**      | **Hours completed for the month:**      |
| **Intersection Skills area**  | **Date of lesson** | **Location** | **Hours** | **Brief description** |
| Approaching |       |       |       |       |
| Analyzing |       |       |       |       |
| Alignment |       |       |       |       |
| Lights |       |       |       |       |
| Nonlights |       |       |       |       |
| Actuated |       |       |       |       |
| Automatic |       |       |       |       |
| Crossing |       |       |       |       |
| Crowns |       |       |       |       |
| Challenging traffic (heavy turn lanes, light traffic at busy intersections, night time) |       |       |       |       |
| Correcting veering |       |       |       |       |
| Other, please specify |       |       |       |       |
| **Intersection skills training hours recommended:**      | **Hours completed for the month:**      |
| **Extra Skills Area**  | **Date of lesson** | **Location** | **Hours** | **Brief description** |
| College campus |       |       |       |       |
| Rural travel |       |       |       |       |
| Airport, train, and bus terminals |       |       |       |       |
| Others as needed, please specify |       |       |       |       |
| **Extra skills training hours recommended:**      | **Hours completed for the month:**      |
| **Additional Comments**   |
| Height of customer:      Height of cane used for training:       |
| Any additional comments or requests for support, if any. Include any travel aids customer uses or may benefit from using:       |
| **Certification**   |
| I certify that all lessons for VR or OIB customers were conducted per SFP 5.4.1: Orientation and Mobility Training Service Description.   Give exact dates of lessons that did not meet the standards, and attach a copy of the written approval sent by the customer’s counselor/OIB worker.       |

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| **Provider Signatures**  |
| **Orientation and Mobility Specialist 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 Orientation and Mobility Specialistas 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**:       |
| **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/OIB Worker)     |
| **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 number of training hours provided in each training area.  | [ ]  Yes [ ]  No |
| Verified that group training was provided to a maximum of three customers.  | [ ]  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/OIB Worker Review**  |
| Verified that the detailed narrative of each skills area addressed during the reporting period and the training location for each lesson and a detailed explanation of anticipated training for the upcoming month is completed.   | [ ]  Yes [ ]  No |
| Verified that any deviation from assessment recommendations is explained. | [ ]  Yes [ ]  No |
| Verified that a detailed narrative of cumulative progress is included if training is completed.  | [ ]  Yes [ ]  No |
| **By typing or printing your name, the VRC/OIB Worker 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 satisfaction with services received.

[ ]  **Approve to pay invoice** [ ]  **Do not approve to pay invoice** |
| **VR Counselor/OIB Worker:**        | Date:       |