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| **Texas Workforce Solutions logo** | **Texas Workforce Commission****Vocational Rehabilitation Services****Vocational Training Specialized Training Plan**   |
| **General Information** |
| **Customer name:**       | **VRS case ID:**       |
| **Service authorization number(s):**       | **Date training plan created or updated:**       |
| **Training Plan**  |
| **Area(s) to be addressed in goals and objectives:** |
| [ ]  Balancing life and work[ ]  Career exploration[ ]  Child care management[ ]  Community resources[ ]  Conflict resolution[ ]  Daily living skills [ ]  Other:       | [ ]  Decision making[ ]  Disability awareness[ ]  Effective communication [ ]  Financial management[ ]  Goal setting [ ]  Grooming and hygiene[ ]  Other:       | [ ]  Household management[ ]  Independent living[ ]  Interpersonal communication[ ]  Leadership[ ]  Stress management[ ]  Other:      [ ]  Other:       |
| **Goal 1:**       |
| **Objectives:** | **Date Set:** | **Projected Achievement Date:** | **Date Achieved:** |
| **A:**       |       |       |       |
| **B**:       |       |       |       |
| **C**:       |       |       |       |
|  **Activities and interventions:**       |
| **Description of abilities at entrance of training:**      |
| **Goal 2:**       |
| **Objectives:** | **Date Set:** | **Projected Achievement Date:** | **Date Achieved:** |
| **A:**       |       |       |       |
| **B**:       |       |       |       |
| **C**:       |       |       |       |
|  **Activities and Interventions:**       |       |       |       |
| **Description of abilities at entrance of program:**      |
| **Goal 3:**       |
| **Objectives:** | **Date Set:** | **Projected Achievement Date:** | **Date Achieved:** |
| **A:**       |       |       |       |
| **B**:       |       |       |       |
| **C**:       |       |       |       |
|  **Activities and Interventions:**       |
| **Description of abilities at entrance of program:**      |
| **Goal 4:**       |
| **Objectives:** | **Date Set:** | **Projected Achievement Date:** | **Date Achieved:** |
| **A:**       |       |       |       |
| **B**:       |       |       |       |
| **C**:       |       |       |       |
|  **Activities and Interventions:**       |
| **Description of abilities at entrance of program:**      |
| **Goal 5:**       |
| **Objectives:** | **Date Set:** | **Projected Achievement Date:** | **Date Achieved:** |
| **A:**       |       |       |       |
| **B**:       |       |       |       |
| **C**:       |       |       |       |
|  **Activities and Interventions:**       |
| **Description of abilities at entrance of program:**      |
| **Recommendations**  |
| **Number of VAT hours requested:****Week 1:**       **Week 2:**       **Week 3:**       **Week 4:**      **Grand of total of hours for month** **Justification for VAT hours:**       |
| VR3135A or VR3136 completed and attached: **[ ]  Yes** **[ ]  No** |
| **Additional Comments** |
| **Additional comments, if any:**      |

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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:       |
| **Vocational Adjustment 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 a Personal Social Adjustment Trainer and/or Work Adjustment Trainer as described in the VR‑SFP or Service Authorization; and
* I signed my signature and entered the date below.
 |
| **Vocational Adjustment Trainer 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 |

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| **TWC Vocational Counselor Signature**  |
| **By signing below, I, the VR Counselor, agree with the goals and objectives in the above Training Plan.**   |
| **VR Counselor typed name**:      | **VR Counselor signature:****X**   | **Date:**      |