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| **Texas Workforce Solutions logo** | | | | | | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Personal Social Adjustment Training (PSAT) and**  **Work Adjustment Training (WAT) Evaluation** | | | | | | | | | | | | |
| **General Information** | | | | | | | | | | | | | | | | | | | | |
| **Customer name:** | | | | | | | | | | | | **VRS Case ID:** | | | | | | | | |
| **Associated service authorization number**: | | | | | | | | | | | | | | | | | | | | |
| **Evaluation Completed for:** Personal Social Adjustment Training Work Adjustment Training | | | | | | | | | | | | | | | | | | | | |
| **Training facilitated**: (Check all that apply) **Note:** WAT Evaluation must be provided in person.  In a group setting (maximum of six customers for each trainer)  In an individual setting (one trainer to one customer)  A combination of group and individual settings  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 | | | | | | | | | | | | | | | | | | | | |
| **If evaluation is facilitated in a group setting, record the VRS case IDs of all customers who participated in the group session(s).** | | | | | | | | | | | | | | | | | | | | |
| 1. | | | 2. | | | 3. | | | | | | | | 4. | | | | 5. | | |
| 6. | | | 7. | | | 8. | | | | | | | | 9. | | | | 10. | | |
| **Attendance** | | | | | | | | | | | | | | | | | | | | |
| **Instructions:**   * For each week of the training, enter the date (mm/dd/yy) of Monday through Sunday in the date column. * For each day of the week, record the number of hour(s) the customer participated by using: * the quarter hour system (.25 increments where .25 = 15 minutes, .50 = 30 minutes, .75 = 45 minutes, and 1.0 = 60 minutes)or * the time keeping system used by the WAT employer. * If customer is absent from the training, record an “A” for the day missed. * Notify the counselor immediately whe the customer is absent. * Total the number of hours that the customer attended the evaluation. | | | | | | | | | | | | | | | | | | | | |
| **Week** | **Date** (Mon-Sun) | **Monday** | | **Tuesday** | | | **Wednesday** | | | | **Thursday** | | | | **Friday** | | **Saturday** | | | **Sunday** |
| 1 |  |  | |  | | |  | | | |  | | | |  | |  | | |  |
| 2 |  |  | |  | | |  | | | |  | | | |  | |  | | |  |
| 3 |  |  | |  | | |  | | | |  | | | |  | |  | | |  |
| 4 |  |  | |  | | |  | | | |  | | | |  | |  | | |  |
| 5 |  |  | |  | | |  | | | |  | | | |  | |  | | |  |
| 6 |  |  | |  | | |  | | | |  | | | |  | |  | | |  |
| **Total number of hours the customer participated in the Evaluation**: | | | | | | | | | | | | | | | | | | | | |
| **Areas to be Evaluated** (based on referral) | | | | | | | | | | | | | | | | | | | | |
| **Personal Social Adjustment Training** | | | | | | | | | | | | | | | | | | | | |
| Acceptable work behaviors  Appropriate use of time and schedule management  Conflict resolution  Developing or restoring self-confidence  Developing socially acceptable behaviors  Disability management  Establishing basic etiquette  Other: | | | | | | | | | | Personal appearance and grooming  Personal health and hygiene  Self-advocacy skills  Self-evaluation  Social relationships  Time/schedule management  Workplace interaction  Other: | | | | | | | | | | |
| **Work Adjustment Training** | | | | | | | | | | | | | | | | | | | | |
| Acceptance of supervision and directions  Daily living skills  Effective communication  Goal setting  Grooming, hygiene, work attire and/or dress code  Motivation  Problem solving  Other: | | | | | | | | | | Self-regulation/reliance  Social skills  Understanding roles and responsibilities in the workplace  Work ethics  Work practices and productivity (including safety and speed)  Work tolerance  Other:  Other: | | | | | | | | | | |
| **Evaluation Summary** | | | | | | | | | | | | | | | | | | | | |
| **Rate the customer’s performance:** | | | | | | | | | | | | | | | | | | | | |
| Ability to learn | | | | | Excellent | | | | Very Good | | | | Good | | | Marginal | | | Poor | |
| Accuracy of work | | | | | Excellent | | | | Very Good | | | | Good | | | Marginal | | | Poor | |
| Accepts assistance | | | | | Excellent | | | | Very Good | | | | Good | | | Marginal | | | Poor | |
| [Adaptability](https://www.southeastern.edu/admin/hr/ee_and_mngr_info/manager_information/ppr_comments.html#adapt) | | | | | Excellent | | | | Very Good | | | | Good | | | Marginal | | | Poor | |
| Appearance and hygiene | | | | | Excellent | | | | Very Good | | | | Good | | | Marginal | | | Poor | |
| Attendance | | | | | Excellent | | | | Very Good | | | | Good | | | Marginal | | | Poor | |
| Communication | | | | | Excellent | | | | Very Good | | | | Good | | | Marginal | | | Poor | |
| Cooperativeness | | | | | Excellent | | | | Very Good | | | | Good | | | Marginal | | | Poor | |
| Initiative | | | | | Excellent | | | | Very Good | | | | Good | | | Marginal | | | Poor | |
| Motivation | | | | | Excellent | | | | Very Good | | | | Good | | | Marginal | | | Poor | |
| Safety practices | | | | | Excellent | | | | Very Good | | | | Good | | | Marginal | | | Poor | |
| Timeliness | | | | | Excellent | | | | Very Good | | | | Good | | | Marginal | | | Poor | |
| **Describe the customer’s ability and willingness to perform skills and tasks for each area identified in the referral including all problematic issues or concerns that emerge. Address all items identified in the referral.** | | | | | | | | | | | | | | | | | | | | |
| **Describe accommodations, compensatory techniques, and special training needs required by the customer.** | | | | | | | | | | | | | | | | | | | | |
| **Evaluations Results:**  No training recommended  Training recommended  **When training is recommended, the VR3137B, Personal Social Adjustment and Work Adjustment Training Plan must be completed and attached.** | | | | | | | | | | | | | | | | | | | | |
| **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: | | | | | | | | |
| **Personal Social Adjustment Trainer or Work Adjustment 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 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. | | | | | | | | |
| **Personal Social Adjustment Trainer Typed or Printed name**: | **Signature:**  (See VR-SFP 3 on Signatures)  **X** | | | | | **Date Signed**: | | |
| **Work 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 | | | | | | | | |
| **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) | | | | | | | | |
| **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 | | | | | | | | |
| **UNTWISE Endorsements:** | | | | | | | | |
| UNTWISE website verifies, for the dates of service, the PSAT or WAT Trainer listed 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 PSAT or WAT Trainer listed 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 |
| Verified the training was provided in the environment(s) (in person, remotely or combination) indicated on the referral form. | | | | | | | | Yes  No |
| When applicable, verify a copy of an approved VR3472 is attached to the report. | | | | | NA  Yes  No | | | |
| Verified 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 that the PSAT or WAT trainer used and documented on the form the  various instructional approaches to meet the customer’s learning styles and preferences | | | | | | | | Yes  No |
| Verified that the PSAT or WAT trainer provided all supplies and resources necessary for the customer  to participate in the training through signature on form or by VR staff member contact with customer | | | | | | | | 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**: | |