Reporting Month and Year:         
 Interim Report  Final Report  Assessment Not Completed  
  
Vendor Company Name:             
Vendor Representative’s Name:              
  
VR Client Name:              
VR Counselor Name:              
DVR Purchase Order #:            
  
Total Hours on Purchase Order for TWE:            
TWE Hours Used During Reporting Month:

**Assessment Site Information**

Name of Site #1/Employer’s Name:              
Location/Address:              
Job Position Assessed:              
Job Position Responsibilities:      

Name of Site #2/Employer’s Name:              
Location/Address:              
Job Position Assessed:              
Job Position Responsibilities:

Enter the VR Client’s actual days of attendance for the reporting month:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** |
| **Start Time** |  |  |  |  |  |  |  |  |  |  |  |
| **End Time** |  |  |  |  |  |  |  |  |  |  |  |
| **Hours** |  |  |  |  |  |  |  |  |  |  |  |
| **Location:** | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R V | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R |
|  | | | | | | | | | | | |
| **Date** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** |
| **Start Time** |  |  |  |  |  |  |  |  |  |  |  |
| **End Time** |  |  |  |  |  |  |  |  |  |  |  |
| **Hours** |  |  |  |  |  |  |  |  |  |  |  |
| **Location:** | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R V | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R |
|  | | | | | | | | | | | |
| **Date** | **23** | **24** | **25** | **26** | **27** | **28** | **29** | **30** | **31** |  |  |
| **Start Time** |  |  |  |  |  |  |  |  |  |  |  |
| **End Time** |  |  |  |  |  |  |  |  |  |  |  |
| **Hours** |  |  |  |  |  |  |  |  |  |  |  |
| **Location:** | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R V | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R | BIH  OI  V/R |  |  |

Evaluate how any of the follow affect the VR Client’s ability to attend work, complete work tasks, concentrate, operate heavy machinery, learn new tasks and/or communicate, etc.:

Prescribed Medications:              
Vision (Difficulty Seeing):

Hearing (Difficulty Hearing):

Mobility (Restrictions on Mobility):

Provide information specific to the VR Client's performance in the following core areas, documenting accommodations provided, functional limitations, and recommended interventions, if any, to enable the VR Client to obtain and maintain competitive, integrated employment. If a given area is not applicable, type "N/A."

1. **Communication**

Observations (at a minimum, include barriers to employment identified, VR Client's abilities and capacity to perform in work situations):      

Accommodations/Support provided:

Recommended supports, interventions, or accommodations for successful employment outcome:

1. **Teamwork**

Observations (at a minimum, include barriers to employment identified, VR Client's abilities and capacity to perform in work situations):

Accommodations/Support Provided:

Recommended supports, interventions, or accommodations for successful employment outcome:

1. **Critical Thinking and Problem Solving**

Observations (at a minimum, include barriers to employment identified, VR Client's abilities and capacity to perform in work situations):

Accommodations/Support Provided:

Recommended supports, interventions, or accommodations for successful employment outcome:

1. **Task and Time Management**

Observations (at a minimum, include barriers to employment identified, VR Client's abilities and capacity to perform in work situations):      

Accommodations/Support Provided:

Recommended supports, interventions, or accommodations for successful employment outcome:

1. **Attendance**

Observations (at a minimum, include barriers to employment identified, VR Client’s abilities and capacity to perform in work situations):

Accommodations/Support Provided:

Recommended supports, interventions, or accommodations for successful employment outcome:

1. **Managing symptoms or effects of disability**

Observations (at a minimum, include barriers to employment identified, VR Client's abilities and capacity to perform in work situations):

Accommodations/Support Provided:

Recommended supports, interventions, or accommodations for successful employment outcome:

1. **Appearance/ Hygiene**

Observations (at a minimum, include barriers to employment identified, VR Client’s abilities and capacity to perform in work situations):

Accommodations/Support Provided:

Recommended supports, interventions, or accommodations for successful employment outcome:

1. **Self-Management**

Observations (at a minimum, include barriers to employment identified, VR Client's abilities and capacity to perform in work situations):

Accommodations/Support Provided:

Recommended supports, interventions, or accommodations for successful employment outcome:

**Results of Trial Work Experience Assessment (To Be Completed on Final Report)**

Is the VR Client capable of participating in Competitive Employment in an integrated setting?

Yes - If applicable, comments:

No - Comment on the clear and convincing evidence that led to this conclusion:

Unable to determine, needs further evaluation - Provide recommendations:

Will the VR Client benefit from additional VR services in terms of an employment outcome due to the severity of the disability?

Yes - If applicable, comments:

No - If applicable, comments:

N/A due to VR Client being unable to participate in employment - If applicable, comments:

If services are finished and a Final Report was not completed, explain why:

VR Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

VR Client Guardian/Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

(if applicable):

Other (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Vendor Representative Signature: Date:

VR Counselor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: