Reporting Month and Year:
[ ]  Final Report [ ]  Assessment Not Completed

Vendor Company Name:

Vendor Representative’s Name:

VR Client Name:

VR Counselor Name:

DVR Purchase Order #:

Assessment Start Date in the Month:

Assessment End Date in the Month:

***\*\*Vendor Representative shall complete all fields and write N/A if not applicable.\*\****

VR Counselor’s Reasons for Referral, Question(s), and Pertinent Background Information:

VR Client’s Stated Vocational Goal:

Identify the barriers confronted by the VR Client in the following areas, if applicable:

[ ]  Employment:

[ ]  Education:

[ ]  Independent Living:

**Assessment Information**
Description of Assessment(s) completed:
Functional Information about the System, Environment or Site that the VR Client uses or will use, including Limitations:

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. **Mobility**

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

Functional information of the system, environment and or/site the VR Client uses/will use:

Accommodations/ Support provided:

Recommended supports, interventions or accommodations for successful employment outcome:

1. **Communication**

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

Functional information of the system, environment and or/site the VR Client uses/will use:

Accommodations/ Support provided:

Recommended supports, interventions or accommodations for successful employment outcome:

1. **Personal Care**

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

Functional information of the system, environment and or/site the VR Client uses/will use:

Accommodations/ Support provided:

Recommended supports, interventions or accommodations for successful employment outcome:

1. **Self-Direction**

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

Functional information of the system, environment and or/site the VR Client uses/will use:

Accommodations/ Support provided:

Recommended supports, interventions or accommodations for successful employment outcome:

1. **Interpersonal Skills**

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

Functional information of the system, environment and or/site the VR Client uses/will use:

Accommodations/ Support provided:

Recommended supports, interventions or accommodations for successful employment outcome:

1. **Work Tolerance**

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

Functional information of the system, environment and or/site the VR Client uses/will use:

Accommodations/ Support provided:

Recommended supports, interventions or accommodations for successful employment outcome:

1. **Work Skills**

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

Functional information of the system, environment and or/site the VR Client uses/will use:

Accommodations/ Support provided:

Recommended supports, interventions or accommodations for successful employment outcome:

1. **Self-Management**

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

Functional information of the system, environment and or/site the VR Client uses/will use:

Accommodations/ Support provided:

Recommended supports, interventions or accommodations for successful employment outcome:

**Results and Recommendations of Assistive Technology Basic Functional Assessment**

Will the VR Client benefit from Rehabilitation Engineering?

 [ ]  Yes [ ]  No

 If Yes, please explain and provide your recommendations:

Will the VR Client benefit from Assistive Technology (AT) and/or Assistive Technology (AT) Devices?

 [ ]  Yes [ ]  No

 If Yes, please explain and provide your detailed recommendations of the specifications for a device, system, trained skill, or service with justification, including advantages over other options, how it addresses the VR Client’s functional limitations and vocational goals, maintenance cost, cost/benefits, and recourse for recommended Assistive Technology devices:

 If Yes for Assistive Technology (AT) Device(s), please provide the three (3) alternatives considered for AT Device(s) recommendation, including a comparison of features, future expansion capabilities, cost, reliability, etc.:

 If fewer options are considered, please provide explanation:

 Is cost of Assistive Technology Device(s) $4,999.00 or higher? [ ]  Yes [ ]  No

  *\*If yes, include/attach device bids.*

Please confirm if Assistive Technology Device(s) have a warranty: [ ]  Yes [ ]  No

 If yes, please describe:

Will the VR Client benefit from Assistive Technology (AT) Services?

 [ ]  Yes [ ]  No

 If Yes, please explain and provide your recommendations:

 Are there requirements for delivering the service (i.e., warranty requirements, maintenance of device, training of the VR Client, their family members, employer, etc.):

 [ ]  Yes [ ]  No

 If yes, please explain:

 Are there necessary modifications to the device/systems or site? [ ]  Yes [ ]  No

 If yes, please explain and include any additional follow-up schedule and potential providers:

Vendor Representative Signature: Date: