Consultation and Planning Meeting Date:

Consultation and Planning Meeting Start Time:

Consultation and Planning Meeting End Time:

Vendor Company Name:

Vendor Representative’s Name:

VR Client Name:

VR Counselor Name:

DVR Purchase Order #:

**Recommendations of Assistive Technology Functional Assessment**

Will the VR Client benefit from Rehabilitation Engineering?

 [ ]  Yes [ ]  No

 Recommended Rehabilitation Engineering for DVR approval:

 Please document what was discussed during the Consultation and Planning meeting:

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

 [ ]  Yes [ ]  No

Recommended Assistive Technology (AT) and/or Assistive Technology (AT) Devices for DVR approval:

 Please document what was discussed during the Consultation and Planning meeting:

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

 [ ]  Yes [ ]  No

Recommended Assistive Technology (AT) Services for DVR approval:

 Please document what was discussed during the Consultation and Planning meeting:

 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 document what was discussed during the Consultation and Planning meeting:

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

 If yes, please document what was discussed during the Consultation and Planning Meeting, including any additional follow-up schedule and potential providers:

1. **SPECIFIC SERVICE OBJECTIVES**

Describe each specific service objective using clear and measurable terms for Rehabilitation Engineering, if applicable:

**Service Objective #1**:

**Service Objective #2**:

**Service Objective #3**:

Anticipated Number of Hours total for Rehabilitation Engineering:

Anticipated location of training (i.e., Virtual, In-Person at Client’s Workplace, etc.):

Anticipated Completion Date for Rehabilitation Engineering:

Describe each specific service objective using clear and measurable terms for Assistive Technology (AT) and/or Assistive Technology (AT) Devices, if applicable:

**Service Objective #1**:

**Service Objective #2**:

**Service Objective #3**:

Anticipated Number of Hours total for Assistive Technology/Assistive Technology Devices:

Anticipated location of training (i.e., Virtual, In-Person at Client’s Workplace, etc.):

Anticipated Completion Date for Assistive Technology/Assistive Technology Devices:

Describe each specific service objective using clear and measurable terms for Assistive Technology (AT) Services, if applicable:

**Service Objective #1**:

**Service Objective #2**:

**Service Objective #3**:

Anticipated Number of Hours total for Assistive Technology Services:

Anticipated location of training (i.e., Virtual, In-Person at Client’s Workplace, etc.):

Anticipated Completion Date for Assistive Technology Services:

1. **Anticipated Purchase Order Planning:**

Total Number of Training Hours Requested, per month:

Total Number of Service Months Required to complete Action Plan:

Total Number of Training Hours Requested to complete Action Plan:

Additional Comments/Feedback/Notes:

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

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

(if applicable):

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

Vendor Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

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