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| Texas Workforce Solutions Logo. | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Referral for Personal Social Adjustment Training and**  **Work Adjustment Training** | | | | | | | | | | |
| **General Instructions** | | | | | | | | | | | |
| **Follow the instructions below when completing this form:**   * Complete the form electronically answering all questions. * VR counselor must evaluate each customer’s case to determine when remote services are in the best interest of the customer and whether the customer has access to required resources and has the skills necessary for effective use. * VR counselor will indicate under each service how the service must be delivered. Some services are not allowed to be conducted remotely. Below is a description of how services can be conducted: * In-person (with the staff and customer(s) at the same physical location) * Remotely training (using a computer-based training platform that allows for face-to-face and/or real time interaction, Refer to VR-SFP 3on Remote Service Delivery for requirements) * Combination, in person and remotely training. * Before faxing, emailing encrypted, or mailing to the provider, review this form to ensure that all questions have been answered.   **Note**:The TWS-VRS staff collects the information and completes **all** sections of this form. | | | | | | | | | | | |
| **Referral Information** | | | | | | | | | | | |
| **Date of the Referral:**  **Referral for:** (check all services that apply)  **Personal Social Adjustment Evaluation and Training**  Skills to be included in the evaluation and training plan: (check all skills to be evaluated) | | | | | | | | | | | |
| 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 | | | | | | | | | Personal appearance and grooming  Personal health and hygiene  Self-advocacy skills  Self-evaluation  Social relationships  Time/schedule management  Workplace interaction | | |
| Others: Specify:  VR counselor approves the training to be provided: (check one)  In person  Remotely  Combination, in person and remotely | | | | | | | | | | | |
| **Work Adjustment Evaluation and Training** (check all skills to be evaluated)  **WAT cannot be conducted remotely.**  Skills to be included in the evaluation and training plan: | | | | | | | | | | | |
| Acceptance of supervision and directions  Daily living skills  Effective communication  Goal setting  Grooming, hygiene, work attire and/or dress code  Motivation | | Problem solving  Self-regulation/reliance  Social skills  Understanding roles and responsibilities in the workplace  Work ethics  Work practices and productivity (including safety and speed)  Work tolerance | | | | | | | | | |
| Others: | | | | | | | | | | | |
| **Customer Identification Information** | | | | | | | | | | | |
| **Customer name:** | | | | | | | | | | | |
| **Street address** (include apartment number, if any): | | | | | | | | | | | |
| **City:** | | | | | | | **State:** | | | | **ZIP code**: |
| **Primary contact number:**  (   ) | | | | | | | **Secondary contact number, if any:**  (   ) | | | | |
| **Email address:** | | | | | | | | | | | |
| **VRS case ID:** | | | | | | | **Date of birth:** | | | | |
| **Customer disability:** | | | | | | | | | | | |
| **Parent/Guardian Information (For Minors Only)** | | | | | | | | | | | | |
| N/A- no guardian | | | | | | | | | | | | |
| **Parent/Guardian’s name:** | | | | | | | | | | | | |
| **Parent/Guardian’s primary contact number:**  (   ) | | | | | | | **Parent/Guardian’s secondary contact number, if any:**  (   ) | | | | | |
| **Parent/Guardian’s email:** | | | | | | | | | | | | |
| **Alternate Contact Person Identification Information** | | | | | | | | | | | | |
| **Alternate contact’s name, if any:** | | | | | | | | | | | | |
| **Alternate contact’s primary contact number:**  (   ) | | | | | | **Alternate contact’s secondary contact number:**  (   ) | | | | | | |
| **Additional Information Provided by VRS at Referral** | | | | | | | | | | | | |
| **Select all that apply.** | | | | | | | | | | | | |
| IPE copy  Medical and/or psychological reports  Case notes (for example: eligibility, assessment, and planning)  Vocational testing | | | | | | | | | Work history collected by VRS  Work references collected by VRS  Other:  Other: | | | |
| **Counselor Contact Information** | | | | | | | | | | | | |
| **Counselor name:** | | | | | | | | | | | | |
| **Counselor primary TWS-VRS office:** | | | | | | | | | | | | |
| **Counselor TWS-VRS office street address** (include suite number, if any): | | | | | | | | | | | | |
| **City:** | | | | **State:** | | | | | | | **ZIP code:** | |
| **Counselor’s primary contact number:**  (   ) | | | | **Counselor’s secondary contact number:**  (   ) | | | | | | | | |
| **Email address:** | | | | | | | | | | | | |
| **Provider Chosen by the Customer** | | | | | | | | | | | | |
| **Provider name**: | | | | | | | | | | | | |
| **Email address**: | | | | | | | | | | | | |
| **Provider phone number**:  (   ) | | | | | **Provider fax number**:  (   ) | | | | | | | |
| **Additional Comments** | | | | | | | | | | | | |
| **Additional Comments, if any**: | | | | | | | | | | | | |