

**VR-142X**

**Driver Rehabilitation Services**

**142X-Vendor Travel for Driver/Vehicle Evaluation for Training Implementation**

|  |  |  |
| --- | --- | --- |
| AV#: | (7 digits) | Click to enter |
| ACCES-VR ID#: | (6 digits) | Click to enter |
| CAMS ID #: | (10 digits) | Click to enter |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| VR District Office: | Click to enter | Provider: | Click to enter | | |
| VRC Name: | Click to enter | NYS Fiscal System ID: | | | Click to enter |
|  | | Report Month: | | Click to enter | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Participant First Name: | Click to enter | | Participant Last Name: | Click to enter |
| Participant Phone Number: | | Click to enter | | |
| Participant Email Address: | | Click to enter | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Is the travel required for this participant to accomplish authorized evaluation or training over 35 miles each way?** | | | | | | | | | |
| If no, this travel is not eligible for reimbursement. | | | | | | | | | |
|  |  | Yes |  | No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Has this service been discussed with the VRC to establish the necessity of this travel?** | | | | | | | | | |
|  |  | Yes |  | No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Is actual mileage and estimated travel time obtained from a valid source and documented within this participant’s record?** | | | | | | | | | |
|  |  | Yes |  | No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Has this service been authorized in tandem with each hour of Driver Rehabilitation Services** (max 10 hours**)?** | | | | | | | | | |
|  |  | Yes |  | No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Units of Service Used this Month:** | | | | | Click to enter | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Identified Outcome:** | | | |  |  |  |  |  |  |
| Click to enter | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |
| **Describe Progress to Date:** | | | | |  |  |  |  |  |
| Click to enter | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |
| **Recommended Next Steps to Reach Identified Outcome:** | | | | | | | | | |
| Click to enter | | | |  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Completed By:** | | | | |
|  | |  | Click to enter | |
| Qualified Staff Signature | |  | Date |  |
| Click to enter | |  | Click to enter | |
| Printed Name |  |  | Title |  |
| Phone Number: | Click to enter |  | Email: | Click to enter |