

**VR-165X**

**Assistive Technology/Rehabilitation Technology**

**165X- Assistive Technology/Rehabilitation Technology Evaluation**

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

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

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| **Total Units of Service Provided:** | | | | | Click to enter | | | | | | | | | | |
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| **Total Units of Service Authorized:** | | | | | Click to enter | | | | | | | | | | |
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| **Functional Limitations:** | | | Click to enter | | | | | | | | | | | | |
|  |  |  |  | |  | |  |  | | |  | |  | |  |
| **Vocational Goal:** | | Click to enter | | | | | | | | | | | | | |
|  |  |  |  | |  | |  |  | | |  | |  | |  |
| **Impediments to Achieving Vocational Goal:** | | | | | | | | |  |  | |  | |  | |
| Click to enter | | | | | | | | | | | | | | | |
|  |  |  |  | |  | |  |  | | |  | |  | |  |
| **Focus Area of Evaluation:** | | | | Click to enter | | | | | | | | | | | |
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| **Will the use of rehabilitation technology be effective?** | | | | | | | | | | | | | | | |
|  |  |  |  | |  | | Yes |  | | | No | |  | |  |
| Please explain and provide details: | | | | | |  | | |  |  | |  | |  | |
| Click to enter | | | | | | | | | | | | | | | |
|  |  |  |  | |  | |  |  | | |  | |  | |  |
| **Have any assistive devises or related services been identified?** | | | | | | | | | | | | | | | |
|  |  |  |  | |  | | Yes |  | | | No | |  | |  |
| Please explain and provide details: | | | | | |  | | |  |  | |  | |  | |
| Click to enter | | | | | | | | | | | | | | | |
|  |  |  |  | |  | |  |  | | |  | |  | |  |
| **Additional Information:** | | | Click to enter | | | | | | | | | | | | |
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| **Was this report completed within 10 days of the last service?** | | | | | | | | | | | | | | | |
|  |  |  |  | |  | | Yes |  | | | No | |  | |  |
| Date of Last Service: | | Click to enter | | | | | | | | | | | | | |
| If No, please explain: | | | Click to enter | | | | | | | | | | | | |
|  |  |  |  | |  | |  |  | | |  | |  | |  |

Was the ACCES-VR VRC offered a chance to attend a conference at the conclusion of the service? (Maintain documentation of this in the participant record.)

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|  | Yes |  | No | Click to enter |
|  |  |  |  | Date |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 |