VR-165X

Assistive Technology/Rehabilitation Technology

165X- Assistive Technology/Rehabilitation Technology Evaluation

AV#:	(7 digits)
ACCES-VR ID#:	(6 digits)
CAMS ID #:	(10 digits)

VR District Office:	Provider:
VRC Name:	NYS Fiscal System ID:
	Report Date:

Participant First Name:	Participant Last Name:
Participant Phone Number:	
Participant Email Address:	

Total Units of Service Provided:

Total Units of Service Authorized:

Functional Limitations:

Vocational Goal:

Impediments to Achieving Vocational Goal:

Focus Area of Evaluation:

Will the use of rehabilitation technology be effective?

☐ Yes ☐ No

Please explain and provide details:

Have any assistive devises or related services been identified?

☐ Yes ☐ No

Please explain and provide details:

Form Revised Date: 11/1/18

Additional Information:

Was this report completed within 10 days of the last service?

☐ Yes ☐ No

Date of Last Service:
If No, please explain:

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.)

☐ Yes ☐ No _____
Date

Completed By:

_____ _____
Qualified Staff Signature Date

_____ _____
Printed Name Title

Phone Number: Email: