

**VR-167X**

**Assistive Technology/Rehabilitation Technology**

**167X-Assistive Technology/Rehabilitation Technology Training**

|  |  |  |
| --- | --- | --- |
| 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 | | | | | | | | | |
|  |  |  |  |  |  | |  | |  | |  | |  |
| **Total Units of Service Authorized:** | | | | Click to enter | | | | | | | | | |
|  |  |  |  |  |  | |  | |  | |  | |  |
| **Dates of Training:** | | Click to enter | | | | | | | | | | | |
|  |  |  |  |  |  | |  | |  | |  | |  |
| **Location of Training:** | | | Click to enter | | | | | | | | | | |
|  |  |  |  |  |  | |  | |  | |  | |  |
| **Pertinent Background:** | | | Click to enter | | | | | | | | | | |
|  |  |  |  |  |  | |  | |  | |  | |  |
| **Effectiveness of Current Accommodation and Application:** | | | | | | | | | | | | | |
| Click to enter | | | | | | | | | | | | | |
|  |  |  |  |  |  | |  | |  | |  | |  |
| **Evaluation/Assessment Process:** | | | | | |  | |  | |  | |  | |
| Click to enter | | | | | | | | | | | | | |
|  |  |  |  |  |  | |  | |  | |  | |  |
| **Recommendation:** | |  |  |  |  | |  | |  | |  | |  |
| Click to enter | | | | | | | | | | | | | |
|  |  |  |  |  |  | |  | |  | |  | |  |
| **Additional Information:** | | | Click to enter | | | | | | | | | | |
|  |  |  |  |  |  | |  | |  | |  | |  |
| **Was this report completed within 10 days or the last service?** | | | | | | | | | | | | | |
|  |  |  |  |  | Yes | |  | | No | |  | |  |
| Last Date of Service: | |  | Click to enter | | | | | | | | | | |
| If no, please explain: | | | Click to enter | | | | | | | | | | |
|  |  |  |  |  |  | |  | |  | |  | |  |

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