VR-165X

Assistive Technology / Rehabilitation Technology

Assistive Technology / Rehabilitation Technology Evaluation

Authorization #	
Aware Participant ID	

VR District Office:	Vendor:
VRC Name:	SFS Vendor ID:
	Report Date:

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

Assistive Technology Evaluation Details
Number of Hours Authorized: **Number of Hours Used:** ***Note:*** Unit = 1 Hour (20 Max) **Employment Outcome:** **Please indicate the Impediments to Achieving the Employment Outcome:** **Please describe how the assistive technology device(s) and/or service(s),recommended in the report, will address the customer's functional limitations in terms of participation in training and/or other services needed to assist in meeting their employment outcome.**

Revised: 2/5/2024

Additional Information and Recommendations:

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

☐ Yes ☐ No

If not, please explain:

Was the VRC offered a chance to attend a conference at the conclusion of the service?
(Maintain documentation of this in the customer record)

☐ Yes ☐ No

Completed By:

Printed Name Title

Phone: Email: