Adjunct Services

M - Mobility Training

Authorization #	
Aware Participant ID	

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

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

Mobility Services Details Unit of service = 1 Hour
Hours used for this Report:
Total Hours Authorized:
Date ACCES-VR referral received:
Training Dates:
Modes of Transportation Identified:
Did Mobility Training begin within 10 business days from referral? ☐ Yes ☐ No
If not, please indicate reason(s):
Describe the type of training provided and the customer's progress in utilizing transportation.
Indicate the travel destinations and how these destinations support the customers employment goal.

Revised: 2/5/2024

Has the Customer gained the understanding and ability to safely travel independently to identified areas and destinations?

☐ Yes ☐ No

If no, please discuss any barriers and your recommendations:

Completed By:

Printed Name

Title

Phone:

Email: