

OOD VR CASE SERVICES INVOICE

TEMPLATE 6: INTAKE

INVOICE DATE: 12/22/15				
INVOICE STATUS: <input checked="" type="checkbox"/> FINAL INVOICE OR <input type="checkbox"/> PARTIAL INVOICE				
VR AUTHORIZATION #: 123456789				
PARTICIPANT NAME: John Q. Participant				
VR STAFF NAME: V.R. Counselor				
PROVIDER NAME, ADDRESS, & TELEPHONE (MUST MATCH EXACTLY AS IT APPEARSON THE VR ORIGINAL AUTHORIZATION & BILLING INVOICE FORM OOD-0020)		Opportunities for Ohioans with Disabilities (OOD) 101 Clinton Street, Suite #1100 Defiance, OH 43512 419.861.8855		
PROVIDER STAFF NAME(S) (IF MULTIPLE STAFF PROVIDED SERVICES THEIR NAMES MUST BE LISTED HERE AND THE REPORT SHOULD CLEARLY INDICATE WHO PERFORMED WORK PER THE VR PROVIDER MANUAL.)		Brutus Buckeye (BB)		
PROVIDER INTERNAL INVOICE # (IF APPLICABLE): INTJQP-1234				
SERVICE START DATE: 12/01/15				
SERVICE END DATE: 12/07/15				
SERVICE NAME: Intake				
SERVICE QUANTITY			R A T E	TOTAL COST
UNITS OF SERVICE BILLED (INDIVIDUAL)	# UOS	Individual Rate		\$0.00
UNITS OF SERVICE BILLED (GROUP)	# UOS	Group Rate		\$0.00
UNITS OF SERVICE BILLED (INDIVIDUAL BILINGUAL)	# UOS	Individual Bilingual Service Rate		\$0.00
UNITS OF SERVICE BILLED (GROUP BILINGUAL)	# UOS			\$0.00
FLAT FEE SERVICE	1	\$120.00		\$120.00
REPORT FEE				\$0.00
MILEAGE BILLED	10	\$0.52		\$5.20
WAGE ADD-ON BILLED (IF APPLICABLE)	# UOS Wages	\$1.02		\$0.00
TRANSPORTATION (IF APPLICABLE)	# UOS # Miles	UOS Rate		\$0.00
EQUIPMENT OR ITEMS (IF APPLICABLE) (MUST BE ITEMIZED. MAY ATTACH ADDITIONAL SHEET(S) IF NECESSARY. TOTAL COST PUT INTO RIGHT COLUMN.) <input type="checkbox"/> CHECK IF ADDITIONAL SHEET(S)	Item 1 Description		Item 1 Cost	\$0.00
	Item 2 Description		Item 2 Cost	
	Item 3 Description		Item 3 Cost	
	Item 4 Description		Item 4 Cost	
	Item 5 Description		Item 5 Cost	
INVOICE TOTAL				\$125.20

PLEASE NOTE: PROVIDERS MUST SUBMIT A PROPER INVOICE, WHICH INCLUDES THE REPORT, WITHIN 15 DAYS OF THE END OF THE SERVICE OR MONTH, WHICHEVER OCCURS FIRST PER THE VR FEE SCHEDULE (OAC 3304-2-52 APPENDIX A).

INTAKE

Instructions: Providers should include a narrative response to the questions below. There are additional “Help Text” available, you may access them by pressing “F1” in the form field, when appropriate. Only Providers who are accredited by the Commission on Accreditation Facilities (CARF), the Joint Commission (JC), and/or the National Accrediting Council (NAC) on organizations serving the Blind and Visually Impaired may charge an Intake Fee per the VR Fee Schedule (OAC 3304-2-52 Appendix A).

Participant’s Name: John Q. Participant

VR Staff Name: V.R. Counselor

Provider Staff Name(s): Brutus Buckeye

Authorization #: 123456789

Date(s), Time, & Location of Intake: 12/07/15 @ 9:30 - 10:30 Opportunities for Ohioans with Disabilities Office (Defiance)

Participant’s preference on how services shall be provided, including but not limited to methods and frequency of contacts, meeting locations, who should be included as part of meetings, etc. (Narrative)

* Participant prefers to communicate via email to set up appointments.

* Participant is willing to meet at the Defiance Office and/or at local public library.

* Participant prefers to meet in person and does not like to talk on the phone due to difficulties hearing on the phone.

* Participant wants to meet weekly to discuss service and set goals for the upcoming week.

* Participant asked that his wife be included in meetings and communications due to difficulty hearing.

Participant did sign a release of information for his wife.

What are the participant’s vocational interests? (Narrative)

Participant does not know what he would like to do for an employment goal. He has discussed a vocational evaluation with his Counselor and that is the reason for the referral today. He indicated that based on the results of the evaluation he may be interested in training or direct job placement. In the past he has worked in the area of human services management, but he is not sure that will be a good option for him moving forward due to handling stress and difficulties hearing. Participant is looking for a position that does not carry over into his personal life from the work environment.

Summary of participant’s disability history, including potential cognitive, physical, and psychological impediments to services and functional limitations. (Narrative)

Participant has a history of hearing loss and anxiety disorder. Participant indicated that he does not have any learning issues and did not participate in special education classes in school. Participant indicated that he does not have any physical impairments that would cause a barrier to employment. Participant stated that he does not use hearing aids. He indicated that his hearing was last tested several years ago and he was on the borderline of hearing aids. Participant indicated that he can hear okay but has trouble with comprehension. He indicates that sometimes he is too embarrassed to ask people to repeat themselves or state that he does not understand. Participant indicated that he has been diagnosed with general anxiety disorder. He indicated that he is currently taking Paxil for anxiety. He indicated that the anxiety causes him difficulties in dealing with new situations, interacting with people, dealing with conflict, and avoidance of certain situations.

Participant’s rights as part of continued participation in provider services. (Narrative)

* Participant has the right to be treated with respect during services. If Participant does not feel that they have been treated with respect they should contact Providers Supervisor and/or their Counselor to discuss the situation.

* Participant has the right to be involved in the decisions about their case. Provider staff will, when possible, follow guidance offered by Participant. If that is not possible, Participant, Provider, and Counselor will discuss the situation.

* Provider will provide an explanation for the purpose of services to Participant before and after services.

* Participant may ask that their case be reassigned to another Provider Staff person.

Participant's education and/or vocational training.

Participant has earned a Bachelor's degree in Business Management. He has also participated in some business leadership trainings and has some professional certificates. He has also worked as a manager in retail sales for the past ten years. Participant is also a member of SHRM (Society for Human Resource Managers).

Potential barriers to services, i.e. criminal history, substance use/abuse, transportation, daycare, etc. and how issues will be resolved to ensure successful services.

Participant reported that they have no criminal history or substance abuse issues. He stated that he has a late model car that is in good condition and will be able to use that to get to and from appointments and/or work. Participant indicated that they have do not have any young kids and would not need any childcare. Participant raised no other potential vocational barriers.

Participant's responsibilities expected outcomes of vocational rehabilitation services?

Responsibility/Outcome	Who will be responsible for it? How will it be measured?
Participant will attend meetings with Provider Staff or call to reschedule at least one day in advance.	Provider & Participant - If Participant misses more than two meetings services will stop until the case can be staffed with his Counselor.
Participant will keep himself "job ready" or notify provider of any changes.	Provider & Participant – If Participant is not able to go for interviews or participant in services for an extended period of time, i.e. a week, he will notify Provider.
Participant will schedule non-VR appointments before or after VR services, when possible.	Provider & Participant If participant misses more than two days of services, he will need to speak with his Counselor before resuming services.
Participant will complete "homework" assignments and be ready to actively participant in services.	If Participant does not complete assignments or is not prepared to actively engage in services, Provider will contact the Counselor to staff the case and decide upon next steps.

Confidentiality:

1. I understand that providers are responsible for keeping information about me confidential.
2. I will be required to sign a written release of information before my provider releases any information about me to any other parties with the exception that information gathered by the provider will be shared with VR staff as the funding source and as part of the services that I receive.

3. I understand providers may be required by law to release information to law enforcement and other parties in certain situations such as, but not limited to, possible concerns about child abuse/neglect or possible concerns about the health and safety of myself or others.

Participant's Signature: John Q Participant

Parent/Guardian's Signature: _____

Date: 12/22/15

Date: _____