

GENERAL INFORMATION:

This Excel file consists of 2 worksheets. Each worksheet is labeled as to its function.

If you are unable to see the tab for the worksheet across the bottom of the screen, click on the maximize button (the center button) located in the upper right-hand corner of the worksheet.

The worksheet is protected to prevent the changing of formulas and formatting features built into the spreadsheets.

You may submit completed forms in an electronic format or printed format. You must ensure that consumer information is protected as required by State and Federal law.

FOR ELECTRONIC FORMATS ONLY: If you submit this form to the regional center electronically, use the following naming standard: Each file must start with the designation of "B" followed by the provider's three digit numerical designation and the month and year. See chart for month designations. For example: B372-JA04 is Form DS 1961 WAP for provider ID# 372 for January 2004.

FOR ELECTRONIC FORMATS ONLY: This form contains information protected under the Health Insurance Portability and Accountability Act (45 C.F.R Parts 160, 162 and 164). **The file must be password protected** to ensure the safety of the consumer's information. Coordinate with the regional center regarding protecting the consumer information contained in this form.

PROVIDER INSTRUCTIONS:**PROVIDER INFORMATION**

Check whether the report is an **Initial**, an **Annual**, or a **Semi-Annual** report.

Date: Enter the date of report in this format mm/dd/yy.

Vendor Name: Enter the name of the agency as vendored by the regional center.

Vendor Number: Enter the agency's number provided by the vendoring regional center.

Address/City/ZIP: Enter the provider's business address, city, and ZIP code. The business street address should be the address the provider uses to conduct all its business activities. If the provider's business address is outside of California, list the two letter state abbreviation in the city field.

Phone: Enter the telephone number, including area code, of the provider. Enter telephone number as XXX XXX-XXXX.

WORK ACTIVITY PROGRAM CONSUMER INFORMATION

Last Name: Enter the consumer's last name.

First Name: Enter the consumer's first name.

UCI: Enter the consumer's seven digit UCI #.

IHSP PARTICIPANTS:

Indicate the names of the individuals who participated in the IHSP meeting.

OBJECTIVES AND PROGRESS

Productivity Rate: Enter the percentage of consumer's productivity each six month period. Enter the consumer's goal and the actual percentage during each period of the program.

Attendance Level: Enter the percentage of consumer's attendance each six month period. Enter the consumer's goal and the actual percentage during each period of the program.

Wages: Enter the percentage of consumer's wages each six months. Enter the consumer's goal and the actual percentage during each period of the program.

Objective #: Enter the objective number and work skills objective

Behavior or Other Work-Related: Enter an "x" in the appropriate box if the objective is based on the consumer's behavior or other work-related issues.

Measurement: State how the the consumer's progress will be recorded in measurable terms.

Goal: State the goal of the objective.

Person Responsible: Provide the name(s) of the staff responsible for the objective services.

Services for Objective: State the services that will be provided to meet the objective's goal.

Current Functioning: State the consumer's current skill level related to the objective.

First Six Month Period: Enter an "x" in the appropriate box during the first six month period whether the consumer met, partially met or did not meet his/her progression goals.

Comments/Summary of Achievements: Provide comments on the consumer's progress. Also provide a summary of any achievements accomplished by the consumer.

Second Six Month Period: Enter an "x" in the appropriate box during the second six month period whether the consumer met, partially met or did not meet his/her progression goals.

Comments/Summary of Achievements: Provide comments on the consumer's progress. Also provide a summary of any achievements accomplished by the consumer.

Continuation sheet (Additional objectives progress: Complete an additional worksheet for each objective as necessary.)

Consumer Signature: Have the consumer sign on this line.

Date: Enter the date the consumer signed the form. Enter date as mm/dd/yy.

Conservator Signature: Have the conservator or designated representative sign on this line.

Date: Enter the date the conservator or designated representative signed the form. Enter date as mm/dd/yy.

Program Staff Signature: Have the program staff person sign on this line.

Date: Enter the date the program staff person signed the form. Enter date as mm/dd/yy.

NOTICE

Read the notice and use the information to safeguard the consumer's information in accordance with the Health Insurance Portability and Accountability Act (45 C.F.R Parts 160, 162 and 164).

DDS Use Only: DDS will complete.

Regional Center ID #:

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|-----|--------|------------------------------------|
| 360 | FDLRC | Frank D. Lanterman Regional Center |
| 361 | GGRC | Golden Gate Regional Center |
| 362 | SDRC | San Diego Regional Center |
| 363 | FNRC | Far Northern Regional Center |
| 364 | ACRC | Alta California Regional Center |
| 365 | SARC | San Andreas Regional Center |
| 366 | TCRC | Tri-Counties Regional Center |
| 367 | CVRC | Central Valley Regional Center |
| 368 | RCOC | Regional Center of Orange County |
| 369 | IRC | Inland Regional Center |
| 370 | RCRC | Redwood Coast Regional Center |
| 371 | NBRC | North Bay Regional Center |
| 372 | KRC | Kern Regional Center |
| 373 | ELARC | East Los Angeles Regional Center |
| 374 | SCLARC | South Central Los Angeles Regional |

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|-----|--------|--|
| 375 | HRC | Harbor Regional Center |
| 376 | WRC | Westside Regional Center |
| 377 | VMRC | Valley Mountain Regional Center |
| 378 | NLACRC | North Los Angeles County Regional Center |
| 379 | SGPRC | San Gabriel/Pomona Regional Center |
| 380 | RCEB | Regional Center of the East Bay |

DOR Vocational Rehabilitation (VR) ID #:

| | | |
|------|----|-------------------------------|
| 2218 | VR | DOR Vocational Rehabilitation |
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Month Designations:

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|----------|----|-------|----|-----------|----|----------|----|
| January | JA | April | AP | July | JL | October | OC |
| February | FE | May | MY | August | AG | November | NO |
| March | MR | June | JN | September | SE | December | DE |