



DIVISION OF VOCATIONAL REHABILITATION (DVR)
INDEPENDENT LIVING SERVICES (IL)
Service Delivery Outcome Report

		AFP NUMBER	
DVR CUSTOMER		SOCIAL SECURITY NUMBER (LAST FOUR DIGITS) XXX-XX-	
IL CONTRACTOR'S NAME		IL REPRESENTATIVE	
DVR COUNSELOR	RATE <input type="checkbox"/> Hourly <input type="checkbox"/> Flat	HOURS BILLED	TOTAL COST \$
IL SERVICE CATEGORY <input type="checkbox"/> IL Work Related Systems Access <input type="checkbox"/> IL Comprehensive Evaluation <input type="checkbox"/> IL Skills Training <input type="checkbox"/> IL Partial Evaluation			
PRE-ETS (PRE-EMPLOYMENT TRANSITION SERVICES) IL SERVICE CATEGORY <input type="checkbox"/> Pre-ETS: IL Self-advocacy			
TIME LINES (OVERALL PLAN) <input type="checkbox"/> Monthly Update From: To: Dates of this Reporting Period: From: To:			
This document is only for reporting purposes. Invoices must be created in a separate document and submitted with this Service Delivery Outcome Report. I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct. (Revised Code of Washington 5.50.050)			
IL REPRESENTATIVE'S SIGNATURE			DATE