

Client Assistance Program [CAP]

Department of Agriculture, Trade, and Consumer Protection

Linda Vegoe, CAP Director

608-224-5070 linda.vegoe@wisconsin.gov

Deb Henderson-Guenther, MS CRC, Complaint Investigator

608-224-5071 deb.hendersonguenther@wisconsin.gov

Toll-free line: 1-800-362-1290 (v/tty)

The Consumer Checklist for the DVR Order of Selection **Waiting List**

A. MOBILITY LIMITATIONS

- | | | | |
|-----|---|-----|----|
| A1. | Are you limited in speed or distance when walking? | Yes | No |
| A2. | Do you require assistance from either a person or a device to walk and/or drive a vehicle? | Yes | No |
| A3. | Is the ability to drive affected by your disability? | Yes | No |
| A4. | Do you require mobility training or help from others in order to get around in the community? | Yes | No |

B. COMMUNICATIONS LIMITATIONS

- | | | | |
|-----|--|-----|----|
| B1. | Is your speech difficult to understand? | Yes | No |
| B2. | Do you need another means of communication such as sign language, lip reading, braille, enlarged print, or a speech board? | Yes | No |
| B3. | Do you have difficulty explaining your needs? | Yes | No |
| B4. | Is it difficult for you to understand what you are reading or to express yourself in writing? | Yes | No |

C. SELF-CARE LIMITATIONS

- | | | | |
|-----|--|-----|----|
| C1. | Do you have difficulty with grooming, hygiene, or dressing yourself? | Yes | No |
| C2. | Do you have problems cooking, shopping, or doing other household chores by yourself? | Yes | No |
| C3. | Do you need help managing your money or managing your time? | Yes | No |
| C4. | Do you need reminders to take your medication? | Yes | No |

D. SELF-DIRECTION LIMITATIONS

- | | | | |
|-----|---|-----|----|
| D1. | Have family, friends, or health care professionals criticized your decisions? | Yes | No |
| D2. | Have you ever been hospitalized to prevent you from hurting yourself or others? | Yes | No |
| D3. | Do you have difficulty following through on things? | Yes | No |
| D4. | Do you have difficulty controlling your own behavior? | Yes | No |

E. LIMITATIONS IN INTERPERSONAL SKILLS OR ACCEPTANCE

- | | | | |
|-----|---|-----|----|
| E1. | Do you feel uncomfortable around other people? | Yes | No |
| E2. | Do you become angry or frustrated easily? | Yes | No |
| E3. | Have you been asked not to return to a place because of your behavior? | Yes | No |
| E4. | Does your disability affect your actions in a way that might be difficult for others to understand? | Yes | No |
| E5. | Does your disability affect your appearance in a way that others may not understand or accept? | Yes | No |

F. WORK TOLERANCE LIMITATIONS

- | | | | |
|-----|--|-----|----|
| F1. | Do you have any restrictions in standing, sitting, bending, lifting, or repetitive motion? | Yes | No |
| F2. | Do you have any restrictions that require frequent rest periods or a flexible work schedule? | Yes | No |
| F3. | Are you restricted from working full time? | Yes | No |
| F4. | Do you require a low stress job with limited responsibilities? | Yes | No |

G. WORK SKILLS LIMITATIONS

- | | | | |
|-----|--|-----|----|
| G1. | Does your disability prevent you from using your work skills or training? | Yes | No |
| G2. | Do you feel your work skills are outdated because your disability has kept you out of the workforce? | Yes | No |
| G3. | Do you need an accommodation to perform the jobs you qualify for? | Yes | No |

After reviewing these questions, what work related functions do you believe are significantly limited by your disability?

- Mobility**
- Communication**
- Self-Care**
- Self-Direction**
- Interpersonal Skills**
- Work Tolerance**
- Work Skills**