

**Client Assistance Program [CAP]**  
**Department of Agriculture, Trade, and Consumer Protection**

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**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 |

## Consumer Checklist page 2

### 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