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| Texas Workforce Solutions logo | **Texas Workforce Commission****Vocational Rehabilitation Services**Diabetes Self-ManagementEducator Notes   |
| **Instructions** |
| * Review previous visit.
* Only describe education provided this visit.
* Set behavior change and education goals for next visit.
* As appropriate, you may use the following abbreviations: NA for “not applicable”, ND for “not disclosed by customer”, or NE for “not evaluated”.
 |
| **Customer Information**   |
| **Customer name:**       | **TWS-VRS Case ID**:      |
| **Counselor name:**       | **Service authorization number:**       |
| **Diabetes Self-Management Education**   |
| **Previous Visit**   |
| **Date of previous visit:**       |
| **What was the behavioral change goal from the previous visit?**       |
| **Did the customer accomplish the behavioral change goal? Describe successes and barriers to change.**       |
| **How did you evaluate the behavioral change goal (return demonstration, verbal feedback, etc.)?**       |
| **What does the customer recall from the previous visit?**      |
| **Was there anything that was difficult for the customer to implement?**      |
| **\*\* AADE7 Self-Care Taught This Visit** | **Describe Education Provided** |
| **Vocational Rehabilitation** |       |
| **Healthy Eating** |       |
| **Being Active** |       |
| **Monitoring** |       |
| **Taking Medications** |       |
| **Healthy Coping** |       |
| **Problem Solving** |       |
| **Reducing Risk** |       |
| **Other Diabetes Concerns** |       |
| **Observations and Comments:**      |
| **Current Blood Glucose Reading:** [ ]  Premeal [ ]  PostmealDate:       Time:       Result:       | **Educational materials provided or community resource referrals:** |
| **Nonvisual training was provided on the following:**       |
| **Educational Setting:** [ ]  Individual [ ]  Group |
| **Behavioral Change Goal for Next Visit**   |
| **Customer will work on this behavioral change goal until our next visit:**      |
| **What will education focus on next visit?**       |
| **Visit date:**      | **Start time:**      | **End time:**      | **Total hours:**      |
| **Hours recommended for next visit:**       |
| **\*\***AADE7 Self-Care is a tool provided by the American Association of Diabetes Educators. The primary goal of diabetes education is to provide knowledge and skill training and to help identify barriers, facilitate problem-solving, and develop coping skills to achieve effective self-care management and behavior change.       |

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| **Provider Signatures**  |
| **Diabetes Educator Signature (Required for all providers)** |
| **By signing below, I certify that:*** the above dates, times, and services are accurate;
* I personally facilitated all training, meeting all outcomes required for payment and documented the service, as prescribed in the VR-SFP and service authorization;
* Verification of the customer’s satisfaction and service delivery obtained as stated above;
* I maintain the staff qualifications required for an Diabetes Educator as described in the VR‑SFP or Service Authorization; and
* I signed my signature and entered the date below.
 |
| **Typed or Printed name**:      | **Signature:**(See VR-SFP 3 on Signatures)**X** | **Date Signed**:      |
| **Director**  |
| **By signing below, I, the Director, certify that:** * I ensure that the services were provided by qualified staff, met all outcomes required for payment, and services were documented, as prescribed in the VR-SFP and service authorization;
* I maintain UNTWISE Director credential, as prescribed in VR-SFP;
* I signed my signature and entered the date below.
 |
| **Typed or Printed name**:      | **Signature:**(See VR-SFP 3 on Signatures)**X** | **Date Signed**:      |
| **Select all that apply:** [ ]  UNTWISE Credentialed with ID:       [ ]  VR3490-Waiver Proof Attached |
| **VRS Use Only** |
| If any question below is answered no or if the report or supporting documentation is missing or incomplete, return the invoice to the provider with the VR3460. Make a case note to document the results of the review and the date VR3460 was sent to provider, when applicable.     |
| **Technical Review to Verify Provider Qualifications**(Completed by any VR staff such as RA, CSC, VR Counselor)   |
| **Director’s Credential:**   |
| UNTWISE website or attached VR3490 verifies, for the dates of service, the director listed above:  [ ]  maintained or waived the UNTWISE Director Credential [ ]  did **not** hold a valid UNTWISE Director Credential |
| **Verification of Service Delivery**  |
| **Technical Review** (completed by any VR staff such as RA, CSC, VR Counselor)   |
| Verified that the report is accurately completed per form instructions | [ ]  Yes [ ]  No |
| Verified that the service(s) was provided within service date of SA and as stated in the VR Standards for Providers and/or the SA | [ ]  Yes [ ]  No |
| When applicable, verify a copy of an approved VR3472 is attached to the report? | [ ]  NA  | [ ]  Yes [ ]  No |
| Verified that this individual session was held for two hours.  | [ ]  Yes [ ]  No |
| Verified that the form was submitted to VRS within 35 days of completion.  | [ ]  Yes [ ]  No |
| Verified that the appropriate fee(s) was invoiced. | [ ]  Yes [ ]  No |
| **Printed name of VR staff member making verification:**  |
| 1.        | Date:       | 2.        | **Date:**       |
| **VR Counselor Review**  |
| Verified that if the diabetes self-management education services include providing the customer with a talking blood glucose meter or other diabetes equipment, the diabetes educator obtained the customer's signature on VR2889, Diabetes Self-Management Education Services, Adaptive Diabetes Equipment Receipt to acknowledge receipt of equipment or supplies, and submitted the VR2889.      | [ ]  NA | [ ]  Yes [ ]  No |
| Verified the evaluation was completed using two competing products and the evaluator named the specific assistive technology he or she used to complete the evaluation.    | [ ]  Yes [ ]  No |
| Verified the evaluator documented any computer and/or software issues that occurred during the interview.  | [ ]  Yes [ ]  No |
| Verified the evaluator affirmed compliance with all service limitations.  | [ ]  Yes [ ]  No |
| **By typing or printing your name, the VRC verifies:** * completion of the technical review,
* services provided met the customer’s individual needs,
* services provided met specifications in the VR-SFP and on the SA, and
* customer’s or legally authorized representative’s satisfaction with services received.

[ ]  **Approve to pay invoice** [ ]  **Do not approve to pay invoice** |
| **VR Counselor:**        | **Date:**       |