



Texas Workforce Commission
Vocational Rehabilitation Services
Diabetes Self-Management
Educator 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 Postmeal Date: 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.			
Provider Signatures			
Diabetes Educator Signature (Required for all providers)			
By signing below, I certify that:			
<ul style="list-style-type: none"> • 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)		Date Signed:
	X		
Director			
By signing below, I, the Director, certify that:			
<ul style="list-style-type: none"> • 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:
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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:
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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: