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| **Texas Workforce Solutions logo** | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Diabetes Self-Management Education**  **Post-Training Assessment** | | | | | | |
| **Instructions** | | | | | | | | | |
| * Review previous visit. * Summarize customer abilities in behaviors and use of adaptive equipment. * Record customer statements and diabetes educator observations and comments. * As appropriate, you may use the following abbreviations:   NA for “not applicable”, ND for “not disclosed by customer”, or NE for “not evaluated”. | | | | | | | | | |
| **General Information** | | | | | | | | | |
| **Customer name:** | | | | | | **TWS-VRS Case ID:** | | | |
| **Counselor name:** | | | | | | **Service authorization number:** | | | |
| **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?** | | | | | |  | | | |
| **Summarize customer’s abilities in the following behaviors:** | | | | | | | | | |
| **Vocational Rehabilitation** |  | | | | | | | | |
| **Healthy Eating** |  | | | | | | | | |
| **Being Active** |  | | | | | | | | |
| **Monitoring** |  | | | | | | | | |
| **Taking Medications** |  | | | | | | | | |
| **Healthy Coping** |  | | | | | | | | |
| **Problem Solving** |  | | | | | | | | |
| **Reducing Risk** |  | | | | | | | | |
| **Is the customer independent with the following adaptive aids? If not, please provide a reason the customer is not independent and the plan of action.** | | | | | | | | | |
| **Adaptive Aid** | | **Yes** | | **No** | **N/A** | | | **Comment** | |
| **Count-a-Dose** | |  | |  |  | | |  | |
| **Insulin Pen** | |  | |  |  | | |  | |
| **Magniguide** | |  | |  |  | | |  | |
| **Blood Glucose Meter** | |  | |  |  | | |  | |
| **Body Weight Scale** | |  | |  |  | | |  | |
| **Blood Pressure Meter** | |  | |  |  | | |  | |
| **Thermometer** | |  | |  |  | | |  | |
| **Other adaptive equipment purchased (Describe in comment)** | |  | |  |  | | |  | |
| **Customer Statements** | | | | | | | | | |
| **What changes in your lifestyle have you made while completing the diabetes program?** | | | | | | | | | |
| **What changes will be difficult to maintain?** | | | | | | | | | |
| **Do you have the information you need to manage your diabetes at work? (VR customers only)** | | | | | | | | | |
| **Final Observations, Comments, and Recommendations** | | | | | | | | | |
| **Does the customer have the skills to manage his or her health during intensive rehabilitation training programs (minitrainings, CCRC, etc.)?** | | | | | | | Yes  No | | Comment: |
| **Observations, comments, and recommendations not covered previously:** | | | | | | | | | |
| **Start time of visit:** | | | | | | **End time of visit:** | | | |
| **Post assessment date:** | | | | | | **Total hours for post assessment:** | | | |

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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 Evaluator 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** (only required for Traditional-Bilateral Contractors) | | | | | | |
| **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 one hour. | | | | | 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 the form summarizes the customer abilities in behaviors and use of adaptive equipment. | | | | | Yes  No | |
| Verified the customer’s satisfaction with the training through signature on the form and/or by VR staff member contact with customer | | | | | 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 satisfaction with services received.   **Approve to pay invoice**  **Do not approve to pay invoice** | | | | | | |
| **VR Counselor:** | | | | | **Date:** | |