



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:

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)

Date Signed:

X

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:
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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 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:
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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: