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| **Texas Workforce Solutions logo** | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Diabetes Self-Management Education**  **Pre and Post Assessment** | | | | | | | | | | | |
| Instructions | | | | | | | | | | | | |
| * Complete all pre-assessment numbers, dates, columns and signatures during the initial assessment and submit. * Save form. * Complete all post-assessment numbers, dates, columns and signatures during the post assessment and submit. * Counselor should be able to compare customer’s knowledge at assessment versus final visit.   **Note:** Vocational Rehabilitation Customers should  understand or should receive training on how to manage diabetes at work regardless of whether they are currently employed or seeking employment.  **Note:** This service can only be provided remotely with a VR3472 that has been approved by the VR Director. | | | | | | | | | | | | |
| General Information | | | | | | | | | | | | |
| **Customer name:** | | | **TWS-VRS Case ID:** | | | | | | | | | |
| **Referral date:** | | | **Counselor name:** | | | | | | | | | |
| **Pre-assessment service authorization number:** | | | **Pre-assessment date:** | | | | | | | | | |
| **Post-assessment service authorization number:** | | | **Post-assessment date:** | | | | | | | | | |
| Pre and Postassessment | | | | | | | | | | | | |
|  | | **Pre-assessment** | | | | | | **Post-assessment** | | | | |
| **Yes** | | | **No** | | **N/A** | **Yes** | | **No** | | **N/A** |
| 1. Does the customer know his or her type of diabetes? | |  | | |  | |  |  | |  | |  |
| 1. Does the customer know symptoms of hypoglycemia? | |  | | |  | |  |  | |  | |  |
| 1. Does the customer know how to appropriately treat hypoglycemia? | |  | | |  | |  |  | |  | |  |
| 1. Does the customer know symptoms of hyperglycemia? | |  | | |  | |  |  | |  | |  |
| 1. Does the customer know how to appropriately treat hyperglycemia? | |  | | |  | |  |  | |  | |  |
| 1. Does the customer know his or her A1c level and what it means? | |  | | |  | |  |  | |  | |  |
| 1. Does the customer understand the impact of foods on blood sugar? | |  | | |  | |  |  | |  | |  |
| 1. Does the customer understand the benefits of activity on managing diabetes? | |  | | |  | |  |  | |  | |  |
| 1. Does the customer perform foot examinations? | |  | | |  | |  |  | |  | |  |
| 1. Does the customer understand his or her role in diabetes management? | |  | | |  | |  |  | |  | |  |
| 1. Does the customer understand the consequences of diabetes mismanagement? | |  | | |  | |  |  | |  | |  |
| 1. Does the customer know how to monitor his or her blood glucose independently? | |  | | |  | |  |  | |  | |  |
| 13. Does the customer use blood glucose values to make daily choices for diabetes management? | |  | | |  | |  |  | |  | |  |
| 14. Does the customer know how medicines lower blood glucose level? | |  | | |  | |  |  | |  | |  |
| 15. Does the customer know the name of his or her oral medicines? | |  | | |  | |  |  | |  | |  |
| 16. Does the customer know the name of his or her insulin? | |  | | |  | |  |  | |  | |  |
| 17. Does the customer know the onset, peak action, and duration of insulin? | |  | | |  | |  |  | |  | |  |
| 18 Is the customer administering and dosing insulin independently? | |  | | |  | |  |  | |  | |  |
| 19 Does the customer practice appropriate sharps disposal? | |  | | |  | |  |  | |  | |  |
| 20 Does the customer know how to monitor his or her blood pressure? | |  | | |  | |  |  | |  | |  |
| 21. Does the customer have the information needed to manage his or her diabetes at work? | |  | | |  | |  |  | |  | |  |
| 22. Does the customer wear a medical ID? | |  | | |  | |  |  | |  | |  |
| **Totals** | | | | | | | | | | | | |
|  | | **Pre-assessment** | | | | | | **Post-assessment** | | | | |
| **Yes** | | **No** | | **N/A** | | **Yes** | **No** | | **N/A** | |
| **Totals:** (questions 1–22) | |  | |  | |  | |  |  | |  | |
| **Blood Sugar Reading** | | | | | | | | | | | | |
| **Pre-assessment blood sugar reading:**  Pre-meal:  Post-meal:  Date:       Time:       Result: | | **Post-assessment blood sugar reading::**  Pre-meal:  Post-meal:  Date:       Time:       Result: | | | | | | | | | | |
| Post-assessment: Customer received       hours of diabetes education, including 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 Diabetes Educatoras 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. | | | | | |
| **Director Typed or Printed name**: | | **Director 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? | | | | Yes  No | |
| Verified that this individual session was held for two hours for the preassessment and 1 hour for the post assessment. | | | | 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 allows a comparison of the customer’s basic knowledge of diabetes management prior to and after training occurred. | | | | 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:** | |