TEXAS WORKFORCE SOLUTIONS

**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.

## 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 Post assessment Facts

**Services were facilitated:**

- ○ Only in-person
- ○ Only remotely
- ○ In person and/or remote as dependent on customer's needs

**Note:** This service can only be provided remotely with a VR3472 that has been approved by the VR Director.

**Note:** Remote service delivery must be face-to-face and/or real time interaction. Voiced telephone and text communication are not acceptable. (see SFP 3.4.8)

## Pre and Post Assessment

| | Pre-assessment | | | Post-assessment | | |
|---|---|---|---|---|---|---|
| | **Yes** | **No** | **N/A** | **Yes** | **No** | **N/A** |
| 1. Does the customer know his or her type of diabetes? | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Does the customer know symptoms of hypoglycemia? | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Does the customer know how to appropriately treat hypoglycemia? | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Does the customer know symptoms of hyperglycemia? | ○ | ○ | ○ | ○ | ○ | ○ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 5. Does the customer know how to appropriately treat hyperglycemia? | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Does the customer know his or her A1c level and what it means? | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Does the customer understand the impact of foods on blood sugar? | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Does the customer understand the benefits of activity on managing diabetes? | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Does the customer perform foot examinations? | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Does the customer understand his or her role in diabetes management? | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Does the customer understand the consequences of diabetes mismanagement? | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. 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.

## 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:**<br>(See VR-SFP 3 on Signatures)<br>**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:**<br>(See VR-SFP 3 on Signatures)<br>**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:**<br>• completion of the technical review,<br>• services provided met the customer's individual needs,<br>• services provided met specifications in the VR-SFP and on the SA, and<br>• customer's satisfaction with services received.<br>○ **Approve to pay invoice** ○ **Do not approve to pay invoice** | | | |
| **VR Counselor:** | | | **Date:** |