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| Texas Workforce Solutions logo | | **Texas Workforce Commission**  **Vocational Rehabilitation Services** Diabetes Self-ManagementEducator 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. | | | | |

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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 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)  **X** | | | | | | **Date Signed**: |
| **Director** | | | | | | | |
| **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 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:** | | |
| **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:** | | |