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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:**       |