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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:**       |