West Virginia Aged and Disabled Waiver Program
PERSONAL ATTENDANT LOG

ADW Participant's First and Last Name: _____	PA Agency or Personal Option: Plan Period:	PAL UPDATE Date Updated by RN/RC: _____ CM/RC Receipt Date: _____
RN/RC Signature: _____Date: _____	Service Level/Hours:	CM/RC Initials: _____
RN Time In: _____ RN Time Out: _____ Hours/Day: _____ Days/Week: _____	Change in hours, days or activities? YES ☐ NO ☐	Service Time In: Service Time Out:

MONTH: ..... YEAR: ..... Date:		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
Time Arrived:																
Time Left:																
Total Hours:																
PA Initial 1 staff per recipient:																
Participant's Initial:																
Describe Activities : S= Supervised; P = Partial; T =Total	DAYS															
Bath: S☐ P☐ T☐																
Skin Care: S☐ P☐ T☐																
Hair: S☐ P☐ T☐																
Nails: S☐ P☐ T☐																
Mouth Care: S☐ P☐ T☐																
Dressing: S☐ P☐ T☐																
Ambulation: S☐ P☐ T☐																
Transfer: S☐ P☐ T☐																
Toileting: S☐ P☐ T☐																
Positioning: Turn every __ hours Up in chair																
Bed Making:																
Medication Prompt:																
Meals: Diet/Special Directions: B☐ L☐ D☐ Snæk☐																
Laundry:																
Vacuum/sweep:																
Mop:																
Dust:																
Straighten:																

Essential Errands (include purpose, destination, frequency and day of week):
Community Activities: (include purpose, destination, frequency and day of week):
Other:
Special Instructions for Transportation:

Date/Start Stop Time **	Total Miles Traveled	How much time did you spend driving? **	Destination and Purpose of Travel ** Complete these sections for medical appointments ONLY and do NOT bill for miles for medical.	Essential Errand Time Spent **	Community Activities Time Spent	** Was Person with You? Yes	No	ADW Person Initials **

I have reviewed this PA Service Log and to the best of my knowledge, the reported information is complete and accurate. No RN for Personal Options.
RN Printed Name: _____

RN Signature: _____ Date: _____
Comments: (if needed, attach additional documentation)
_____
_____
_____

PAL Updates: Changes in days, times, activities: Date: _____ RN Initials:_____
RN/RC spoke to person by phone ☐ or Face to Face to Face ☐ regarding changes

By signing, I certify that the reported information is complete and accurate. I understand that payment for the services certified on this form will be from federal and state funds, and that any false claims, statements, or documents or concealment of material fact, may be prosecuted under Medicaid fraud.

Participant/Legal Representative Signature: _____ Date: _____
(or Program Representative for Personal Options)

Personal Attendant Printed Name: _____

Personal Attendant Signature: _____ Date: _____

Unless prior approved, services must follow Plan. For Personal Options, follow the person's budget.
Must send updated PAL to CM or RC

Date	Wellness Scale	Comments *Wellness Scale 1-10 (1=poor; 10 =great)*	Date	Wellness Scale	Comments *Wellness Scale 1-10 (1=poor; 10 =great)*	Date	Wellness Scale	Comments *Wellness Scale 1-10 (1=poor; 10 =great)*