West Virginia Aged and Disabled Waiver Program
PERSONAL ATTENDANT LOG

ADW Participant’s First and Last Name: 

PA Agency or Personal Option: 

RN/RC Signature: 

Service Level/Hours: 

RN Time In: 

PA Initial 1 staff per recipient: 

RN Time Out: 

Participants Initial: 

Change in hours, days or activities? YES or NO 

PAL UPDATE 

Date Updated by RN/RC: 

CM/RC Receipt Date: 

RN/RC Signature: 

Service Time In: 

CM/RC Initials: 

Service Time Out: 

MONTH:  Year:  Date:  

Time Arrived: 

Total Hours:  

PA Initial 

Participant’s Initial: 

DESCRIPTION OF SERVICES – RN or RC Describe activities, circle type of assist, list days of week. PA – Initial on day activity provided. 

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 

Medication Prompt: 

Meals: Diet/Special Directions: B  L  D  Snack 

Laundry: 

Vacuum/sweep: 

Mop: 

Dust: 

Straighten: 

3/3/2016
### 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:

<table>
<thead>
<tr>
<th>Date/Start Stop Time **</th>
<th>Total Miles Traveled</th>
<th>How much time did you spend driving? **</th>
<th>Destination and Purpose of Travel **</th>
<th>Essential Errand Time Spent **</th>
<th>Community Activities Time Spent **</th>
<th>Was Person with You?</th>
<th>ADW Person Initials **</th>
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**Complete these sections for medical appointments ONLY and do NOT bill for miles for medical.**

### Wellness Scale:

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<tr>
<th>Date</th>
<th>Wellness Scale</th>
<th>Comments</th>
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<tbody>
<tr>
<td></td>
<td>Wellness Scale 1-10 (1=poor; 10 =great)</td>
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**Wellness Scale 1-10 (1=poor; 10 =great) (1=poor; 10 =great)**

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 ___ 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

3/3/2016