TRAUMATIC BRAIN INJURY WAIVER PROGRAM
PERSONAL ATTENDANT SERVICES NON-MEDICAL TRANSPORTATION LOG

PARTICIPANT NAME: ______________________

Attendant Name: ______________________ **Begin Date:** __________ **End Date:** __________

All transportation with, or on behalf of, the person receiving TBIW services must be included on the Service Plan.
All personal care assistance needs as outlined on the service plan must take place before essential errands (EE) or community activities (CA) can occur.

DATE	MILES DRIVEN	TRAVEL TIME	DESTINATION	PURPOSE OF TRAVEL	TYPE OF TRAVEL (EE OR CA)	STARTING LOCATION	ENDING LOCATION
TOTAL MILES:			Supervisor's signature and date on page 1 indicates that this transportation log has been reviewed and approved.				