West Virginia Aged and Disabled Waiver Program
PERSONAL ATTENDANT LOG

ADW Participant's First and Last Name: _____	PA Agency or Personal Options: Plan Period:	
RN/RC Signature: _____Date: _____	Service Level/Hours:	
RN Time In: _____ RN Time Out: _____ Hours/Day: _____ Days/Week: _____	Change in hours, frequency, or activities? YES or 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**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
Time Arrived:																																
Time Left:																																
Total Hours:																																
Participant's Initial:																																
DESCRIPTION OF SERVICES – RN or RC: *Describe activities, circle type of assist,* PA: *Mark an "X" on day activity was provided.*																																
Describe Activities S = Supervised; P = Partial/Physical; T =Total/Physical	Frequency																															
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:																																

Date/Start Stop Time **	Total Miles Traveled	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 frequency, times, activities: Date: _____
RN/RC spoke to person by phone ___ or Face to Face ___ regarding changes. RN Initials:_____

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, 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/RC

Date	Comments	Date	Comments	Date	Comments

PAL was provided to the ADW participant and the Case Management Agency: Date: _____ *Note: If you are accessing this document on Word, any alterations of the original form may result in improper documentation and disallowance.