TRAUMATIC BRAIN INJURY WAIVER
Personal Attendant Worksheet

Member's First and Last Name: _____ Begin Date: _____
Personal Attendant's(PA) Name: _____ End Date: _____

Month:																	**Reflect Month and Day of the Week**
Date: PA Circle correct day	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 Arrive:																	**Supervisor Comments:**
Time Left:																	
Total Hours:																	
PA Initials:																	
Member's Initials:																	

Personal Attendant Comments and Notes for the 2-week period: (notes should reflect services provided and member's response to the services)

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

_____ Personal Attendant Signature and Date

_____ Member Signature and Date

_____ Supervisor Signature and Date

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Personal Attendant Worksheet

					MEMBER NAME:					
Attendant Name:					**Begin Date:**		**End Date:**			

Personal Attendant must enter date and initial each block to show services were provided as planned. All services listed must be reflected on the Service Plan.

Description of Service/Care								
ADLs/IADLs								
COMMUNITY ACTIVITIES W/MEMBER								
ESSENTIAL ERRANDS								

Personal Attendant Non – Medical Transportation Log
Special instructions for Transportation:

Date	Total Miles Driven	Travel Time	Destination and Purpose of Travel	Type of Travel (EE or CA)	Starting Location	Ending Location	Was Person with You? Yes	No	Member's Initials
Total Miles:						**Supervisor's signature and date on page 1 indicates that this transportation log has been reviewed and approved.**			