

West Virginia Aged and Disabled Waiver Program PERSONAL ATTENDANT LOG

ADW Participant's First and Last Name: _____ RN/RC Signature: _____ Date: _____ RN Time In: _____ RN Time Out: _____ Hours/Day: _____ Days/Week: _____	PA Agency or Personal Option: Plan Period: _____ Service Level/Hours: _____ Change in hours, days or activities? YES or NO	PAL UPDATE Date Updated by RN/RC: _____ CM/RC Receipt Date: _____ CM/RC Initials: _____ Service Time In: Service Time Out:															
MONTH: YEAR: Date:	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Time Arrived:																	
Time Left:																	
Total Hours:																	
PA Initial 1 staff per recipient:																	
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:																	

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 <u>medical appointments ONLY</u> and do <u>NOT bill for miles for medical.</u>	Essential Errand Time Spent **	Community Activities Time Spent	** Was Person with You?		ADW Person Initials **
						Yes	No	

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 <i>Wellness Scale 1-10 (1=poor; 10 =great)</i>	Date	Wellness Scale	Comments <i>Wellness Scale 1-10 (1=poor; 10 =great)</i>	Date	Wellness Scale	Comments <i>Wellness Scale 1-10 (1=poor; 10 =great)</i>

