AGED AND DISABLED WAIVER – PERSONAL ATTENDANT LOG (PAL)

ADW Participant's Name: _____ Plan Month/Year: _____

ADW Participant's First and Last Name:		PA Agency/Personal Options:		
RN/RC Signature: Date: RN Time In: RN Time Out:		Plan Period: Service Level/Hours:		
Hours/Day:	**Days/Week:**	Was this a change in hours, frequency or activities?	**Service Time In:**	**Service Time Out:**

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 Arrived:																
Time Left:																
Total Hours:																
ADW Participant's Initials:																

DESCRIPTION OF SERVICES: RN or RC - *Describe activities, frequency & circle type of assist.* ***PA –*** *Mark an "**X**" on day activity is provided.*

Describe Activities **S = Supervised; P = Partial; T =Total**	**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 ____Hrs. Up in Chair																	
Bed Making:																	
Medication Prompt:																	
Meals: Diet/Special Directions B | L | D | Snack																	
Laundry:																	
Vacuum/Sweep:																	
Mop:																	
Dust:																	
Straighten:																	

AGED AND DISABLED WAIVER – PERSONAL ATTENDANT LOG (PAL)

ADW Participant's Name: _____ Plan Month/Year: _____

Essential Errands *(include purpose, destination & frequency):*

Community Activities: *(include purpose, destination & frequency):*

Other:

Special Instructions for Transportation:

Date	Start/Stop Time **	Total Miles Traveled	Destination and Purpose of Travel ** Complete these sections for medical appointments and do NOT bill for miles for medical.	Essential Errand Time **	Community Activities Time	**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:_____

(If needed, attach additional documentation).

Comments:_____

_____

_____

_____

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*_____*Date:*_____

(Program Representative for Personal Options)

Personal Attendant Printed Name: _____

Personal Attendant Signature: _____*Date:* _____

Unless prior approved by the RN, services must follow Plan. For Personal Options, follow person's budget.

PAL Updates: Change in days, times, activities.
Date:
RN/RC Initials:

RN/RC spoke to person by phone____ Face to Face____ regarding changes.

Must send updated PAL to CM or RC.

Date	Personal Attendant Comments	Date	Personal Attendant 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.