TRAUMATIC BRAIN INJURY WAIVER PROGRAM
PERSONAL ATTENDANT SERVICES WORKSHEET

PARTICIPANT NAME: ____________________

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

Date M/D/Y									**CONDITION OF PARTICIPANT KEY**
Time Arrived									The attendant must list a Condition of Participant on the worksheet at the end of each shift worked. **Excellent** **Good** **Poor*** If poor, please explain in the notes section
Time Left									
Total Hours Worked									
Part./LR Initials:									
Condition of Participant									
Date M/D/Y									**Supervisor Comments:**
Time Arrived									
Time Left									
Total Hours Worked									
Part./LR Initials:									
Condition of Participant									

Personal Attendant Comments and Notes for the 2-week period: (notes should reflect services provided and person'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

Participant/Legal Representative Signature and Date

Supervisor Signature and Date

PERSONAL ATTENDANT SERVICES WORKSHEET

PARTICIPANT 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/PERSON								
ESSENTIAL ERRANDS								

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.				