West Virginia Aged and Disabled Waiver Program PERSONAL ATTENDANT LOG

ADW Participant's Firs	t and Las	st Nan	ne:							Agenc 1 Perio		ersor	ial Op	tions:								D C	ate U M/RC	pdate Rece	ed by i ipt Da	<u>PAL</u> RN/RO ate: _	. UPD/ ::					
RN/RC Signature:					Da	te:			Serv	vice Le	evel/H	lours:										C	M/RC	Initia	ls:					_		
RN Time In: Hours/Day:		_ RN ⁻	Time	Out: _					Cha	nge ir	n houi	rs, day	/s or a	ctivit	ies? Y	ES or	NO					Se	ervice	Time Time	In:							
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:																															
Т	ime Left:																															
Tota	al Hours:																															
PA Initial (1 staff per re	cipient):																															
Participant	's Initial:																															
DESCRIPTION OF SERVICE	S – RN or	RC De	scribe	activit	ies, ci	rcle ty	pe of a	issist, l	ist day	rs of w	eek. F	A – Ini	itial or	day a	ctivity	provic	led.				I								1			1
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:																																



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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 ** <u>Complete these sections for</u> <u>medical appointments ONLY and do</u> <u>NOT bill for miles for medical.</u>	Essential Errand Time Spent **	Community Activities Time Spent	Was Perso	** n with You? 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:	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.							
RN Signature: Date: Comments: (if needed, attach additional documentation)	Participant/Legal Representative Signature:	ate:						
		ate:						
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	Unless prior approved, services must follow Plan. For Personal Options, follow the pe Must send updated PAL to CM or RC	erson's budget.						

Date	Wellness Scale	Comments Wellness Scale 1-10 (1=poor; 10 =great)	Date	Wellness Scale	Comments Wellness Scale 1-10 (1=poor; 10 =great)	Date	Wellness Scale	Comments Wellness Scale 1-10 (1=poor; 10 =great)
Health Health Busenfor Medical Services								
BURGAUPOR MEDICAL SERVICES								3/3/2016