TRAUMATIC BRAIN INJURY WAIVER PROGRAM
PERSONAL ATTENDANT SERVICES WORKSHEET

PARTICIPANT NAME: _____

Attendant Name: _____ **Begin Date:** _____ **End Date:** _____

Date M/D/Y								
Time Arrived								
Time Left								
Total Hours Worked								
Part./LR Initials:								
Condition of Participant								
Date M/D/Y								
Time Arrived								
Time Left								
Total Hours Worked								
Part./LR Initials:								
Condition of Participant								

CONDITION OF PARTICIPANT KEY

The attendant must list a Condiditon of Participant on the worksheet at the end of each shift worked.

Excellent

Good

Poor* If poor, please explain in the notes section

Supervisor Comments:

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

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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								