

**TRAUMATIC BRAIN INJURY WAIVER PROGRAM
PERSONAL ATTENDANT SERVICES WORKSHEET**

MEMBER NAME: _____

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

Personal Attendant must 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		SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
		Week 1						
Week 2								
Week 1								
Week 2								
Week 1								
Week 2								
Week 1								
Week 2								
Week 1								
Week 2								
COMMUNITY ACTIVITIES (Any mileage associated with Community Activities must be documented and available for review)								
Week 1								
Week 2								
Week 1								
Week 2								
ESSENTIAL ERRANDS (Any mileage associated with Essential Errands must be documented and available for review)								
Week 1								
Week 2								
Week 1								
Week 2								
OTHER								
Training by Cognitive Rehabilitation Therapist	Week 1							
	Week 2							
Special Directions:	Week 1							
	Week 2							