ADW Participant's First	and Las	t Nan	ne:							Agenc Perio		ersor	nal Op	tions	:							С	M/RC	Rece	ipt Da	RN/R	<u>UPD</u> C: _				<u>—</u>	
RN/RC Signature:					Da	ite:			Serv	vice Le	evel/F	lours:										С	CM/RC Initials:									
RN Time In:					_	Change in hours, frequency, or activities? YES or NO											Service Time In: Service Time Out:															
,								est \	Vira	inia	Aa	ed a	and	Dis	abl	ed V	Vaiv	er l	Pro	arar	n											
															END					•												
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 A	rrived:																															
Tim	e Left:																															
Total	Hours:																															
Participant's	Initial:																															
DESCRIPTION OF SERVICES	– RN or	RC: De	escribe	e activ	ities, c	ircle ty	ype of	f assist,	PA: A	1ark a	n "X" c	on day	activii	ty was	provid	ded.	1								1						<u></u>	
Describe Activities S = Supervised; P = Partial/Physical; T =Total/Physical	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																															<u> </u>	
Transfer: S P T																															<u> </u>	
Toileting: S P T																																
Positioning: Turn every hours Up in chair																																
Medication Prompt:																																
Meals: Diet/Special Directions: B L D Snack																																
Laundry:	-																															
Vacuum/sweep:																																
Mop:																																
Dust:																																



Straighten:										
Essential Errands (in	clude purpose, destination, a	and frequency):								
Community Activitie	s: (include purpose, destinati	ion, and frequency):								
Other:										
Special Instructions	for Transportation:									
Date/Start Stop Tin **	ne Total Miles Traveled	How much time did you spend driving? **	** COMPLETE TO MEDICAL APPO AND DO NOT B	d Purpose of Travel HESE SECTIONS FOR OINTMENTS ONLY ILL FOR MILES FOR EDICAL.	Essential Errand Tir Spent **	ne Community Activities Time Spent	Was Perso	** n with You? No	ADW Person Initials **	
		+								
complete and accurat RN Printed Name: RN Signature:	A Service Log and to the best of net. (No RN for Personal Options.) , attach additional documentation	Date:		services certified documents or co Participant/Lega	fy that the reported infor on this form will be from ncealment of material fac Representative Signatur resentative for Personal C	federal and state fu t, may be prosecute e:	ınds, and that ar ed under Medica	ny false claims, id fraud.		
				Personal Attenda	ant Printed Name:					
					nnt Signature:				ate:	
	in frequency, times, activities: Dn by phone or Face to Face		nitials:	Unless pric	r approved, services mus		Personal Options			
Date	Comments		Date	Co	mments	Date		Comments		
HEALTH BURNING		4/1/21				1				
		• •				1				