

COMMUNITY CHOICES WAIVER (CCW) SERVICE LOG

PROVIDER AGENCY NAME:											DIRECT SERVICE WORKER'S NAME:																													
PARTICIPANT NAME:											PARTICIPANT DOB:																													
Week Of:											Through:																													
Day Of Week:	Sunday			Monday			Tuesday			Wednesday			Thursday			Friday			Saturday																					
Date→																																								
1 st Arrival Time w/ Initials→																																								
1 st Departure Time w/ Initials→																																								
2 nd Arrival Time w/ Initials→																																								
2 nd Departure Time w/ Initials→																																								
↓ Indicate Task Completed Each Day W/Initials in Column for the Type PAS provided ↓																																								
↓ Tasks ↓	F	F	F	A	P	F	F	F	A	P	F	F	F	A	P	F	F	F	A	P	F	F	F	A	P	F	F	F	A	P	F	F	F	A	P					
	O	O	O			O	O	O			O	O	O			O	O	O			O	O	O			O	O	O			O	O	O			O	O	O		
	R	R	R	M	M	R	R	R	M	M	R	R	R	M	M	R	R	R	M	M	R	R	R	M	M	R	R	R	M	M	R	R	R	M	M	R	R	R	M	M
	1	2	3			1	2	3			1	2	3			1	2	3			1	2	3			1	2	3			1	2	3			1	2	3		
Eating																																								
Bathing																																								
Dressing																																								
Grooming																																								
Transferring																																								
Ambulation																																								
Toileting																																								
Light Housekeeping																																								
Food Preparation & Storage																																								
Shopping																																								
Laundry																																								
Medication Reminders																																								
Assist To Sched Med Appts																																								
Assist To Arrange Med Trans																																								
Accompany To Med Appts																																								
Protective Supervision																																								
Supv/Assist w/Health Tasks																																								
Escort for Assist w/Comm Tasks																																								
Extension of Therapy Services																																								
Daily Total # Of Hours →																																								

WEEKLY TOTAL # of Hours→ WEEKLY PAS for 1: _____ HOURS WEEKLY PAS for 2: _____ HOURS WEEKLY PAS for 3: _____ HOURS WEEKLY PAS AM _____ WEEKLY PAS PM _____

PARTICIPANT/DESIGNATED RESPONSIBLE REPRESENTATIVE/LEGAL REPRESENTATIVE SIGNATURE & DATE: _____ DIRECT SERVICE WORKER'S PRINTED NAME, SIGNATURE, & DATE: _____

DSW SUPERVISOR'S REVIEW SIGNATURE & DATE (Use of this line is optional): _____

NOTE: DAILY SERVICES/SUPPORTS DESCRIPTIONS, COMMENTS AND PROGRESS NOTES ARE TO BE RECORDED ON PAGE 2 OF THIS FORM. ADDITIONAL PAGES MAY BE USED.

