LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

COMMUNITY CHOICES WAIVER (CCW) PERSONAL ASSISTANCE SERVICES (PAS) LOG

PROVIDER'S NAME: Precision Caregivers	DIRECT SERVICE WORKER'S NAME (PRINT):
PARTICIPANT'S NAME:	PARTICIPANT'S DOB:
Week Of: Through:	

Day Of Week:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date→							
Tasks:	Indicate Tasks Completed Each Day by Signing with Worker's Initials.						
Eating							
Bathing							
Dressing							
Grooming							
Transferring							
Ambulation							
Toileting							
Light Housekeeping							
Food Preparation & Storage							
Shopping							
Laundry							
Medication Reminders							
Assist To Scheduled Medical Appointment							
Assist To Arrange Medical Transportation							
Accompany To Medical Appointments							
Protective Supervision							
Supervision/Assistance with Health Tasks							
Escort for Assistance with Community Tasks							
Extension of Therapy Services							

PARTICIPANT/RESPONSIBLE REPRESENTATIVE/LEGAL REPRESENTATIVE'S SIGNATURE : _____ DATE: _____

DIRECT SERVICE WORKER'S SIGNATURE: _____ DATE: _____

NOTE: TIMES OF SERVICE DELIVERY, AS WELL AS LOCATION AT TIME OF CHECK IN/OUT, ARE DOCUMENTED THROUGH THE ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM.

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NOTE: THIS PAGE IS TO BE DUPLICATED AS NEEDED TO COMPLETE PROGRESS NOTE DOCUMENTATION

PROVIDER'S NAME: Precision Caregivers	
DIRECT SERVICE WORKER'S NAME (PRINT):	
PARTICIPANT'S NAME:	**PARTICIPANT'S DOB:**
WEEK OF:	**THROUGH:**

DATE:	**PROGRESS NOTES:** - **Observed changes in physical and mental condition (if applicable)** - **Documentation of any SIGNIFICANT DEVIATION from what is in the Plan of Care (POC)** - **Important information for the next worker or caregiver**

PARTICIPANT/RESPONSIBLE REPRESENTATIVE/LEGAL REPRESENTATIVE'S INITIALS: _____ DATE: _____

DIRECT SERVICE WORKER'S INITIALS: _____ DATE: _____