

PERSONAL CARE WEEKLY SUMMARY REPORT

Sheltered Workshop: _____

Consumer's Name: _____

SSN: _____

Week of: _____ Year: _____

DIRECTIONS – Place a check mark in the boxes provided below that represent the areas in which personal care services/supports were provided for the consumer noted above, as described in their Personal Care Assistance (PCA) Service Support Plan.

PERSONAL CARE PROVIDED			
Meal Assistance		Assist w/Med Adm.	
Dressing		Administer Meds	
Toileting/Continence		Other:	
Mobility/Transfer			

Also note any additional personal care services provided that were not identified in the individual's PCA Service Support Plan. Indicate why these services were necessary. If the services will be ongoing, the PCA Service Support Plan should be revised to include these services.

Consumer Signature _____ Date _____

Personal Care Assistant Signature _____ Date _____