

Specialized Residential Personal Care and Community Living Supports Log

Consumer Name: _____
 Consumer ID#: _____

Provider: _____
 Provider Telephone: _____
 Month: _____

Personal Care Code: T1020
 CLS Code: H2016
 Year: _____

Hands-on Services/Supports	Days of the Month																														
	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
Personal Care (PC) - Provide/Assist																															
A. Eating/Feeding																															
B. Toileting																															
C. Bathing																															
D. Dressing																															
E. Grooming																															
F. Transferring																															
G. Ambulation/Mobility																															
H. Taking Medication																															
Community Living Supports (CLS) -Guide/Direct																															
A. Assisting/Observing/Guiding and/or:																															
1. Meal Preparation																															
2. Laundry																															
3. Routine Household Care/Maintenance																															
4. Activities of Daily Living (bathing, eating, dressing, personal hygiene)																															
5. Shopping																															
B. Assistance/Support/Training the Recipient with:																															
1. Money Management																															
2. Socialization and Relationship Building																															
3. Transportation																															
4. Leisure Choice and Participation in Regular Community Activities and recreation opportunities.																															
5. Attending Medical Appointments																															
C. Monitoring/Protection of Health and Safety (includes sleeping hours)																															
D. Monitoring Self-Administration of Medications																															
Put "X" for each day resident receives at least one activity in the home *Exception-when consumer transfers to another per diem code (e.g., hospitalizations, transfers to another home)																															

I certify the services named above on the days indicated have been provided. **CSM/SC Review Completed By:** _____ **Date:** _____

Providers Signature: _____ **Date:** _____