

## PERSONAL CARE SERVICES (Lifeskills Class)

\* I: Student must have the need for an Individual Aide in the IEP/ARD documentation

**STUDENT NAME:** \_\_\_\_\_  
**MEDICAID #:** \_\_\_\_\_  
**SCHOOL DISTRICT:** \_\_\_\_\_

**Group**      **or**      **Individual\***      (circle one)  
**DOB:** \_\_\_\_\_  
**CO-OP/SSA:** \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Monday	Tuesday	Wednesday	Thursday	Friday
<b>Date (mm/dd/yy)</b>										
<b>Start Time</b>										
<b>Stop Time</b>										
<b>Total Minutes for the Day (A)</b>										

**Duduction for time Spent in:**

Deducted Time for other Svcs		Monday	Tuesday	Wednesday	Thursday	Friday	Monday	Tuesday	Wednesday	Thursday	Friday	
	Occupational Therapy											
	Physical Therapy											
	Speech Therapy											
	School Health Svc/Nursing											
	Other: _____											
<b>Total Minutes (B)</b>												

<b>Total Minutes Billable for the Day (A-B)</b>											
<b>Units</b>											
<b>Initials</b>											

**A C T I V I T I E S**

Check all that apply

Bathing/Sponge Bath											
Dressing											
Toileting/Diapering											
Orientation & Mobility											
Exercises											
Eating (Assisted Feeding)											
Telephone											
Personal Hygiene											
Light Housework/Chores											
Laundry											
Meal Preparation											
Transferring/Escort											
Grocery Shopping											
Money Management											
Other:											

**Provider's Name:** \_\_\_\_\_  
 (Please Print)

**Signature:** \_\_\_\_\_  
 (Required)