ATTENDANT CARE STATEMENT

Client Name: _____ Claim No.: _____

Care Provider's Name: _____

Care Provider's Address: _____

Telephone No.: (_____) _____ Social Security No.: _____

Describe specifically what services were provided:

A. Assist with clothing/dressing
B. Assist with bathing/hygiene
C. Change bandages/wound care
D. Assist with toileting
E. Assist with medications
F. Assist with transfers/ambulation
G. Assist with stand-by care
H. Remain on call
I. Assist with home physical therapy
J. Assist with planning activities
K. Assist with anger management
L. Other _____
M. Other _____
N. Other _____
O. Other _____

Indicate on the following calendar what services (by letter) were performed on which dates:

MONTH: _____ YEAR: 20__

Date 1	Date 2	Date 3	Date 4	Date 5	Date 6	Date 7
hrs	hrs	hrs	hrs	hrs	hrs	hrs
Date 8	Date 9	Date 10	Date 11	Date 12	Date 13	Date 14
hrs	hrs	hrs	hrs	hrs	hrs	hrs
Date 15	Date 16	Date 17	Date 18	Date 19	Date 20	Date 21
hrs	hrs	hrs	hrs	hrs	hrs	hrs
Date 22	Date 23	Date 24	Date 25	Date 26	Date 27	Date 28
hrs	hrs	hrs	hrs	hrs	hrs	hrs
Date 29	Date 30	Date 31				
hrs	hrs	hrs				

*I expect to be paiid for these serviices.

Care Provider Signature: _____ Date: _____