CIVITAN FOUNDATION

ATTENDANT CARE FORM

Month/Year: _____ 20_____
Consumer ID: _____

Consumer Name: _____
Direct Care Staff Name: _____

ACTIVITY	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

MonthlySummary:_____

_____

_____

_____

Provider Signature: _____

Supervisor's Signature: _____

✓ = task completed by provider
X = consumer completed task independently
* = completed together

Rev. 12/15/05