## **IEP Services Personal Care Assistant Activities Checklist**

Mental Health Behavior Aid services are not PCA service and cannot be documented on this form

## **Student Information:**

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Student Name:	School:
DOB:	Type of Service/Code: Personal Care Assistant (T1018-U6)

## Service Providers: (Print all names and initials of all PCAs who provide covered activities.)

## \*To document time you can use information form a mini-time study conducted to determine the amount of time required to complete daily activities. Keep all documentation for 5 years.

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Date of Service MM/DD/YY	Activities	Enter i	# in group	Time* HH:MM						
	Eating									
	Toileting									
	Behavior									
	Transfers									
	Dressing									
	Mobility									
	Grooming									
	Orthotics									
	ROM									

Date of Service MM/DD/YY	Activities	Enteri	Enter initials of service provider each time the activity is provided daily											Time* HH:MM
	Eating													
	Toileting													
	Behavior													
	Transfers													
	Dressing													
	Mobility													
	Grooming													
	Orthotics													
	ROM													

Date of Service MM/DD/YY	Activities	Enter initials of service provider each time the activity is provided daily	# in group	Time* HH:MM
	Eating			
	Toileting			
	Behavior			
	Transfers			
	Dressing			
	Mobility			
	Grooming			
	Orthotics			
	ROM			

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	Dressing													
	Mobility													
	Grooming													
	Orthotics													
	ROM													

Initials/Signature of PCA

Initials/ Signature of PCA

Initials/Signature of PCA

Initials/ Signature of PCA

Student Name:	Dates of Time Study:
School:	Date of Birth:

Based on the completed care plan and time study, the student needs assistance with the following personal care activities:

Assistance needed:	Description:
Eating	
Toileting	
Behavior	
Mobility	
Transfers	
Dressing	
Grooming	
Orthotics	
Range of Motion	

nature and date:	
nted name and Title:	