CIVITAN FOUNDATION

Promoting Lifelong Fun Adventures for the Developmentally Disabled Since 1968

ATTENDANT CARE FORM

Month/Year: _____ 20_____

Consumer Name: _____

Consumer ID: _____

DDD Support Coordinator: _____

Direct Care Staff Name: _____

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

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

Monthly Summary:

_____

_____

_____

Provider Signature: _____

Supervisor's Signature: _____

Rev. 1/20/2010