ATTENDANT CARE FORM

CLAIMANT: _____ DATE OF LOSS: _____

PROVIDED BY: _____CLAIM #/ POLICY #: _____

A. Supervision
B. Fall Prevention
C. Help Walking/stairs
D. On/off Bed and Chairs
E. Exercise/Massage/Therapy
F. Comforting/Wound Care
G. Dressing/Shoes
H. Help w/ Medications
I. Hygiene/ Bathing
J. Grooming/Shaving/ Cosmetics
K. Transfer care
L. Night assistance
M. Repositioning Body
N. Overseeing Med. Care
O. Toileting
P. Assistance Feeding one's self
Q. Other: _____

DATE	SERVICES PROVIDED	# HOURS/DAY

Provider Signature: _____