Arizona Bridge to Independent Living (ABIL)
Personal Assistance Services

☐ Consumer Needs Assessment / ☐ Service Agreement

(Please check which form or forms are being completed)

Consumer: *(Use Last name, First name format)*

Personal Care Assistant: *(Use Last name, First name format*

☐ **PERSONAL CARE ASSISTANCE**

Eating/Feeding ☐ Ind. ☐ Self fed w/set up ☐ Fed by Attendant ☐ Tube fed (☐ Nurse ☐ Family Only)

Comments:

Oral Care ☐ Ind. ☐ Assist ☐ Full care

Comments:

Grooming ☐ Ind. ☐ Assist ☐ Full care

Comments:

Shaving ☐ Ind. ☐ Assist ☐ Full care ☐ Diabetic/Blood Thinner ☐ Electric Shaver Only

Comments:

Nail Care ☐ Ind. ☐ Assist ☐ Full care ☐ Diabetic/Blood Thinner ☐ Filing Only

Comments:

Begin here to determine level of care

_____ **Dressing** ☐ Ind. ☐ Assist ☐ Full care

Comments:

_____ **Bathing/Skin Care** ☐ Ind. ☐ Assist ☐ Full care ☐ Shower _____ x week

☐ Bed/Sponge bath _____ x week

Comments:

_____ **Bed Mobility** ☐ Ind. ☐ Reposition _____ Hour(s) ☐ As needed

Comments:

_____ **Transfers** ☐ Ind. ☐ Pivots ☐ Assist w/transfer ☐ Full transfer ☐ Hoyer Lift

Comments:

_____ **Mobility** ☐ Ind. ☐ Wheelchair ☐ Walker ☐ Cane ☐ Other

Comments:

_____ **Ambulation** ☐ Ind. ☐ Unsteady ☐ Assist

Comments:

_____ **Weakness/Paralysis** ☐ Right ☐ Left side ☐ Upper ☐ Lower

Range of Motion ☐ Ind. ☐ Assist

Comments:

_____ **Bladder Status** ☐ Continent ☐ Incontinent _____ x week ☐ Total Incontinent

☐ Assist to bathroom ☐ Urinal

☐ Bedpan ☐ Brief ☐ Foley ☐ Condom Cath ☐ Catheterization

Comments:

_____ **Bowel Status** ☐ Continent ☐ Incontinent _____ x week ☐ Total incontinent ☐ Assist

Comments:

☐ Bowel program (☐ Nurse ☐ Family Only)

Comments:

Overall Level of Care ☐ **H** ☐ **M** ☐ **L** **H = High M = Medium L = Low**

☐ **HOMEMAKING TASKS – Consumer's areas only (Indicate how many days per week, 1 to 7)**

☐ **Dust:** ☐ **Bedroom** ☐ **Living area**

☐ **Floor:** ☐ **Sweep** ☐ **Mop** ☐ **Vacuum**

☐ **Bathroom / Bedroom / Kitchen**

☐ **Oven/refrigerator as needed**

☐ **Change bed linens**

☐ **Laundry** (folding, putting away, ironing as needed)

☐ **Errands** (shopping for Consumer's household supplies, food, medicine)

☐ **Prepare meals** (per day) ☐ Breakfast ☐ Lunch ☐ Dinner

Comments:

GENERAL SUPERVISION

Remind and/or assist Consumer with Self-Medication: ☐ Ind. ☐ Remind ☐ Assist ☐ Family ☐ Other

Provide companionship suited to the Consumer: Conversation / Games / Reading / Walking / Other

Accompany Consumer to appointments: ☐ Y ☐ N ☐ As Needed
Type of Transp. ☐ Family ☐ Public ☐ Medical ☐ Other

DAYS AND HOURS WORKING - Total Number of Authorized Hours

AM		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	Start							
	End							
PM	**Start**							
	End							

Comments:

Consumer Signature, ***Consumer Needs Assessment/Service Agreement***

PCA Signature, ***Consumer Needs Assessment/Service Agreement***

Form Completed by:
PCA Supervisor

Date: