

STATE OF HAWAII  
Personal Assistance Tool

<b>Member Name:</b>					<b>Medicaid #:</b>							<b>Date of Assessment:</b>								
<b>Task</b>	<b>Total Minutes of Care Required/Week</b>				<b>Total Minutes of Care Performed by Unpaid Support System/Week</b>							<b>Total Minutes of Care Performed by Health Plan Provider/Week</b>								
	Frequency/ Day	Minutes/ Task	Days/ Week	Total Minutes/ Week	S U N	M O N	T U E	W E D	T H U	F R I	S A T	Total Minutes/ Week	S U N	M O N	T U E	W E D	T H U	F R I	S A T	Total Minutes/ Week
<b>Personal Assistance Level 1</b>																				
1	Routine House Cleaning																			
2	Laundry																			
3	Shopping/Errands																			
4	Transportation/Escort																			
5	Meal Preparation																			
6	Other																			
<b>Personal Assistance Level 2</b>																				
1	Eating/Feeding																			
2	Bathing																			
3	Dressing (Upper and Lower Body)																			
4	Grooming/Personal Hygiene																			
5	Toileting																			
6	Ambulation																			
7	Bed Mobility/Transfers																			
8	Manual Wheelchair Mobility																			
9	Medication Assistance																			
10	Other																			
<b>SUBTOTAL MINUTES/WEEK</b>		<b>Total Minutes/Week</b>			<b>Total Minutes/Week</b>							<b>Total Minutes/Week</b>								
<b>Total Minutes of Care Required/Week</b>																				
<b>Total Minutes of Care Performed by Unpaid Support System/Week</b>																				
<b>Total Minutes of Care Performed by Health Plan Provider/Week</b>																				
<b>Total Hours of Care Performed by Health Plan Provider/Week</b>																				
<b>Total Hours of Care Performed by Health Plan Provider/Month (based on 7Days/Week x 31Days/Month)</b>																				
<b>Justification for Allocation of Hours:</b>																				
<b>Assessor Signature</b>										<b>Print Name/Title</b>										