State of Illinois
Department of Human Services
Division of Rehabilitation Services
PERSONAL ASSISTANT EVALUATION

Customer: _____

Personal Assistant (PA):_____
PA Address: _____
PA Phone Number(s):_____

Please place a check mark in front of the statement that best evaluates the PA. Use the comments section if further explanation is appropriate.

1. ACCURACY OF WORK

___ Makes many errors
___ Is careless
___ Usually accurate
___ Is careful
___ Consistently accurate

2. CARE OF WORKING AREA

___ Very untidy
___ Careless
___ Keeps area clean
___ Keeps area clean and orderly
___ Exceptionally clean and orderly

3. USE OF WORKING TIME

___ Very wasteful
___ Wasteful
___ Fair use of time
___ Keeps busy
___ Busy and effective

4. RESPONSIBILITY

___ Irresponsible
___ Evades responsibility
___ Accepts responsibility
___ Seeks responsibility
___ Seeks and handles well

5. ATTENDANCE

___ Frequently absent or late
___ Absent or late often
___ Absent or late occasionally
___ Seldom absent or late
___ Never absent or late

6. ATTITUDE TOWARDS CONSUMER (DRS CUSTOMER)

___ Disrespectful/uncooperative
___ Poor cooperation
___ Cooperates when asked
___ Cooperates willingly
___ Very respectful, helpful and cooperative

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Please respond with a Yes or No to the following questions. If additional explanation of the question is appropriate, use the "Comments" section.

A. Are you satisfied with your PA's overall performance?_____

B. Are the hours satisfactory?_____ Please explain a "No" response in the comments section.

C. Is your PA honest in charging DHS-DRS for the actual hours worked?_____

D. Does your PA do the work as listed on the Service Plan (IL488-1049)?_____ If "No", explain in comments section.

E. In the last year was there any period of time you were not in the home due to hospitalization, vacation, visiting out of town, etc.? ____

F. Does your PA keep a record of hours of care provided or keep copies of the Home Services Documentation of Service (IL488-2251)?_____

COMMENTS

_____

_____

_____

_____

_____

X _____ _____

Customer Signature Date

_____ _____

Parent, Guardian or Witness, as appropriate Date

A copy of this form should be provided to the HSP counselor and the Personal Assistant.