# PCA Time and Activity Documentation 1:1 Care

**FAX: 612-722-2186**

| WEEK 1 | SAT | SUN | MON | TUE | WED | THUR | FRI |
|---|---|---|---|---|---|---|---|
| Month/Day/Year | 02/06/21 | 02/07/21 | 02/08/21 | 02/09/21 | 02/10/21 | 02/11/21 | 02/12/21 |
| VISIT ONE | | | | | | | |
| TIME IN | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| TIME OUT | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| VISIT TWO | | | | | | | |
| TIME IN | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| TIME OUT | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| | | | | | | | |
| Total Daily Hrs: | | | | | | | |
| WEEK 1 | | | | 1:1Total weekly hours: | | | |
| Activities | | | | | | | |
| Dressing | | | | | | | |
| Grooming | | | | | | | |
| Bathing | | | | | | | |
| Eating | | | | | | | |
| Transfers | | | | | | | |
| Mobility | | | | | | | |
| Positioning | | | | | | | |
| Toileting | | | | | | | |
| Behavior | | | | | | | |
| IADL | | | | | | | |
| Meds Reminder | | | | | | | |
| Clean Equipment | | | | | | | |

| WEEK 2 | SAT | SUN | MON | TUE | WED | THU | FRI |
|---|---|---|---|---|---|---|---|
| Month/Day/Year | 02/13/21 | 02/14/21 | 02/15/21 | 02/16/21 | 02/17/21 | 02/18/21 | 02/19/21 |
| VISIT ONE | | | | | | | |
| TIME IN | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| TIME OUT | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| VISIT TWO | | | | | | | |
| TIME IN | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| TIME OUT | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| | | | | | | | |
| Total Daily Hrs: | | | | | | | |
| WEEK 2 | | | | 1:1Total weekly hours: | | | |
| Activities | | | | | | | |
| Dressing | | | | | | | |
| Grooming | | | | | | | |
| Bathing | | | | | | | |
| Eating | | | | | | | |
| Transfers | | | | | | | |
| Mobility | | | | | | | |
| Positioning | | | | | | | |
| Toileting | | | | | | | |
| Behavior | | | | | | | |
| IADL | | | | | | | |
| Meds Reminder | | | | | | | |
| Clean Equipment | | | | | | | |

***Acknowledgements & Signatures:***

After the PCA has documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from the PCA. Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on PCA billings for Medical Assistance payment. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the PCA Care Plan.

| | |
|---|---|
| ***Print Recipient Name*** | **Member # or DOB** |
| **Recipient/Responsible Party Signature:** | **Date:** |
| ***Print PCA Name*** | ***PCA Provider #*** |
| **PCA Signature:** | **Date:** |

**Dates and location of Recipient stay in Hospital or Care Facility.**

**Please use standard 12 hr time, in 15 min increments, with minutes noted.**

**Timesheet must indicate AM or PM for every Time IN and every Time OUT.**

**Every date box must have month/day/year entered for entire timesheet.**

**Timesheet must be filled out each shift.**

**Timesheet must be an ORIGINAL timesheet - not photocopied.**

**Incomplete, incorrect, or illegible timesheets cannot be accepted for billing.**

**Time sheets with white out will not be accepted**


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**Reminder: Timesheets are due by 5:00 PM on Monday 02/22/2021**