**PCA Time and Activity Documentation- English Version 01-2024**

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| **PCA Agency Name**My Home Care, Inc. 1736 Cope Avenue Suite #4, Maplewood, MN 55109 | **Phone: (651) 955-3683****Fax: (651) 369-2916** |
| **Dates/Location of recipient Stay in Hospital/ Care Facility/Incarceration** |
|  |
| **Date of Service** | **Sunday****MM/DD/YYYY** | **Monday****MM/DD/YYYY** | **Tuesday****MM/DD/YYYY** | **Wednesday****MM/DD/YYYY** | **Thursday****MM/DD/YYYY** | **Friday****MM/DD/YYYY** | **Saturday****MM/DD/YYYY** |
| (in consecutive order) |  |  |  |  |  |  |  |

**Activities** (your initials indicate you provided the services as described in the PCA Care Plan)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Dressing |  |  |  |  |  |  |  |
| Grooming |  |  |  |  |  |  |  |
| Bathing |  |  |  |  |  |  |  |
| Eathing |  |  |  |  |  |  |  |
| Transfers |  |  |  |  |  |  |  |
| Mobility |  |  |  |  |  |  |  |
| Positioning |  |  |  |  |  |  |  |
| Toileting |  |  |  |  |  |  |  |
| Health Related |  |  |  |  |  |  |  |
| Behavior |  |  |  |  |  |  |  |

**IADLs** (Covered services for recipients over age of 18 years only)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Light Housekeeping |  |  |  |  |  |  |  |
| Laundry |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

**Visit One**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Ratio Staff to recipient | 1:1 1:2 1:3 | 1:1 1:2 1:3 | 1:1 1:2 1:3 | 1:1 1:2 1:3 | 1:1 1:2 1:3 | 1:1 1:2 1:3 | 1:1 1:2 1:3 |
| Share services location |  |  |  |  |  |  |  |
| Time in(circle AM/PM) | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| Time out (circle AM/PM) | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |

**Visit Two**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Ratio Staff to recipient | 1:1 1:2 1:3 | 1:1 1:2 1:3 | 1:1 1:2 1:3 | 1:1 1:2 1:3 | 1:1 1:2 1:3 | 1:1 1:2 1:3 | 1:1 1:2 1:3 |
| Share services location |  |  |  |  |  |  |  |
| Time in(circle AM/PM) | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| Time out (circle AM/PM) | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |
| **Daily Total** (minutes) | Minutes | Minutes | Minutes | Minutes | Minutes | Minutes | Minutes |
| **Total Minutes****this timesheet** | Total 1:1 | Total 1:2 | Total 1:3 |
| Minutes |  | Minutes |  | Minutes |  |

Acknowlegement and Required Signatures

After the PCA has documentated his/her time and activity, the recipient must draw a line through any date/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 billing 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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Recipient Name (First, MI, Last)** | **MA Member # or DOB** | **Recipient/ Responsible party Signature** | **Date** |
|  |  |  |  |

I Certify and swear under penalty of law that I have auccurately reported on this time sheet the hours I actually worked, the servieces I provided, and the dates and times worked. I understand that misreporting my hours is fraud for which I could face criminal prosecution and civil proceedings.

|  |  |  |  |
| --- | --- | --- | --- |
| **PCA Name (First, MI, Last)** | **PCA NPI/UMPI** | **PCA Signature** | **Date** |
|  |  |  |  |