Clear Form

Minnesota Department of **Human Services**

DHS-4691-ENG 8-16

PCA Time and Activity Documentation

PCA AGENCY NAME	DATES/LOCATION OF RECIPIENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION	PHONE NUMBER
Nova Home Health Care LLC		(612) 263-4219

Dates of Service (in consecutive order)	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Activities	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behavior							
IADLs							

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
Shared 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
Shared 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 Time Sheet	**Total 1:1**	**Total 1:2**	**Total 1:3**
	MINUTES	MINUTES	MINUTES

Acknowledgement and Required Signatures

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

RECIPIENT NAME (FIRST, MI, LAST)	MA MEMBER # or DATE OF BIRTH	RECIPIENT/RESPONSIBLE PARTY SIGNATURE	DATE

I certify and swear under penalty of law that I have accurately reported on this time sheet the hours I actually worked, the services 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

Review PCA Provider Time and Activity Documentation for additional policy information about timesheet requirements.