Trust Home Care LLC

100 S 5th Street Ave, STE 1900 MPLS, MN 55402

763-501-0792 ( ) 612-465-2172 ( )

Pay Period End: _____/_____/_____

Client Name: _____ **PCA Name:** _____

Client MA # or DOB: _____ **PCA Provider #:** _____ **PCA Ph. #:** _____

Circle Am/ PM & Initial Cares provided for each shift. Draw a line through any days NOT worked.

	Date	Shift One In	Shift One Out	Shift Two In	Shift Two Out	Shift Three In	Shift Three Out	Daily Total	Dressing	Grooming	Bathing	Eating	Transfers	Mobility	Positioning	Toileting	Behavior	Health Related	I.A.D.L's	Laundry	Meal Prep.
Sun		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
Mon		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
Tue		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
Wed		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
Thu		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
Fri		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
Sat		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
							Weekly Hours														
Sun		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
Mon		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
Tue		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
Wed		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
Thu		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
Fri		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
Sat		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM														
							Weekly Hours												Pay Period Total Hrs		

Please note: this timecard is for 1:1 services only. For shared care option, you must use DHS-4691

****After the PCA has documented his/her time and activity, the client/RP must draw a line through any dates & times he/she did not receive services from the PCA. Review the completed timesheet 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 & services entered above are accurate & that the services were performed as specified in the PCA Care Plan.****

Client Signature: _____ **Date** _____

PCA Signature: _____ **Date** _____

White Copy - Fax, email time card, 1 copy for client & 1 copy for PCA

Hospitalization dates, change in condition, etc.:

_____

_____

_____