PCA Time and Activitiy Documentation- English Version 12-2019

PCA Agency Name **Maplewood Home Care, 1736 Cope Ave E, Suite 2, Maplewood, MN 55109**	**Phone: (952) 456 - 6561** **Fax: (952) 777- 1668**

Dates/Location of recipient Stay in Hospital/ Care Facility/Incarceration

Date of Service (in consecutive order)	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
Activities (your initials indicate you provided the services as described in the PCA Care Plan)							
Dressing							
Grooming							
Bathing							
Eating							
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	AM	AM	AM	AM	AM	AM	AM
(circle AM/PM)	PM	PM	PM	PM	PM	PM	PM
Time out	AM	AM	AM	AM	AM	AM	AM
(circle AM/PM)	PM	PM	PM	PM	PM	PM	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	AM	AM	AM	AM	AM	AM	AM
(circle AM/PM)	PM	PM	PM	PM	PM	PM	PM
Time out	AM	AM	AM	AM	AM	AM	AM
(circle AM/PM)	PM	PM	PM	PM	PM	PM	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	

Acknowledgment and Required Signatures

After the PCA has documentation 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 if 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**