Your Journey Home Care Solutions TIMESHEET

Version 7

Timesheet Email: yourjourneyhcs@gmail.com Minneapolis MN 55445
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CLIENT FIRST NAME	LAST NAME	**Caregiver** FIRST NAME	LAST NAME	Circle if LPN / RN

Client MA# and PCA UMPI documented electronically

Write in week Dates: **Mon**____/____/____ thru **Sun**____/____/____
MM DD YY MM DD YY

Fill in Month and Day	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**
Visit One	**NOTE: All shifts Single Client unless otherwise noted. For Shared Care PCA circle client ratio**						
Service	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3
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							
Service	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3
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 Three							
Service	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3	Shared 1:2 1:3
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

Activities- *******PLEASE INITIAL ACTIVITIES PERFORMED*******

Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behavior							
Other							
IADL's (not for kids)							

	Mon	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**
Total Hours for Each Day							

Total Hours for This Week	**Total Hours-Single Client**	**Total Hours -Shared 1:2_**	**Total Hours - Shared 1:3**

Acknowledgment and Required Signatures

After the PCA has documented his/her time and activity, the client 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. I certify and swear that I have accurately reported on this time sheet the hours actually worked, the services provided, and the dates and times worked. I understand that misreporting hours is fraud for which I could face criminal prosecution and civil proceedings. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the PCA Care Plan.

NOTE- IF TIMESHEET IS NOT ACCURATELY FILLED OUT IT CANNOT BE PAID ON UNTIL CORRECTED!

CLIENT/RESPONSIBLE PARTY SIGNATURE	**DATE Signed (m/d/y)**	Caregiver SIGNATURE (If Nurse, list title)	**DATE Signed (m/d/y)**

ALL TIMESHEETS MUST BE RECEIVED ANY DAY OR TIME BEFORE 5PM ON THE TUESDAY FOLLOWING THE END OF THE PAY PERIOD