PCA TIME AND ACTIVITY DOCUMENTATION

1821 W University Ave., N188
Saint Paul, Minnesota 55104
Phone: 651-203-7091
Fax: 651 927-0199

WEEK 1	THU	FRI	SAT	SUN	MON	TUE	WED
Month/Day/Year							
VISIT ONE							
TIME IN	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
TIME OUT	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
VISIT TWO							
TIME IN	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
TIME OUT	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
Total Daily Hrs:							

WEEK 1	1:1 Total weekly hours:

Activities	THU	FRI	SAT	SUN	MON	TUE	WED
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Behavior							
Health-Related							
Instrumental Activities of Daily Living (only Recipients age 18+)							
Laundry							
Housekeeping							
Other (note activity)							

WEEK 2	THU	FRI	SAT	SUN	MON	TUE	WED
Month/Day/Year							
VISIT ONE							
TIME IN	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
TIME OUT	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
VISIT TWO							
TIME IN	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
TIME OUT	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
Total Daily Hrs:							

WEEK 2	1:1 Total weekly hours:

Activities	THU	FRI	SAT	SUN	MON	TUE	WED
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Behavior							
Health-Related							
Instrumental Activities of Daily Living (only Recipients age 18+)							
Laundry							
Housekeeping							
Other (note activity)							

Acknowledgements & Signatures:
After the PCA has documented his/her time and activity, the recipient 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. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the PCA Care Plan.

Print PCA Name	**PCA Provider #**
PCA Signature:	**Date:**
Print Recipient Name	***MA Member # or DOB***
Recipient/Responsible Party Signature:	**Date:**
Dates and location of Recipient stay in Hospital or Care Facility.	

Please use standard 12 hr time, in 15 min increments, with minutes noted.
Timesheet must indicate AM or PM for every Time IN and every Time OUT.
Every date box must have month/day/year entered for entire timesheet.
Timesheet must be filled out each shift.
Timesheet must be an ORIGINAL timesheet - not photocopied.
Incomplete, incorrect, or illegible timesheets cannot be accepted for billing.

ICARE TEAM HOME HEALTH CARE, LLC
1821 UNIVERSITY AVE W #N188
SAINT PAUL, MN 55104

PH: 952 221-0729
FAX: 651-927-0199
PH 2: