2740 American Blvd West, Suite 100, Bloomington MN 55431
TEL: (952) 858-8827 FAX: (952) 540-4672

PCA Time and Activity Documentation

Dates of service	MM/DD/YY (Saturday)	MM/DD/YY (Sunday)	MM/DD/YY (Monday)	MM/DD/YY (Tuesday)	MM/DD/YY (Wednesday)	MM/DD/YY (Thursday)	MM/DD/YY (Friday)

Activities

Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behavior							
IADL's (18 and up)							

IADL's= meal prep, laundry, household tasks, shopping/errands, accompany to appointments (18 and over ONLY)

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 care 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 care 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 Three

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 care 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 Timesheet	**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 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 preformed as specified in the PCA Care Plan.

RECIPIENT NAME (FIRST, MI LAST)	MA MEMBER # OR BIRTH DATE	PCA NAME (FIRST, MI, LAST)	PCA NPI/UMPI

RECIPIENT/ RESPONSIBLE PARTY SIGNATURE	DATE	PCA SIGNATURE	DATE

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PROGRESS NOTES

CLIENT NAME:_____

EMPLOYEE NAME:_____

DATE	TIME	NOTES SHOULD BE SIGNED BY CARE GIVER