



# PCA Time and Activity Documentation

|  |  |                                     |                                   |
|--|--|-------------------------------------|-----------------------------------|
| PCA AGENCY NAME<br><b>CARINGHANDS HOME HEALTH CARE INC.</b>              |  | PHONE NUMBER<br><b>651-207-8245</b> | FAX NUMBER<br><b>651-493-6975</b> |
| DATES/LOCATION OF RECIPIENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION |  |                                     |                                   |
| INDIVIDUAL PCA PROVIDER NAME   |  | RECIPIENT NAME                      |                                   |

| Dates of Service<br>(in consecutive order) | MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY | MM/DD/YY  |
|--|----------|----------|----------|----------|----------|----------|-----------|
|  | Thursday | Friday   | Saturday | Sunday   | Monday   | Tuesday  | Wednesday |
| Dressing                                   |          |          |          |          |          |          |           |
| Grooming                                   |          |          |          |          |          |          |           |
| Bathing                                    |          |          |          |          |          |          |           |
| Eating                                     |          |          |          |          |          |          |           |
| Transfers                                  |          |          |          |          |          |          |           |
| Mobility                                   |          |          |          |          |          |          |           |
| Positioning                                |          |          |          |          |          |          |           |
| Toileting                                  |          |          |          |          |          |          |           |
| Health Related                             |          |          |          |          |          |          |           |
| Behavior                                   |          |          |          |          |          |          |           |
| IADLs                                      |          |          |          |          |          |          |           |

## 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 |
| Shared services location   |          |     |     |          |     |     |          |     |     |          |     |     |          |     |     |          |     |     |
| Time in<br>(circle AM/PM)  | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     |
| Time out<br>(circle AM/PM) | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>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 |
| Shared services location   |          |     |     |          |     |     |          |     |     |          |     |     |          |     |     |          |     |     |
| Time in<br>(circle AM/PM)  | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     |
| Time out<br>(circle AM/PM) | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     | AM<br>PM |     |     |

## Daily Total (minutes)

|         |         |         |         |         |         |         |
|---------|---------|---------|---------|---------|---------|---------|
| MINUTES | MINUTES | MINUTES | MINUTES | MINUTES | MINUTES | MINUTES |
|---------|---------|---------|---------|---------|---------|---------|

## Total Minutes This Time Sheet

|                  |  |                  |  |                  |  |
|------------------|--|------------------|--|------------------|--|
| <b>Total 1:1</b> |  | <b>Total 1:2</b> |  | <b>Total 1:3</b> |  |
| 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/times he/she did not receive services from the PCA. Review the completed time sheet for accuracy before signing. It is a crime to provide false information on PCA billings for Medical Assistance payment. By signing below you swear and verify the time and services entered above are accurate and that the services were performed by the PCA listed below as specified in the PCA Care Plan.

|                                  |                              |                                       |      |
|----------------------------------|------------------------------|---------------------------------------|------|
| RECIPIENT NAME (FIRST, MI, LAST) | MA MEMBER # or DATE OF BIRTH | RECIPIENT/RESPONSIBLE PARTY SIGNATURE | DATE |
|----------------------------------|------------------------------|---------------------------------------|------|

I certify and swear under penalty of 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 |
|----------------------------|--------------|---------------|------|