



____ / ____ / ____ / to ____ / ____ / ____
Dates of Pay Period

____ / ____ / ____
 Print Client Name Date

____ / ____ / ____
 Print PCA Name Date

USE BLACK OR DARK BLUE INK PEN

DATE Visit 1 in / out Visit 2 in / out Visit 3 in / out

Circle AM/PM Circle staff ratio

Ratio staff to recipient	1:1	1:2	1:3	1:1	1:2	1:3	1:1	1:2	1:3
Shared care location									

Month / Day / Year

DATE		Day	AM	PM	Total Hours	GROOMING/HYGIENE	BATHING	DRESSING	EATING	TRANSFERS	POSITIONING	MOBILITY	TOILETING	HEALTH RELATED	BEHAVIOR	IADL's (only recipients age 18+)	LIGHT HOUSEKEEPING	LAUNDRY	OTHER NEEDS	
/ /	Sat																			
/ /	Sun																			
/ /	M																			
/ /	T																			
/ /	W																			
/ /	Th																			
/ /	F																			
/ /	Sat																			
/ /	Sun																			
/ /	M																			
/ /	T																			
/ /	W																			
/ /	Th																			
/ /	F																			
					Total Hours	Initial above boxes for skills worked on each day														

Location of hospital, nursing home, or incarceration stay:

Admitted ____ / ____ / ____ : ____ am or pm
DATE TIME

Client Date of Birth (required) ____ / ____ / ____

Discharged ____ / ____ / ____ : ____ am or pm
DATE TIME

Client MHCP ID# (required) _____

PCA Provider ID# _____

Notice: That it is a federal crime to provide false information for Medical Assistance payment

Acknowledgment 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 that time and services entered above are accurate and that the services were performed as specified in the PCA Care Plan.

I verify the above information to be correct:

____ / ____ / ____
 Client Signature Date

____ / ____ / ____
 PCA Signature Date

FOR OFFICE USE ONLY!

Regular Hours _____

Overtime Hours _____

Paid _____

Billed _____

Client Total _____

651-645-9887

Please indicate your time with an AM or PM after it.

Please draw a line through the dates and times when services were not received

*** fax time sheets NOT ACCEPTED ***

State requires month, day, year be on all days worked.

PLEASE DO NOT USE WHITE OUT AT ALL!!

Instructions for PCA Time and Activity Documentation

This form documents time and activity between one PCA and one recipient. Document up to two visits per day on this form. Employers may have additional instructions or documentation requirements. For shared care, you must use a separate form for each person for whom you are providing care.

Name of PCA Provider Agency

Enter name of the PCA provider agency and its telephone number.

Recipient Stays

Enter dates and location of recipient stays in a hospital, care facility or incarceration.

Dates of Service

Dates of service must be in consecutive order. Enter the date in mm/dd/yy format for each date you provide service. The recipient must draw a line through any dates and times PCA services were not provided.

Activities

For each date you provided care, write your initials next to all the activities you provided. Your initials indicate you provided the service as described in the PCA Care Plan. If you provide a service more than once in a day, initial only once. The following are general descriptions of activities of daily living and instrumental activities of daily living.

Dressing – Choosing appropriate clothing for the day, includes laying-out of clothing, actual applying and changing clothing, special appliances or wraps, transfers, mobility and positioning to complete this task.

Grooming – Personal hygiene, includes basic hair care, oral care, nail care (except recipients who are diabetic or have poor circulation), shaving hair, applying cosmetics and deodorant, care of eyeglasses, contact lenses, hearing aids

Bathing – Starting and finishing a bath or shower, transfers, mobility, positioning, using soap, rinsing, drying, inspecting skin and applying lotion.

Eating – Getting food into the body, transfers, mobility, positioning, hand washing, applying of orthotics needed for eating, feeding, preparing meals and grocery shopping.

Transfers – Moving from one seating/reclining area or position to another.

Mobility – Moving including assistance with ambulation, including use of a wheelchair. Mobility does not include providing transportation for a recipient.

Positioning – Including assistance with positioning or turning a recipient for necessary care and comfort.

Toileting – Bowel/bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area and inspecting skin and adjusting clothing.

Health-related Procedures and Tasks –

Health related procedures and tasks according to PCA policy. Examples include: range of motion and passive exercise, assistance with self-administered medication including bringing medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, interventions, monitoring and observations for seizure disorders, and other activities listed on the care plan and considered within the scope of the PCA service meeting the definition of health-related procedures and tasks.

Behavior – Redirecting, intervening, observing, monitoring and documenting behavior.

IADLs (Instrumental Activities of Daily Living) – Covered service for recipients over age 18 years only, such as: meal planning and preparation, basic assistance with paying the bills, shopping for food, clothing, and other essential items, performing household tasks integral to the personal care assistance services; assisting with recipient's communication by telephone, and other media, and accompanying the recipient with traveling to medical appointments and participation in the community.

Light Housekeeping – Light housekeeping integral to personal care may include washing dishes, putting dishes in dishwasher, clearing tables, taking out garbage, making the bed and cleaning bathroom.

Laundry – Laundry integral to personal care, includes sorting clothes, putting clothes in washer and dryer, adding soap and/or dryer sheet, folding and putting away clothes.

Other

Visit One Documentation of the first visit of the day.

Ratio of PCA to Recipient –

1:1 = One PCA to one recipient

1:2 = One PCA to two recipients (shared services)

1:3 = One PCA to three recipients (shared services)

Circle the appropriate ratio of PCA to recipients for this visit

Shared Care Location – (Required for shared care only) Write a brief description of the location where you provided the shared care, examples include school, work, store and home.

Time in – Enter time in hours and minutes that you started providing care and circle AM or PM.

Time out – Enter time in the hours and minutes that you stopped providing care and circle AM or PM.

Visit Two

This is documentation for the second visit of the day. Follow instructions for Visit One above.

Daily Total

Add the total time in minutes that you spent with this recipient for the care documented in one column.

Total Minutes This Time Sheet

Add the time in minutes for all visits on this entire time sheet and enter the total in the appropriate ratio box.

Acknowledgement and Required Signatures

Recipient/responsible party prints the recipient's first name, middle initial, last name, and MA Member (MHCPID) Number or birth date (for identifying purposes). Recipient/responsible party signs and dates form. PCA prints his/her first name, middle initial, last name, individual PCA Unique Minnesota Provider Identifier (UMPI) (for identifying purposes). PCA signs and dates form.