**ELEGED HOME CARE INC** **PHONE: (612) 315-4497 •** **FAX: (612) 435-2770** **PCA Time and Activity Documentation**

**DATES/LOCATION OF RECIPIENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION:**

| **Dates of Service (in consecutive order)** | SATURDAY | SUNDAY | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|---|---|---|---|---|---|---|---|
| **ACTIVITIES** | | | | | | | |
| Dressing | | | | | | | |
| Grooming | | | | | | | |
| Bathing | | | | | | | |
| Eating | | | | | | | |
| Transfers | | | | | | | |
| Mobilty | | | | | | | |
| Positioning | | | | | | | |
| Toileting | | | | | | | |
| Health Related | | | | | | | |
| Behavior | | | | | | | |
| **IADL's** (only recipients age 18+) | | | | | | | |
| Light Housekeeping | | | | | | | |
| Laundry | | | | | | | |
| Other | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|
| 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 |
|---|---|---|---|---|---|---|---|
| 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** (in minutes) | MINUTES | MINUTES | MINUTES | MINUTES | MINUTES | MINUTES | MINUTES |
|---|---|---|---|---|---|---|---|

| **Total Minutes This Time Sheet** | **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 performed as specified in the PCA Care Plan.

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

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| Eating | | | | | | | |
| Transfers | | | | | | | |
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|---|---|---|---|---|---|---|---|
| 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 |
|---|---|---|---|---|---|---|---|
| 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** (in minutes) | MINUTES | MINUTES | MINUTES | MINUTES | MINUTES | MINUTES | MINUTES |
|---|---|---|---|---|---|---|---|

| **Total Minutes This Time Sheet** | **Total 1:1** | **Total 1:2** | **Total 1:3** |
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