

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

**Dates of Service  
(in consecutive order)**

SATURDAY	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
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**ACTIVITIES**

Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behavior							
<b>IADL's (only recipients age 18+)</b>							
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
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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
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**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 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	RECIPIENT/RESPONSIBLE PARTY SIGNATURE	DATE
PCA NAME (FIRST, MI, LAST)	PCA NPI/UMPI	PCA SIGNATURE	DATE

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**Visit Two**

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(in minutes)**

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