



Alliance Health Services

PCA TIME AND ACTIVITY DOCUMENTATION

CLIENT NAME (First, MI, Last)	MA ID # OR BIRTH DATE	PCA NAME (First, MI, Last)	PCA PROVIDER #
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For the week of: **Sunday** ___/___/___ thru **Saturday** ___/___/___
MM DD YY MM DD YY

DATES OF SERVICE	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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VISIT ONE	Staff to Client Ratio (Circle One)	Single	Shared	Single	Shared	Single	Shared	Single	Shared	Single	Shared	Single	Shared	Single	Shared
	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	Staff to Client Ratio (Circle One)	Single	Shared	Single	Shared	Single	Shared	Single	Shared	Single	Shared	Single	Shared	Single	Shared
	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	Staff to Client Ratio (Circle One)	Single	Shared	Single	Shared	Single	Shared	Single	Shared	Single	Shared	Single	Shared	Single	Shared
	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

ACTIVITIES	To ensure payment you MUST write your INITIALS next to all the activities you provided for each date you provided care. If Other, please DESCRIBE.														
	Dressing														
	Grooming														
	Bathing														
	Eating														
	Transfers														
	Mobility														
	Positioning														
	Toileting														
	Light Housekeeping														
	Laundry														
	Health Related														
Behavior															
Other / Describe =															

DAILY TOTAL HOURS															
TOTAL HOURS FOR WEEK	TOTAL HOURS-Single Client							TOTAL HOURS-Shared Care (If Approved)							

ACKNOWLEDGMENT AND REQUIRED SIGNATURES

After the PCA has documented his/her time and activity, the client must draw a line through any dates and time he/she did not receive services from the PCA. Client/Responsible Party and Staff MUST review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on PCA billings for any Medical Assistance payment, or any other source of payment. By signing below your signature verifies the time and services entered above are accurate and that the services were performed in the clients home, as specified in the PCA Care Plan and that the client was in the PCA's care and was not in a hospital, care facility, or incarcerated during this time. If the client was in a hospital, care facility or was incarcerated during the week of this timecard, please indicate the dates and location of stay here: DATES: LOCATION:

CLIENT/RESPONSIBLE PARTY SIGNATURE	DATE (MM/DD/YY)	PCA SIGNATURE	DATE (MM/DD/YY)
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ADMIN (Initial)	QP (Initial & Date)

NOTE: ALL TIMESHEETS MUST BE RECEIVED EVERY MONDAY BY 10:00AM FOLLOWING THE WEEK WORKED. PLEASE CALL AFTER YOU SEND YOUR TIMESHEETS TO MAKE SURE THEY WERE RECEIVED. BLANK TIMESHEETS CAN BE FOUND AT OUR WEBSITE WWW.ALLIANCEHEALTHCARE.COM