2260 Cliff Road – Eagan, Minnesota 55122
Phone: 651-895-8030 Toll Free: 1-800-548-0980 Fax: 651-895-8070

AHC PCA

Revised May 2017

PCA TIME AND ACTIVITY DOCUMENTATION

CLIENT NAME (First, MI, Last)	MA ID # OR BIRTH DATE	PCA NAME (First, MI, Last)	PCA PROVIDER #

For the week of: **Sunday**_____/_____/_____ thru **Saturday**_____/_____/_____
MM DD YY MM DD YY

DATES OF SERVICE		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
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 <u>INITIALS</u> 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 client's 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)

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