

# PCA Time and Activity Documentation

Pay Period: \_\_\_\_\_ to \_\_\_\_\_

## For 1:1 Services

Dates of Service Week One	MM/DD/YY-Sun	MM/DD/YY-Mon	MM/DD/YY-Tues	MM/DD/YY-Wed	MM/DD/YY-Thur	MM/DD/YY-Fri	MM/DD/YY-Sat
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Activities (Initial all that apply for EACH day worked)

### COMPLETE BOTH SIDES OF THIS SHEET

Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
IADLs							
Complex Health							
Behavior							

#### Visit One

Pay Type	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR
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

Pay Type	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR
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

Pay Type	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR
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 Four

Pay Type	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR
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 Totals (Hours)

HOURS	HOURS	HOURS	HOURS	HOURS	HOURS	HOURS	HOURS
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#### Total Hours Week One

**Page 1**

**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)	Birthdate	PCA NAME (First, MI, Last)	PCA PROVIDER NUMBER
RECIPIENT / RESPONSIBLE PARTY SIGNATURE	DATE	PCA SIGNATURE	DATE

Dates of Service Week Two	MM/DD/YY-Sun	MM/DD/YY-Mon	MM/DD/YY-Tues	MM/DD/YY-Wed	MM/DD/YY-Thur	MM/DD/YY-Fri	MM/DD/YY-Sat
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Activities (Initial all that apply for EACH day worked)

**COMPLETE BOTH SIDES OF THIS SHEET**

Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
IADLs							
Complex Health							
Behavior							

**Visit One**

Pay Type	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR
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**

Pay Type	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR
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**

Pay Type	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR
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 Four**

Pay Type	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR	SD TR
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 Totals (Hours)**

	HOURS	HOURS	HOURS	HOURS	HOURS	HOURS	HOURS
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**Total Hours Week Two**

Office Use Only

**Total Hours Pay Period**

Office Use Only

PCA AGENCY NAME

Southern Minnesota Independent Living Enterprises & Services, Inc.

PHONE NUMBER

507-345-7139

DATES/LOCATION OR RECIPIENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION

TR = Training SD = Shift Differential  
Time Increments to use: 15min=.25 30min=.5 45min=.75

yes, PCA's last check. Last day worked is \_\_\_\_\_

	<b>Reg</b>	<b>SD</b>	<b>CI</b>	<b>HO</b>	<b>TR</b>	<b>OT</b>	<b>Total</b>