V-CARE™ HOME HEALTH, INC.

DHS-4691-ENG 9-11

Homemaker and Activity Documentation

PCA AGENCY NAME	PHONE NUMBER
V-Care Home Health, Inc.	(651) 793 - 7635

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

INDIVIDUAL PCA PROVIDER NAME	RECIPIENT NAME

Dates of Service (in consecutive order)

MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY

IADL's

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Meal Preparation							
Light House Keeping							
Laundry							
Grocery Shopping							
Medical Appointments							
Participate in Community							
Blood Sugar\Blood Pressure							
Reminder of Medication Intake							

Visit One

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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
Shared services location							
Time in (check AM/PM)	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Time out (check AM/PM)	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM

MR# _____

Visit Two

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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
Shared services location							
Time in (check AM/PM)	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
Time out (check AM/PM)	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Recepient/Responsible Party Initial							

Daily Total (minutes)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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 Homemaker 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 Homemaker. Review the completed time sheet for accuracy before signing. It is a crime to provide false information on Homemaker billings for Medical Assistance payment. By signing below you swear and verify the time and service entered above are accurate and that the services by the Homemaker listed below as specified in the Client Care Plan.

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

Homemaker Comment :