V-CARE HOME HEALTH, INC.

DHS-4691-ENG 9-11

PCA Time 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

Activities	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behaviours							
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 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 service entered above are accurate and that the services were performed as specified in the PCA 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

PCA Comment :

MR#
DHS-4691-ENG 9-11