VALLEY VIEW HOME CARE LLC. PCA Time and Activity Document

FAX TO: (612) 249-6469

1. Activities*								Activities*							
Dressing								Dressing							
Grooming								Grooming							
Bathing								Bathing							
Eating								Eating							
Transfers								Transfers							
Mobility								Mobility							
Positioning								Positioning							
Toileting								Toileting							
Behavior								Behavior							
Health-Related								Health-Related							
IADL's								IADL's							
WEEK 1	**THUR**	**FRI**	**SAT**	**SUN**	**MON**	**TUE**	**WED**	**WEEK 2**	**THUR**	**FRI**	**SAT**	**SUN**	**MON**	**TUE**	**WED**
mm/dd/yyyy	**3/10/19**	**3/11/19**	**3/12/19**	**3/13/19**	**3/14/19**	**3/15/19**	**3/16/19**	**mm/dd/yyyy**	**3/17/19**	**3/18/19**	**3/19/19**	**3/20/19**	**3/21/19**	**3/22/19**	**3/23/19**
Time IN*	#NAME? AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	***Time IN****	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time OUT*	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	***Time OUT****	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time IN	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	***Time IN***	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time OUT	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	***Time OUT***	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Daily Hrs:	*	*	*	*	*	*	*	**Daily Hrs:**	*	*	*	*	*	*	*
WEEK 1				1:1 Total hours:	*			**WEEK 2**				1:1 Total hours:	*		

Acknowledgements & 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.

Print Recipient Name	***MA # or DOB***
Recipient/Responable Party Signature:	***Date:***

I certify and swear under penalty of law that I have accurately reported on this time sheet the hours I actually worked, the services I provided, and the dates and times worked. I understand that misreporting my hours is fraud for which I could face criminal prosecution and civil proceedings.

Print PCA Name	***PCA UMPI#***
PCA Signature:	***Date:***

Dates and location of Recipient stay in Hospital or Care Facility.

Please use standard 12 hr time, in 15 min increments, with minutes noted.

Timesheet must indicate A(AM) or P(PM) for every Time IN and every Time OUT.

Every date box must have month/day/year entered for entire timesheet.

Timesheet must be filled out each shift.

Timesheet must be an ORIGINAL timesheet - not photocopied.

Incomplete, incorrect, or illegible timesheets cannot be accepted for billing.

*** = MUST COMPLETE**

***** = MUST SIGN AND DATE FOR IT TO BE VALID (DO NOT BILLED UNLESS ITS VALID)**

#3. Only complete if there was a PCA Service Verification Call done.

Total hours	**#3. PCA SVC**	**Date: _____/_____/_____**	**Attemp1 Time:**	**Attemp2 Time:**

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Reminder: Timesheets are due Monday and no later then 12PM on Tuesday.