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PCA TIME & ACTIVITY DOCUMENTATION

☐ Regular ☐ Extended ☐ Temp Increase/Decrease

Client Name: _____

Dates of Service (mm/dd/yy)	WEEK 1							WEEK 2						
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Activities (Document (R) if client refuses care)	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials
Dressing														
Grooming														
Bathing														
Eating														
Transfers														
Mobility														
Positioning														
Toileting														
Health Related														
Behavior														
IADLs														
Dates/Location of Recipient stay in Hospital/Care Facility/Incarceration (no hours can be claimed):							Admit (Date/Time)		Discharged (Date/Time)			Location		

VISIT INFORMATION

	Day	Date	VISIT 1		VISIT 2		Daily Total
			Time In	Time Out	Time In	Time Out	
WEEK 1	MON		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	TUE		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	WED		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	THU		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	FRI		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	SAT		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	SUN		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	Week 1 Total						

	Day	Date	VISIT 1		VISIT 2		Daily Total
			Time In	Time Out	Time In	Time Out	
WEEK 2	MON		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	TUE		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	WED		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	THU		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	FRI		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	SAT		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	SUN		☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	
	Week 2 Total						

Acknowledgement and Required Signatures

After the PCA has documented his/her time and activity, the recipient must draw a line through any dates/times he/she did not receive services from the PCA. Review the completed time sheet for accuracy before signing. It is a crime to provide false information on PCA billings for Medical Assistance payment. By signing below, you swear and verify the time and services entered above are accurate and that the services were performed by the PCA listed below as specified in the PCA Care Plan.

CLIENT NAME (FIRST, LAST)	PMI # OR DOB	CLIENT/RESPONSIBLE PARTY SIGNATURE	DATE
I certify and swear under penalty of law that I have accurately reported on this time sheet the hours I 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.			
PCA NAME (FIRST, LAST)	PCA UMPI #	PCA SIGNATURE	DATE

INSTRUCTIONS FOR PCA TIME AND ACTIVITY DOCUMENTATION

This form documents time and activity between one PCA and one recipient. Document up to two visits per day on this form. Use additional forms if you do more than two visits per day.

USE BLACK PEN ONLY

Work week is MONDAY through SUNDAY.

DATES OF SERVICE

Dates of service must be in consecutive order. Enter the date in mm/dd/yy format for each date you provide service. The recipient must draw a line through any dates and times PCA services were not provided.

ACTIVITIES

For each date you provided care, write your initials next to all the activities you provided. Your initials indicate you provided the service as described in the Care Plan. If you provide a service more than once a day, initial only once. Each employee MUST use Universal Precautions with every client. This includes frequent Hand Washing and using Personal Protective Equipment. The client must draw a line through any dates and times services were not provided. Document (R) if client refuses any type of activity. The following are general descriptions of activities of daily living and instrumental activities of daily living.

DRESSING

Choosing appropriate clothing for the day includes laying out of clothing, actual applying and changing clothing, special appliances or wraps, transfers, mobility, and positioning to complete this task.

GROOMING

Personal hygiene includes basic hair care, oral care, nail care (except recipients who are diabetic or have poor circulation), shaving hair, applying cosmetics and deodorant, care of eyeglasses, contact lenses, hearing aids.

BATHING

Starting and finishing a bath or shower, transfers, mobility, positioning, using soap, rinsing, drying, inspecting skin, and applying lotion.

EATING

Getting food into the body, transfers, mobility, positioning, hand washing, applying orthotics needed for eating, feeding, preparing meals and grocery shopping.

TRANSFERS

Moving from one seating/reclining area or position to another.

MOBILITY

Moving includes assistance with ambulation, including use of a wheelchair. Mobility does not include providing transportation for a recipient.

POSITIONING

Including assistance with positioning or turning a recipient for necessary care and comfort.

TOILETING

Bowel/bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area and inspecting skin and adjusting clothing.

HEALTH RELATED

Health related procedures and tasks according to PCA policy. Examples include range of motion and passive exercise, assistance with self- administered medication including bringing medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, interventions, monitoring and observations for seizure disorders, and other activities listed on the care plan and considered within the scope of the PCA service meeting the definition of health-related procedures and tasks.

BEHAVIOR

Redirecting, intervening, observing, monitoring and documenting behavior.

IADLS (Instrumental Activities of Daily Living)

Covered service for recipients over age 18 years only, such as: meal planning and preparation, basic assistance with paying the bills, shopping for food, clothing, and other essential items, performing household tasks integral to the personal care assistance services; assisting with recipient's communication by telephone, and other media, and accompanying the recipient with traveling to medical appointments and participation in the community.

DATE

Enter the date in mm/dd/yy format for each date you provide service.

VISIT ONE

Documentation of the first visit of the day.

Time In: Enter exact time in hours and minutes that you started providing care and check AM or PM.

Time Out: Enter the exact time in hours and minutes that you stopped providing care and check AM or PM.

If your shift is 8 hours or more, you must document a minimum of 30 minutes for lunch break.

VISIT TWO

Same as visit one.

DAILY TOTAL

Add the total time in hours and minutes that you spent with this client for the care documented in each row.

WEEKLY TOTAL

Add the time in hours and minutes for all visits on this entire timesheet and enter the total in the appropriate box.

ACKNOWLEDGEMENT AND REQUIRED SIGNATURES

Client/responsible party prints the Client's first name, last name, and MA Member Number or birth date. Client/Responsible party signs and dates form.

PCA prints his/ her first name, last name, individual PCA Unique Minnesota Provider Identifier (UMPI) (for identifying purposes). PCA signs and dates form.