PCA TIME AND ACTIVITY DOCUMENTATION

Silver Mountain Home Health Care LLC 1607 Chicago Ave S, Minneapolis, MN 55404
Tel: (612) 226-5375 Fax: (651) 204-9193

Dates/Locations Recipient Stay in Hospital/Care Facility (rehab or treatment/Incarceration, Jail, etc.)

Dates of Service	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)
	06/13/2024	06/14/2024	06/15/2024	06/16/2024	06/17/2024	06/18/2024	06/19/2024
Activities							
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behavior							
Other							
IADLs (only recipient age 18+)							
Light House Keeping							
Laundry							
Other							
Visit One							
Ratio Staff to recipient shared care location	**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**
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							
Ratio staff to recipient shared care location	**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**
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 (Total Hours)	**HR**	**HR**	**HR**	**HR**	**HR**	**HR**	**HR**
Total Hours This Time Sheet	**Total 1:1 Hours**		**Total 1:1 Hours**			**Total 1:1 Hours**	

Acknowledgement and Required Signature

After the PCA has documented his/her time and activity, the recipient must draw a line through any dates and time he/she didn't 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 service was performed as specified in the PCA Care Plan.

Recipient Name(First, MI, Last)	**Date of Birth**	**Recipient/Responsible 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.

PCA Name(First, MI, Last)	**PCA UMPI#**	**PCA Signature**	**Date**