**Attain Home Care LLC**

**Phone: 320-420-1484**

**Fax: 320-983-8131**

**PCA Time and Activity Documentation**

 **INITIAL** ALL ACTIVITIES PER CARE PLAN

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  **( First, MI, Last )****Recipient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_** | **Dressing** | **Grooming** | **Bathing** | **Eating** | **Transfers** | **Mobility** | **Positioning** | **Toileting** | **Health Care** | **Behavior** | **IADL’s/LHKP** |
| **Week 1** | Date | Time In | Time Out | PCA | HM | Shared | Total |
| DAY | MM/DD/YY | AM/PM | AM/PM | **HRS** | **HRS** | **HRS** |  |
| Sun |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mon. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tues. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Wed. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Thurs. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Friday |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Sat. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

 **Week 1 Total hours worked: \_\_\_\_\_\_**

 **INITIAL** ALL ACTIVITIES PER CARE PLAN

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Week 2** | Date | Time In | Time Out | PCA | **HM** | **Shared** | Total |  |  |  |  |  |  |  |  |  |  |  |
| DAY | MM/DD/YY | AM/PM | AM/PM | **HRS** | **HRS** | **HRS** |  |
| Sun. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mon. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tues. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Wed |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Thurs. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Friday |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Sat. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

 **Week 2 Total hours worked: \_\_\_\_\_\_**

 **Total Hours PCA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Hospitalized, Incarcerated, care facility yes\_\_\_\_ no\_\_\_\_ **If yes** dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Total Hours Shared Care: \_\_\_\_\_\_\_**

 **Total Hours Homemaker: \_\_\_\_\_\_\_**

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 **FELONY (even just $1 worth)** to provide false information on PCA billing 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. \***By Signing, I certify that the employee listed below worked the stated hours above**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recipient Signature OR Responsible Party Signature Date**