Granny's Helpful Hands, LLC

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PCA Time and Activity Documentation

UMPI# A53445200	Thurs	Fri	Sat	Sun	Mon	Tues	Weds
DATES OF SERVICE:							
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Health Related							
Behavior							
IADLS (only recipeints age 18+)							
Light Housekeeping							
Toileting							
Other							

Visit One

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 care location																						
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	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 care location																						
Time in (circle AM/PM)			AM PM			AM PM			AM PM			AM PM			AM PM			AM PM			AM PM	
Time out (circle AM/PM)			PM			PM			PM			PM			PM			PM			PM	

Timesheets must contain the Month, Day, and Year for each day. Any days NOT worked must have a STRAIGHT LINE drawn through them, every job task must be initialed, NO WHITE OUT, NO OVERCORRECTION OF DATES, and 1:1's must be circled for each day of work. If you DO NOT know your PCA PROVIDER #, PLEASE CALL THE OFFICE TO REQUEST IT, ANY TIMESHEETS THAT HAVE ERRORS WILL BE REJECTED AND WILL "NOT BE PAID UNTIL CORRECTED'.

(DAILY TOTAL HOURS)	HOURS	HOURS	HOURS	HOURS	HOURS	HOURS	HOURS
	Total 1:1		Total 1:2		Total 1:3		
TOTAL HOURS	HOURS		HOURS		HOURS		

Acknowledgment 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 services entered above are accurate and that the services were performed as specified in the PCA Care Plan

RECIPIENT PRINTED NAME (FIRST,M,LAST)	DATE OF BIRTH	RECIPIENT/RESPONSIBLE PARTY SIGNATURE	DATE

PCA PRINTED NAME (FIRST,M,LAST)	PCA SIGNATURE	PCA PROVIDER #	DATE