



PCA Time and Activity Documentation

PCA AGENCY NAME Alliance Home Health Care & Nursing Services		PHONE NUMBER (763) 208-6295
DATES/LOCATION OF RECIPIENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION		
INDIVIDUAL PCA PROVIDER NAME	REPCIPIENT NAME	

Dates of Service	SATURDAY	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
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Activities

Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behavior							
IADL's							

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)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Daily Total (minutes)	MINUTES	MINUTES	MINUTES	MINUTES	MINUTES	MINUTES
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Total Minutes This Time Sheet	Total 1:1	Total 1:2	Total 1:3
MINUTES	MINUTES	MINUTES	MINUTES

Relationship

I am related to the recipient as: (use the appropriate modifier on the claim, for example: U1 if the individual PCA provider is the parent or adoptive parent of the recipient)

Parent, Sibling, Adult Child, Grandparent, Grandchild (U1) None of these (UD)

Acknowledgement 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 NAME (FIRST, MI, LAST)	MA MEMBER # or DATE OF BIRTH	RECIPIENT/RESPONSIBLE PARTY SIGNATURE	DATE
PCA NAME (FIRST, MI, LAST)	PCA NPI/UMPI	PCA SIGNATURE	DATE



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Time in (circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
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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
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Daily Total (minutes)	MINUTES	MINUTES	MINUTES	MINUTES	MINUTES	MINUTES	MINUTES
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