

PCA TIME AND ACTIVITY DOCUMENTATION

HMONG HOME HEALTH CARE, INC.

Ph: 651-488-1680 Fax: 651-488-4087

DATES/LOCATION OF RECIPIENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION:

DATES OF SERVICE
(in consecutive order)

MON (MM/DD/YY)	TUE (MM/DD/YY)	WED (MM/DD/YY)	THU (MM/DD/YY)	FRI (MM/DD/YY)	SAT (MM/DD/YY)	SUN (MM/DD/YY)

MON (MM/DD/YY)	TUE (MM/DD/YY)	WED (MM/DD/YY)	THU (MM/DD/YY)	FRI (MM/DD/YY)	SAT (MM/DD/YY)	SUN (MM/DD/YY)

ACTIVITIES WEEK 1

Dressing						
Grooming						
Bathing						
Eating						
Transfers						
Mobility						
Positioning						
Toileting						
Health Related						
Behavior						
IADLs						

WEEK 2

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
Shared services location																		
Time In (circle AM/PM)	AM			AM			AM			AM			AM			AM		
Time Out (circle AM/PM)	PM			PM			PM			PM			PM			PM		

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
AM			AM			AM			AM			AM			AM			AM		
PM			PM			PM			PM			PM			PM			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
Shared services location																		
Time In (circle AM/PM)	AM			AM			AM			AM			AM			AM		
Time Out (circle AM/PM)	PM			PM			PM			PM			PM			PM		

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
AM			AM			AM			AM			AM			AM			AM		
PM			PM			PM			PM			PM			PM			PM		

Daily Total
(Minutes)

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Total Minutes
(Minutes)

Total 1:1	Total 1:2	Total 1:3

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Total 1:1	Total 1:2	Total 1:3

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 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

Please use **BLACK** ink only. White out is not permitted on this form.