Asian-American Home Health Care Services, Inc.
225 W. University Ave, Suite 123B St. Paul, MN 55103
Phone: (Line 1) 651-641-8660, (Line 2) 651-683-2913, (Line 3) 651- 350-7113 **Fax**: 651-641-8652
Email: officeteam@asianamericanhhc.com

PCA TIME AND ACTIVITY DOCUMENTATION

Insurance
- ❑ Medical Assistance
- ❑ Medica
- ❑ Blue Cross Blue Shield
- ❑ Health Partners
- ❑ UCare

DATES/LOCATION OF RECIPENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION
(ATTACH ANY ADDITIONAL NOTES ON BACK OF SHEET)

DATES OF SERVICE	MON	TUE	WED	THUR	FRI	SAT	SUN
	04/19/21	04/20/21	04/21/21	04/22/21	04/23/21	04/24/21	04/25/21

MON	TUE	WED	THUR	FRI	SAT	SUN
04/26/21	04/27/21	04/28/21	04/29/21	04/30/21	05/01/21	05/02/21

ACTIVITIES	WEEK 1							WEEK 2						
Dressing														
Grooming														
Bathing														
Eating														
Transfers														
Mobility														
Positioning														
Toileting														
Health Related														
Behavior														
IADLs														

VISIT ONE

Ratio PCA to Client	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1
Shared care location														
Time In (Circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	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	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

VISIT TWO

Ratio PCA to Client	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1	1:1
Shared care location														
Time In	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
DAILY TOTAL (HOURS)														
TOTAL (HOURS)	**Total 1:1**		**Total 1:2**		**Total 1:3**			**Total 1:1**		**Total 1:2**		**Total 1:3**		
	HR							**HR**						

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.

PLEASE USE BLACK INK. WHITE OUT IS NOT PERMITTED ON THIS FORM

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