



Asian-American Home Health Care Services, Inc.

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PCA TIME AND ACTIVITY DOCUMENTATION

| Insurance | |
|---|--|
| <input type="checkbox"/> Medical Assistance | <input type="checkbox"/> Health Partners |
| <input type="checkbox"/> Medica | <input type="checkbox"/> UCare |
| <input type="checkbox"/> Blue Cross Blue Shield | |

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

| DATES OF SERVICE | MON | TUE | WED | THUR | FRI | SAT | SUN |
|------------------|----------|----------|----------|----------|----------|----------|----------|
| | 06/28/21 | 06/29/21 | 06/30/21 | 07/01/21 | 07/02/21 | 07/03/21 | 07/04/21 |

| MON | TUE | WED | THUR | FRI | SAT | SUN |
|----------|----------|----------|----------|----------|----------|----------|
| 07/05/21 | 07/06/21 | 07/07/21 | 07/08/21 | 07/09/21 | 07/10/21 | 07/11/21 |

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

| WEEK 2 | | | | | | |
|--------|--|--|--|--|--|--|
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| VISIT ONE | | | | | | | |
|-------------------------|----------|----------|----------|----------|----------|----------|----------|
| Ratio PCA to Client | 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 |
| Time Out (Circle AM/PM) | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM |

| | | | | | | |
|----------|----------|----------|----------|----------|----------|----------|
| 1:1 | 1:1 | 1:1 | 1:1 | 1:1 | 1:1 | 1:1 |
| | | | | | | |
| 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 |
| Shared care location | | | | | | | |
| Time In | 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 |
| DAILY TOTAL (HOURS) | | | | | | | |
| TOTAL (HOURS) | Total 1:1 | | Total 1:2 | | Total 1:3 | | HR |

| | | | | | | |
|------------------|----------|------------------|----------|------------------|----------|-----------|
| 1:1 | 1:1 | 1:1 | 1:1 | 1:1 | 1:1 | 1:1 |
| | | | | | | |
| 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 |
| Total 1:1 | | Total 1:2 | | Total 1:3 | | 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 |