



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 07/25/22	TUE 07/26/22	WED 07/27/22	THUR 07/28/22	FRI 07/29/22	SAT 07/30/22	SUN 07/31/22
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MON 08/01/22	TUE 08/02/22	WED 08/03/22	THUR 08/04/22	FRI 08/05/22	SAT 08/06/22	SUN 08/07/22
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ACTIVITIES WEEK 1

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

WEEK 2

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

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

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

	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