

Asian-American Home Health Care Services, Inc.

225 W. University Ave, Suite 123B St. Paul, MN 55103

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Email: officeteam@asianamericanhhc.com PCA TIME AND ACTIVITY DOCUMENTATION

Insurance								
Medical Assistance		Health Partners						
Medica		UCare						
Blue Cross Blue Shield								

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

DATES OF	MON	TUE	WED	THUR	FRI	SAT	SUN	N	10N	TU	E	WED	TH	IUR	FRI	SAT		SUN
SERVICE	02/07/22	02/08/22	02/09/22	02/10/22	02/11/22	02/12/22	02/13/22	02	/14/22	02/	15/22	02/16/22	02/	/17/22	2/18/22	02/19/2	2 0	2/20/22
ACTIVITIES	WEEK 1	WEEK 2											<u></u>					
Dressing								1										
Grooming																		
Bathing																		
Eating																		
Transfers																		
Mobility																		
Positioning																		
Toileting																		
Health Related																		
Behavior																		
IADLs																		
VISIT ONE		1.	· II	. N	1	V		_				1			.			
Ratio PCA to Clier		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)	A 19	М A И РІ					M A			AM PM		M M	AM PM	AI Pi		AM PM	AM PM	
Time Out	A						M A			AM		М	AM	Al		AM	AM	Al
(Circle AM/PM)	PI	M PI	M PN	/I PN	1 PI	M P	M P	Ν		PM	F	М	PM	PI	И	PM	PM	PI
VISIT TWO	T	T	T	1	T	1	1	_										1
Ratio PCA to Clier Shared care location		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
Time In	A	M A	M AN	И AN	Л A	Μ Δ	M AN	1		AM		M	AM	Al	м	AM	AM	Al
Time in	PI						M PN			PM		М	PM	PI		PM	PM	
Time Out	Al Pi						M AN			AM PM		M M	AM PM	IA 19		AM PM	AM PM	
DAILY TOTAL	+							1								- 111	1 101	
(HOURS)															<u> </u>			
TOTAL (HOURS)		Total 1:1			Total 1:2 Total 1:3			4	Total 1:1 Total 1:2 Total 1:3									
(HOOKS)	HR														H	К		
								_	_									

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						