PCA Time and Activity Documentation 2024

Email / ts@prohealthcare.net (FAX: 763-746-8154)

WEEK 1	MON 24	TUE 24	WED 24	THU 24	FRI 24	SAT 24	SUN 24	WEEK 2	MON 24	TUE 24	WED 24	THU 24	FRI 24	SAT 24	SUN 24
Mo/Day/Yr	/	/	/	/	/	/	/	Mo/Day/Yr	/	/	/	/	/	/	/
TIME IN	am pm	am pm	am pm	am pm	am pm	am pm	am pm	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	TIME OUT	am pm	am pm	am pm	am pm	am pm	am pm	am pm
TIME IN	am pm	am pm	am pm	am pm	am pm	am pm	am pm	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	TIME OUT	am pm	am pm	am pm	am pm	am pm	am pm	am pm
T,D, Hrs:								T, D, Hrs:							
Supports	Total WK 1 Hrs: (1:1) (1:2) (1:3) :							Supports	Total WK 2 Hrs: (1:1) (1:2) (1:3) :						
Dressing								Dressing							
Grooming								Grooming							
Bathing								Bathing							
Eating								Eating							
Transfers								Transfers							
Mobility								Mobility							
Positioning								Positioning							
Toileting								Toileting							
Health-Rel.								Health-Rei.							
Behavior								Behavior							
IADL's (Only reciepients Age 18+								IADL's (Only reciepients Age 18+							
Light Hskping								Light Hskping							
Laundry								Laundry							
Other								Other							

Acknowledgment 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.

Dates/Tmes/Location of client stay in Hospital/Care Facility/Incarceration

NOTE: All times of client stay in any of the above locations are **NOT** counted as PCA Service Hours, and therefore are **NOT** billable.

Print PCA Name	Provider #
PCA Signature:	Date: / / 2024
Print Client Name	*MA # or DOB*
Client or Responsible Party Signature:	Date: / / 2024

Please use standard 12 hr time and circle AM or PM.

PCA's: Initial each box in which supports were provided by you for each visit.

Timesheets are due on Monday after the last Sunday on the timesheet at 4:30 PM

OFFICE USE ONLY

Two Week Total:

Phone Number: 763-746-8155 After Hours Phone: 612-757-2320

Pro-Health Care, Inc / 4710 Central Ave NE , Columbia Heights MN 55421

PCA Phone number:_____. Is there a change of PCA or Client Address? ❑ Yes ❑ No, If Yes , please update address on the line below.

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