

# Arise Cares

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Saint Cloud, MN 56301  
Ph: 320-230-6348

Office use only	
GOVERNMENT	PRIVATE PAY
S5130	S5135
S5130.TF	
S5130.TG	

## Homemaking Time and Activity Documentation

Start Date: / / End Date: / /

If CLIENT was in the hospital, care facility, or detention center, please list dates:

Shadowing Date: Total hours: (No more than 2 or as directed by your Coordinator; do not claim time below)

### Week One- Do not include shadowing

	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
Dates of Service	/	/	/	/	/	/	/
Ratio staff to Recipient	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2
Shared Service (1:2 only) Location							
Time In (15 minute increments)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (15 minute increments)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Ratio staff to Recipient	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2
Shared Service (1:2 only) Location							
Time In (15 minute increments)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (15 minute increments)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Daily Total Hours:							

### Activities (Please initial cares you provided)

Meal Prep							
Clean Table / Counter							
Tops / Floors							
Refridgerator/ Freezer							
Stove Top / Microwave							
Take out Garbage							
Wash Dishes / Dishwasher							
Clean Sinks / Tubs / Toilets							
Clean Mirrors							
Change Bedding / Make Bed							
Laundry / Ironing							
Dusting							
Help Organize							
Appointment / Errand							
Other (Explain)							
PP ONLY Transport / Mileage							

Total time rounded to quarter hours (15 mins=.25 etc). Not including shadowing.	Total Week 1	Total Week 2	TIMESHEET TOTAL 1:1	TIMESHEET TOTAL 1:2

### Week Two- Do not include shadowing

	Sun	Mon	Tues	Weds	Thurs	Fri	Sat
Dates of Service	/	/	/	/	/	/	/
Ratio staff to Recipient	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2
Shared Service (1:2 only) Location							
Time In (15 minute increments)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (15 minute increments)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Ratio staff to Recipient	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2	1:1 1:2
Shared Service (1:2 only) Location							
Time In (15 minute increments)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
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Clean Sinks / Tubs / Toilets							
Clean Mirrors							
Change Bedding / Make Bed							
Laundry / Ironing							
Dusting							
Help Organize							
Appointment / Errand							
Other (explain)							
PP ONLY Transport / Mileage							

Recipient Name \_\_\_\_\_ DOB \_\_\_\_\_

Recipient/Responsible Party Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

PCA Name \_\_\_\_\_ UMPI/PCA # \_\_\_\_\_

PCA Signature \_\_\_\_\_ Date \_\_\_\_\_

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 the PCA did not work. Review the completed timesheet for accuracy before signing. It is a federal crime to provide false information on PCA billings for medical 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.

Incorrect time sheets will be returned for correction and not paid on time. Time sheet MUST be filled out in BLACK or BLUE PEN and NO WHITEOUT OR PENCIL!