Arise Cares
2907 Clearwater Rd.
Saint Cloud, MN 56301
Ph: 320-230-6348

PCA 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 Location **(1:2 only)**							
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 Location **(1:2 only)**							
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)							
Dressing (Appropriate clothing, changing, or dressing, incl. orthotics)							
Grooming (Hair, oral care, nail care, shaving, cosmetics, glasses)							
Bathing (Bed bath, tub bath, or shower)							
Eating (Preparing meals and feeding client)							
Transfers (from chair to bed etc.)							
Mobility (move around in wheelchair)							
Positioning (In bed or chair)							
Toileting (bathroom and diapering)							
Health Related (Tube Feeding, Respirator, Catheter, Bowel Program, Seizures, Rx)							
Behaviors (Redirecting, intervening, and monitoring)							
IADL's Includes laundry and light house keeping (MUST be 18 or on Care Plan)							
Other (Explain)							

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 Location **(1:2 only)**							
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 Location **(1:2 only)**							
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)							
Dressing (Appropriate clothing, changing, or dressing, incl. orthotics)							
Grooming (Hair, oral care, nail care, shaving, cosmetics, glasses)							
Bathing (Bed bath, tub bath, or shower)							
Eating (Preparing meals and feeding client)							
Transfers (from chair to bed etc.)							
Mobility (move around in wheelchair)							
Positioning (In bed or chair)							
Toileting (bathroom and diapering)							
Health Related (Tube Feeding, Respirator, Catheter, Bowel Program, Seizures, Rx)							
Behaviors (Redirecting, intervening, and monitoring)							
IADL's Includes laundry and light house keeping (MUST be 18 or on Care Plan)							
Other (Explain)							

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**

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!

Recipient Name _____ **DOB**_____

Recipient/Responsible Party Signature_____ **Date**_____

PCA Name _____ **UMPI/PCA #** _____

PCA Signature_____ **Date**_____