Global Home Health Care Inc.

PCA Timesheet and Activity Documentation

All time sheets must be turned into the office no later than Monday by 5:00pm
Time sheets may be mailed to the office, but they must be postmarked by Monday.

Dates/Location of recipient stay in hospital/care facility/incarceration:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Dates of Service: (in consecutive order)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)
Activities							
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behavior							
IADL's (only recipients age 18+)							
Light Housekeeping							
Laundry							
Other:							
FIRST VISIT OF THE DAY (Visit One)							
Ratio staff to recipient	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3
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
SECOND VISIT OF THE DAY (Visit One)							
Ratio staff to recipient	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3
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
THIRD VISIT OF THE DAY (Visit One)							
Staff to recipient ratio	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3	1:1 1:2 1:3
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
Daily Total Hours							
Total Hours on This Timesheet	**Total 1:1**		**Total 1:2**		**Total 1:3**		

Acknowledgement and Required Signature

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.

Recipient's Name (First, MI, Last)	**MA Member # or D. O. B**	**Recipient/Responsible Party Signature**	**Date**

I Certify and swear under penalty of law that I have accurately reported on this time sheet the hours I worked, the services I provided, and the dates and times worked. I understand that misreporting my hours is fraud for which I could face criminal prosecution and civil proceedings.

PCA's Name (First, MI, Last)	**Provider ID #**	**PCA Signature**	**Date**

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