PCA TIME AND ACTIVITY DOCUMENTATION

1:1 CARE

Rainbow Home Healthcare - 1358 7th St. E - St. Paul, MN 55106			PHONE NUMBER: (651) - 778 - 0562 | FAX: (651) - 778 - 9967	
Recipient Name (First, MI, LAST)	**PMI# or DOB**	**R#**	**PCA NAME (FIRST, MI, LAST)**	**PCA UMPI**

DATES/LOCATION OF RECIPIENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION

Activities	WEEK 1							Activities	WEEK 2						
DATE OF SERVICES	Mon	Tue	Wed	Thu	Fri	Sat	Sun	DATE OF SERVICES	Mon	Tue	Wed	Thu	Fri	Sat	Sun
1. Dressing								1. Dressing							
2. Grooming								2. Grooming							
3. Bathing								3. Bathing							
4. Eating								4. Eating							
5. Transfer								5. Transfer							
6. Mobility								6. Mobility							
7. Toileting								7. Toileting							
8. Positioning								8. Positioning							
9. Health Related								9. Health Related							
10. Behavior								10. Behavior							
11. IADLS (Recipient 18yrs)								11. IADLS (Recipient 18yrs)							
Visit One								Visit One							
Time In (Circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	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	Time Out (Circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Visit Two								Visit Two							
Time In (Circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	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	Time Out (Circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Daily Total								Daily Total							
WEEK 1	1:1 Total Hours							**WEEK 2**	1:1 Total Hours						

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.

RECEPIENT/RESPONSIBLE PARTY SIGNATURE	DATE	RECEPIENT/RESPONSIBLE PARTY SIGNATURE	DATE
PCA SIGNATURE	**DATE**	**PCA SIGNATURE**	**DATE**

I certify and swear under penalty of law that I have accurately reported on this time sheet the hours I actually 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.