**PCA TIME AND ACTIVITY DOCUMENTATION** | **1:1 CARE** | **LAST DAY DUE: 2/1/23 by 5PM** | **PAY DAY 2/10/23**

| **Rainbow Home Healthcare - 1358 7th St. E - St. Paul, MN 55106** | | | **PHONE NUMBER: (651) - 778 - 0562 \| FAX: (651) - 778 - 9967** | | **4** |
|---|---|---|---|---|---|
| **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** |
| | **01/16/23** | **01/17/23** | **01/18/23** | **01/19/23** | **01/20/23** | **01/21/23** | **01/22/23** | | **01/23/23** | **01/24/23** | **01/25/23** | **01/26/23** | **01/27/23** | **01/28/23** | **01/29/23** |
| **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.