

Superior Home Care, Inc.
 10597 165th Street W.
 Lakeville, MN 55044

Phone: 952-898-4911
 Fax: 952-898-3088

PCA Time and Activity Documentation

CLIENT NAME (First,MI,Last)			MA# or BIRTHDAY			PCA NAME (First,MI,Last)			PCA PROVIDER #		
ADDRESS OF THE LOCATION WHERE SERVICES WERE PROVIDED (DO NOT USE POST OFFICE BOX NUMBERS)						PHONE NUMBER OF NEXT WEEKS SERVICE LOCATION					
DATES/LOCATION OF RECIPIENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION						RECIPIENT () -			CAREGIVER () -		
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	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY

Visit One	Sunday			Monday			Tuesday			Wednesday			Thursday			Friday			Saturday		
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
Time in (circle AM/PM)		AM			AM			AM			AM			AM			AM			AM	
		PM			PM			PM			PM			PM			PM			PM	
Time Out (circle AM/PM)		AM			AM			AM			AM			AM			AM			AM	
		PM			PM			PM			PM			PM			PM			PM	

Visit Two	Sunday			Monday			Tuesday			Wednesday			Thursday			Friday			Saturday		
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
Time in (circle AM/PM)		AM			AM			AM			AM			AM			AM			AM	
		PM			PM			PM			PM			PM			PM			PM	
Time Out (circle AM/PM)		AM			AM			AM			AM			AM			AM			AM	
		PM			PM			PM			PM			PM			PM			PM	

Daily Totals →																		
	Total 1:1			Total 1:2			Total 1:3			Hours worked for other agency								
Weekly Total →																		

Activities	If NO hours worked for another agency, mark the circle → <input type="radio"/>																				
Dressing																					
Grooming																					
Bathing																					
Eating																					
Transfers																					
Mobility																					
Positioning																					
Toileting																					
Health Related																					
Behavior																					

IADL's (only recipients age 18+)																					
Light Housekeeping																					
Laundry																					
Other																					

Acknowledgement and Required Signatures

After the caregiver 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 caregiver. Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on billings for Medical Assistance payments. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the Care Plan.

RECIPIENT/RESPONSIBLE PARTY SIGNATURE	DATE	CAREGIVER SIGNATURE	DATE
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Timesheets must be submitted by email, fax, mail or in person within thirty (30) days after the first original date of service to which the timesheet relates. Timesheets received after 30 days will be held for confirmation of payment to SHC before paycheck is issued.