



**COMFORT SERVICES LLC TIME AND ACTIVITY DOCUMENTATION**

**HOMEMAKING**

**DATE/LOCATION OF RECIPIENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION:**

Instrumental Activities of Daily Living (IADLs): \*Only recipients age 18+ who are authorized to receive homemaking services\*

Date of Service Activities	12/15/2018 Saturday	12/16/2018 Sunday	12/17/2018 Monday	12/18/2018 Tuesday	12/19/2018 Wednesday	12/20/2018 Thursday	12/21/2018 Friday
Meal Preparation							
Laundry							
Accompany to Medical Appointment							
Shopping Food/Clothing							
Light Housekeeping/Chores							
Other							
Other							
Other							

**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
Share 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

**Visit Two**

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
Share 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

**Visit Three**

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
Share 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

<b>Office use ONLY</b>	Daily Total [HOURS]	HOURS:	HOURS:	HOURS:	HOURS:	HOURS:	HOURS:
	Total HOURS This Time Sheet	Total 1:1		Total 1:2		Total 1:3	

**Acknowledgement and Required Signatures**

After the PCA had 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 billing for Medical Assistance payment. Your signature verifies the time and services entered are accurate and that the services were performed as specified in the PCA care plan

<u>PRINT RECIPIENT NAME [First, MI, Last]</u>	<u>DATE OF BIRTH</u>	<u>PRINT PCA NAME [First, MI, Last]</u>	<u>PCA UMPI NUMBER</u>
<u>RECIPIENT/ RESPONSIBLE PARTY SIGNATURE</u>	<u>DATE</u>	<u>PCA SIGNATURE</u>	<u>DATE</u>



**COMFORT SERVICES LLC TIME AND ACTIVITY DOCUMENTATION**

**HOMEMAKING**

**DATE/LOCATION OF RECIPIENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION:**

Instrumental Activities of Daily Living (IADLs): \*Only recipients age 18+ who are authorized to receive homemaking services\*

Date of Service Activities	12/22/2018 Saturday	12/23/2018 Sunday	12/24/2018 Monday	12/25/2018 Tuesday	12/26/2018 Wednesday	12/27/2018 Thursday	12/28/2018 Friday
Meal Preparation							
Laundry							
Accompany to Medical Appointment							
Shopping Food/Clothing							
Light Housekeeping/Chores							
Other							
Other							
Other							

**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
Share 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

**Visit Two**

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
Share 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

**Visit Three**

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
Share 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

<b>Office use ONLY</b>	Daily Total [HOURS]	HOURS:	HOURS:	HOURS:	HOURS:	HOURS:	HOURS:
	Total HOURS This Time Sheet	Total 1:1		Total 1:2		Total 1:3	

**Acknowledgement and Required Signatures**

After the PCA had 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 billing for Medical Assistance payment. Your signature verifies the time and services entered are accurate and that the services were performed as specified in the PCA care plan

<u>PRINT RECIPIENT NAME [First, MI, Last]</u>	<u>DATE OF BIRTH</u>	<u>PRINT PCA NAME [First, MI, Last]</u>	<u>PCA UMPI NUMBER</u>
<u>RECIPIENT/ RESPONSIBLE PARTY SIGNATURE</u>	<u>DATE</u>	<u>PCA SIGNATURE</u>	<u>DATE</u>