



COMFORT SERVICES LLC TIME AND ACTIVITY DOCUMENTATION

**PCA**

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

Date of Service Activities	05/05/2018 Saturday	05/06/2018 Sunday	05/07/2018 Monday	05/08/2018 Tuesday	05/09/2018 Wednesday	05/10/2018 Thursday	05/11/2018 Friday
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related Needs							
Behavior Observation & Redirection							
IADLs							

IADL'S \* (not allowed for recipients under age 18) including: Light housekeeping, laundry, meal preparation, 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
Shared Services 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
Shared Services 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
Shared Services 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

**PCA**

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

Date of Service Activities	05/12/2018 Saturday	05/13/2018 Sunday	05/14/2018 Monday	05/15/2018 Tuesday	05/16/2018 Wednesday	05/17/2018 Thursday	05/18/2018 Friday
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related Needs							
Behavior Observation & Redirection							
IADLs							

IADL'S \* (not allowed for recipients under age 18) including: Light housekeeping, laundry, meal preparation, 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
Shared Services 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
Shared Services 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
Shared Services 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:	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>