

### COMFORT SERVICES LLC TIME AND ACTIVITY DOCUMENTATION

## **PCA**

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

Date of Service Activities		08/25/2018 08/26/2018					08/27/2018			08/28/2018			08/29/2018			08/30/2018			08/31/2018		
		Saturday		Sunday			Monday		Tuesday			Wednesday			Thursday				Friday		
ţ											· ·										
ng																					
																		1			
rs																		†			
7																		†			
ing																		1			
g																		+			
Related Needs																		+			
Observation &																					
																		1			
	recipients	under a	ge 18)	inclu	uding: I	ight l	house	keeping	g, laur	ndry,	meal p	repar	ation	, other*	:						
	1								1			1			1						
	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	
ervices Location																					
3.6 (D) 6)		AM			AM			AM			AM			AM			AM			AM	
																		<del>                                     </del>		PM AM	
M/PM)		PM			PM			PM			PM			PM			PM			PM	
wo																					
ff 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	
ervices Location																					
M/DM)		AM			AM			AM			AM			AM			AM			AM	
(M/PM) t																				PM AM	
M/PM)		PM			PM			PM			PM			PM			PM			PM	
ree If to recipient	1:1 1:2	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	
ervices Location	1.1 1.2		1												1.1			1.1			
<b>ДДМ</b> )		AM			AM			AM			AM			AM			AM	1		AM	
		AM			AM			AM			AM			AM			AM	1		PM AM	
M/PM)	1	PM	1		PM			PM			PM	-		PM			PM	↓		PM	
Daily Total [HOURS]	HOURS	HOURS:			HOURS:			HOURS:			HOURS:			HOURS:			HOURS:				
	Total 1:1							Total 1:2						Total 1:3							
	sing selated Needs Observation & on * (not allowed for me ff to recipient ervices Location M/PM) wo ff to recipient ervices Location M/PM) t M/PM) ree f to recipient ervices Location M/PM) To recipient ervices Location M/PM) To recipient ervices Location	Service Activities  Saturation  Ing  Related Needs Observation & Son  * (not allowed for recipients  me  ff to recipient  I:1 1:1  ervices Location  M/PM)  tt M/PM)  tt M/PM)  tt M/PM)  ree  f to recipient  1:1 1:2  ervices Location  M/PM)  tt M/PM)  To recipient  I:1 1:2  I:1 1:2  I:1 1:2  I:1 I:2  III III I:2  III III I:2  III III III III III III III III III I	Service Activities  Saturday  Saturd	Service Activities  Saturday  Saturd	Service Activities	Service Activities	Service Activities	Service Activities	Saturday   Sunday   Monday   Monday	Saturday   Sunday   Monday   Sunday   Sunday   Monday   Sunday   Sunday   Monday   Sunday   Sunday   Sunday   Monday   Sunday   Sunday   Sunday   Monday   Sunday   Sunday	Service Activities	Service Activities	Service Activities	Service Activities	Saturday   Sunday   Monday   Tuesday   Wednesday	Service Activities	Service Activities	Service Activities	Service Activities	Service Activities	

**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

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

09/06/2018

09/07/2018

09/05/2018

09/01/2018

**Date of Service Activities** 

09/02/2018



09/04/2018

## COMFORT SERVICES LLC TIME AND ACTIVITY DOCUMENTATION

# **PCA**

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

09/03/2018

		Sa	turday		Sund	ay	N	Mond	ay	7	Tuesd	lay	W	edne	sday	7	Thurs	sday		Frid	ay
Dressing																					
Grooming																					
Bathing																					
Eating																			+		
Transfers																			+		
Mobility																			┼		
Positioning		+																	—		
																			<u> </u>		
Toileting																			ــــــ		
Health Related	Needs																				
Behavior Observa Redirection	ation &																				
IADLs																					
IADL'S * (not a	llowed for	recipien	ts under	age 18	) incl	uding: I	ight l	ouse	keeping	g, lauı	ıdry,	meal p	repara	ation	, other*	:					
T. I. O.																					
Visit One	• .	1								1											
Ratio staff to reci	pient	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 I	ocation																				
Time In			AM			AM			AM			AM			AM			AM			AM
(circle AM/PM)			PM			PM			PM			PM			PM			PM			PM
Time Out			AM			AM			AM			AM			AM			AM			AM
(circle AM/PM)			PM			PM			PM			PM			PM			PM			PM
Visit Two Ratio staff to reci	niant									ı			1								
Kano stan to reci	pieni	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 I	ocation																				
Time In			AM			AM			AM			AM			AM			AM			AM
(circle AM/PM)			PM			PM			PM			PM			PM			PM			PM
Time Out (circle AM/PM)			AM PM			AM PM			AM PM			AM PM			AM PM			AM PM			AM PM
Visit Three		I .		·						I		1111	1		11,1			11.1			
Ratio staff to recip	ient	1:1 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 L	ocation																				
Time In			AM	1		AM			AM			AM			AM			AM	1		AM
(circle AM/PM)			PM			PM			PM			PM			PM	-		PM	<del> </del>		PM
Time Out (circle AM/PM)			AM PM			AM PM			AM PM			AM PM			AM PM			AM PM			AM PM
Daily T		HOUI	HOURS: HOURS:				но	URS:		HOURS:			HOURS:			HOURS:			HOURS:		
Total H		Total 1:1												1		Total	1				
<del>-</del> -	ne Sheet			1 013	1 111				Total 1:2								TULAL	1.0			
Ackn	owledgeme	ent and I	Required	Signat	ures			1													

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

1 c.1 care plan			
PRINT RECIPIENT NAME [First, MI, Last]	DATE OF BIRTH	PRINT PCA NAME [First, MI, Last]	PCA UMPI NUMBER
RECIPIENT/ RESPONSIBLE PARTY SIGNATURE	<u>DATE</u>	PCA SIGNATURE	<u>DATE</u>