

## COMFORT SERVICES LLC TIME AND ACTIVITY DOCUMENTATION

## **PCA**

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

D	12/29/2018	12/30/2018	12/31/2018	01/01/2019	01/02/2019	01/03/2019	01/04/2019	
Date of Service Activities Saturday		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	
Dressing	•	·						
Grooming								
Bathing								
Eating								
Transfers								
Mobility								
Positioning								
Toileting								
Health Related Needs								
Behavior Observation &								
Redirection								
IADLs								
IADL'S * (not allowed for	recipients under a	ge 18) including: L	ight housekeeping	g, laundry, meal p	reparation, 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	
<b>Shared Services Location</b>								
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 Two	1 1/1	1 141	1 101	1 171	1 171	1 141	1 141	
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	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								
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	AM	AM	AM	AM	AM	AM	AM	
(circle AM/PM) Time Out	PM AM	PM AM	PM AM	PM AM	PM AM	PM AM	PN AN	
(circle AM/PM)	PM	PM	PM	PM	PM	PM	PM	
Daily Total [HOURS]  Total HOURS This Time Sheet	HOURS:	HOURS:	HOURS:	HOURS:	HOURS:	HOURS:	HOURS:	
	Total 1:1					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

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>	<u>PCA SIGNATURE</u>	<u>DATE</u>

01/10/2019

01/11/2019

01/09/2019

01/05/2019

**Date of Service Activities** 

01/06/2019



01/08/2019

## COMFORT SERVICES LLC TIME AND ACTIVITY DOCUMENTATION

# **PCA**

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

01/07/2019

Dute of		Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	
Dressing	6								
Groomi	ng								
Bathing									
Eating									
Transfe	rs								
Mobility	y								
Position	ing								
Toiletin	g								
Health I	Related Needs								
Behavior Redirect	r Observation &								
IADLs									
IADL'S	* (not allowed for	 recipients under a	ge 18) including: Li	ight housekeeping	. laundry, meal p	reparation, other*			
				g	,,				
Visit O		1	1				I I		
Ratio sta	aff 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 S	Services Location								
Time In		AM	AM	AM	AM	AM	AM	AM	
	AM/PM)	PM	PM	PM	PM	PM	PM	PM	
Time O	ut AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
Visit T		1 171	1 101	1 101	1 101	1 1V1	1 1/1	1 101	
	aff to recipient	1.1 1.2 1.2	1.1 1.2 1.2	1.1 1.2 1.2	1.1 1.2 1.2	1.1 1.2 1.2	1.1 1.0 1.2	1.1 1.2 1.2	
		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	
	Services Location								
Time In (circle A		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
Time Ou		AM	AM	AM	AM	AM	AM	AM	
(circle A	M/PM)	PM	PM	PM	PM	PM	PM	PM	
Visit Th			T						
Ratio stat	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	
Shared S	Services Location								
Time In	MADMO	AM	AM	AM	AM	AM	AM	AM	
(circle Al		PM AM	PM AM	PM AM	PM AM	PM AM	PM AM	PM AM	
(circle Al		PM	PM	PM	PM	PM	PM	PM	
use Y	Daily Total [HOURS]	HOURS:	HOURS:	HOURS:	HOURS:	HOURS:	HOURS:	HOURS:	
J.C.	Total HOURS Total 1:1			Total 1:2		Total 1:3			
Off	Flours Hours: Ho				- 2000 - 200				
	Acknowledgeme	nt and Required S	ignatures	•		<u>'</u>			

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

	Coll value 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>			
				'			