Office # (952) 814-7400 **TIME SHEET** Fax #(952) 853-0966

Client:_____ **MA#:**_____ **PCA:**_____ **MHCP#:**_____

(NOTE: You cannot bill while client is in the hospital. Put EXACT DATES and TIMES of entering and coming out of hospital.)

PLACE SERVICE PROVIDED: Home____Work____Vacation____School____ Hospital____Other____

Dates of Service:

DAY	DD/MM/YY	TIME IN AM	TIME IN PM	TIME OUT AM	TIME OUT PM	TIME IN AM	TIME IN PM	TIME OUT AM	TIME OUT PM	TOTAL HRS
1. Thursday										
2. Friday										
3. Saturday										
4. Sunday										
5. Monday										
6. Tuesday										
7. Wednesday										
8. Thursday										
9. Friday										
10. Saturday										
11. Sunday										
12. Monday										
13. Tuesday										
14.Wednesday										

Note: This is document is not suited and will not be used for Shared Care.

*After the PCA has documented his/her time and activity, the recipient must draw a line through any dates and time he/she did not receive services from the PCA.

TOTAL HRS_____

Please note any **changes in ability, medications, or request in assistance below:** _____

Procedure-Day #	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Dress/Undress														
Bathing														
Grooming														
Eating/Feeding														
Transfers														
Positioning														
Mobility														
Toileting														
Asst w/Meds														
Redirect Behavr														
Seizure Intrvnt														
Laundry														
Lt. Housekeeping														
Range of Motion														
Skin Care														
Respiratory Asst														
Cln/maintain Eq.														
Acmp to Med Apt														
Maintain Art Limb														
Other (Specify)														

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

PCA Signature:_____ Date:_____

Client Signature:_____ Date:_____

Mail to: All Home Health Inc, PO Box 20104, Bloomington, MN 55420