

# HOMEMAKER Time and Activity Documentation

FAX: (651) 666-1229

WEEK 1	SAT	SUN	MON	TUE	WED	THU	FRI	WEEK 2	SAT	SUN	MON	TUE	WED	THU	FRI
Month/Day/Year								Month/Day/Year							
<b>VISIT ONE</b>								<b>VISIT ONE</b>							
TIME IN	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM TIME IN	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
TIME OUT	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM TIME OUT	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
<b>VISIT TWO</b>								<b>VISIT TWO</b>							
TIME IN	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	PM TIME IN	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
TIME OUT	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	PM TIME OUT	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
<b>Total Daily Hrs:</b>								<b>Total Daily Hrs:</b>							
<b>WEEK 1</b>				1:1 Total hours:				<b>WEEK 2</b>				1:1 Total hours:			
<b>Activities</b>								<b>Activities</b>							
Tidy Bathroom								Tidy Bathroom							
Vacuum								Vacuum							
Make Bed								Make Bed							
Dust								Dust							
Sweep								Sweep							
Mop								Mop							
Wash Dishes								Wash Dishes							
Take Out Trash								Take Out Trash							
Change Linens								Change Linens							
Run Errands								Run Errands							
Instrumental Activities of Daily Living (only Recipients age 18+)								Instrumental Activities of Daily Living (only Recipients age 18+)							
Laundry								Laundry							
Housekeeping								Housekeeping							
Other (note activity)								Other (note activity)							

**Acknowledgements & Signatures:**

After the PCA has 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 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.

<b>Print PCA Name</b>	<b>PCA Provider #</b>	<b>Please use standard 12 hr time, in 15 min increments, with minutes noted.</b>
<b>PCA Signature:</b>	<b>Date:</b>	<b>Timesheet must indicate AM or PM for every Time IN and every Time OUT.</b>
<b>Print Recipient Name</b>	<b>MA Member # or DOB</b>	<b>Every date box must have month/day/year entered for entire timesheet.</b>
<b>Recipient/Responsible Party Signature:</b>	<b>Date:</b>	<b>Timesheet must be filled out each shift.</b>
<b>Dates and location of Recipient stay in Hospital or Care Facility.</b>		<b>Timesheet must be an ORIGINAL timesheet - not photocopied.</b>
		<b>Incomplete, incorrect, or illegible timesheets cannot be accepted for billing.</b>
		<b>Alliance Home Care Services</b>
		<b>1977 Nortonia Ave</b>
		<b>Saint Paul, MN 55119</b>
		<b>Phone: (651)-399-4923</b>
		<b>Cell: (651)-434-3210</b>
		<b>Email: info@ahcsvc.com</b>
<b>Reminder: Timesheets are due by 4 pm on Tuesday.</b>		