

Care on Wheels Homecare Services, LLC | PCA Timesheet | 763-566-3038 | Fax: 763-566-3029

***Was the client in a hospital/ care facility/ incarcerated? ____ If Yes, Date & Location: _____

| Activities | Sun | Mon | Tue | Wed | Thurs | Fri | Sat | Sun | Mon | Tue | Wed | Thurs | Fri | Sat |
|----------------------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| | 5/2/21 | 5/3/21 | 5/4/21 | 5/5/21 | 5/6/21 | 5/7/21 | 5/8/21 | 5/9/21 | 5/10/21 | 5/11/21 | 5/12/21 | 5/13/21 | 5/14/21 | 5/15/21 |
| Dressing | | | | | | | | | | | | | | |
| Bathing | | | | | | | | | | | | | | |
| Grooming | | | | | | | | | | | | | | |
| Eating | | | | | | | | | | | | | | |
| Transfers | | | | | | | | | | | | | | |
| Mobility | | | | | | | | | | | | | | |
| Positioning | | | | | | | | | | | | | | |
| Health Related | | | | | | | | | | | | | | |
| Toileting | | | | | | | | | | | | | | |
| Behavior | | | | | | | | | | | | | | |
| IADL' (Only Recipients age 18+) | | | | | | | | | | | | | | |
| IADLs | | | | | | | | | | | | | | |
| PT | | | | | | | | | | | | | | |
| Ratio staff to Recipient | 1:1 1:2 | 1:1 1:2 | 1:1 1:2 | 1:1 1:2 | 1:1 1:2 | 1:1 1:2 | 1:1 1:2 | 1:1 1:2 | 1:1 1:2 | 1:1 1:2 | 1:1 1:2 | 1:1 1:2 | 1:1 1:2 | 1:1 1:2 |
| Time in | | | | | | | | | | | | | | |
| Time Out | | | | | | | | | | | | | | |
| Time In | | | | | | | | | | | | | | |
| Time Out | | | | | | | | | | | | | | |
| Total (HRS) | | | | | | | | | | | | | | |
| Weekly Total | | | | | | | | | | | | | | |

Acknowledgement & Required Signatures

After the PCA has documented his/her time and activity, the recipient must draw a line through any dates and times he or 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.

| | | | |
|----------------|------------|--|------|
| RECIPIENT NAME | MA Number | RECIPIENT/ RESPONSIBLE PARTY SIGNATURE | DATE |
| PCA NAME | PCA Number | PCA SIGNATURE | DATE |