Care on Wheels Homecare Services, LLC |PCA Timesheet| Email:outreach@careonwheelshc.com

****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
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/Staff NAME	PCA Number (if available)	PCA/ Staff SIGNATURE	DATE