RECIPIENT NAME (*please print*) : _____ **PCA NAME** (*please print*) : _____

MN Health Care ID Number : _____ **PROVIDER ID#** : _____

CLIENT/RP SIGN: _____ **DATE**: _____ **EMP. SIGN**: _____ **DATE**: _____

	SUN	MON	TUES	WED	THURS	FRI	SAT		SUN	MON	TUES	WED	THURS	FRI	SAT
								DATE							
VISIT 1	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	**TIME IN**	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
	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
								TOTAL HOURS							

	SUN	MON	TUES	WED	THURS	FRI	SAT		SUN	MON	TUES	WED	THURS	FRI	SAT
VISIT 2	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	**TIME IN**	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
	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
								TOTAL HOURS							

TOTAL HOURS WEEK 1:

TOTAL HOURS WEEK 2:

DATES/LOCATION OF RECIPIENTS STAY IN HOSPITAL / CARE FACILITY / INCARCERATION / VACATION / AWAY:

SUN	MON	TUE	WED	THUR	FRI	SAT	ACTIITIES	SUN	MON	TUE	WED	THUR	FRI	SAT
							DRESSING							
							GROOMING							
							BATHING							
							EATING							
							TRANSFERS							
							MOBILITY							
							POSITIONING							
							TOILETING							
							LL HOUSEKEEP							
							HEALTH RELATED							
							BEHAVIORS							
							OTHER							

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PHONE: 320-269-2929
FAX: 320-269-2278

PAY PERIOD END DATE: _____ / _____ / _____

TOTAL HOURS

AFTER THE PCA HAS DOCUMENTED HIS/HER TIME AND ACTIVITY, THE RECEPIENT MUST DRAW A LINE THROUGH ANY DATE AND TIMES HE/SHE DID NOT RECEIVE SERVICES FORM THE PCA. REVIEW THE COMPLETED TIME SHEET FOR ACCURACY BEFORE SIGNING. IT IS A FEDERAL CRIME TO PROVIDE FALSE INFORMATION ON A PCA BILLINGS FOR MEDICAL ASSISTANCE PAYMENT. YOUR SIGNATURE VERIFIES THE TIME ANS SERVICES ENTERED ABOVE ARE ACCURATE AND THAT THE SERVICES WERE PERFORMED AS SPECIFIED IN THE PCA CARE PLAN