



# PCA Time and Activity Documentation

PCA AGENCY NAME	PHONE NUMBER (      )
DATES/LOCATION OF RECIPIENT STAY IN HOSPITAL/CARE FACILITY/INCARCERATION	

**Dates of Service**  
(in consecutive order)

MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
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**Activities**

Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behavior							
<b>IADL's (only recipients age18+)</b>							
Light Housekeeping							
Laundry							
Other							

**Visit One**

Ratio staff to recipient	1:1	1:2	1:3	1:1	1:2	1:3	1:1	1:2	1:3	1:1	1:2	1:3	1:1	1:2	1:3	1:1	1:2	1:3
Shared care location																		
Time in (circle AM/PM)			AM PM			AM PM			AM PM			AM PM			AM PM			AM PM
Time out (circle AM/PM)			AM PM			AM PM			AM PM			AM PM			AM PM			AM PM

**Visit Two**

Ratio staff to recipient	1:1	1:2	1:3	1:1	1:2	1:3	1:1	1:2	1:3	1:1	1:2	1:3	1:1	1:2	1:3	1:1	1:2	1:3
Shared care location																		
Time in (circle AM/PM)			AM PM			AM PM			AM PM			AM PM			AM PM			AM PM
Time out (circle AM/PM)			AM PM			AM PM			AM PM			AM PM			AM PM			AM PM

**Daily Total**  
(minutes)

MINUTES	MINUTES	MINUTES	MINUTES	MINUTES	MINUTES	MINUTES
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**Total Minutes  
This Time Sheet**

Total 1:1		Total 1:2		Total 1:3	
MINUTES		MINUTES		MINUTES	

**Acknowledgement and Required 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.

RECIPIENT NAME (FIRST, MI, LAST)	MA MEMBER # or DATE OF BIRTH	RECIPIENT/RESPONSIBLE PARTY SIGNATURE	DATE
PCA NAME (FIRST, MI, LAST)	PCA NPI/UMPI	PCA SIGNATURE	DATE

## Instructions for PCA Time and Activity Documentation

This form documents time and activity between one PCA and one recipient. Document up to two visits per day on this form. Employers may have additional instructions or documentation requirements. For shared care, you must use a separate form for each person for whom you are providing care.

**Name of PCA Provider Agency**

Enter name of the PCA provider agency and its telephone number.

**Recipient Stays**

Enter dates and location of recipient stays in a hospital, care facility or incarceration.

**Dates of Service**

Dates of service must be in consecutive order. Enter the date in mm/dd/yy format for each date you provide service. The recipient must draw a line through any dates and times PCA services were not provided.

**Activities**

For each date you provided care, write your initials next to all the activities you provided. Your initials indicate you provided the service as described in the PCA Care Plan. If you provide a service more than once in a day, initial only once. The following are

general descriptions of activities of daily living and instrumental activities of daily living.

**Dressing** – Choosing appropriate clothing for the day, includes laying-out of clothing, actual applying and changing clothing, special appliances or wraps, transfers, mobility and positioning to complete this task.

**Grooming** – Personal hygiene, includes basic hair care, oral care, nail care (except recipients who are diabetic or have poor circulation), shaving hair, applying cosmetics and deodorant, care of eyeglasses, contact lenses, hearing aids

**Bathing** – Starting and finishing a bath or shower, transfers, mobility, positioning, using soap, rinsing, drying, inspecting skin and applying lotion.

**Eating** – Getting food into the body, transfers, mobility, positioning, hand washing, applying of orthotics needed for eating, feeding, preparing meals and grocery shopping.

**Transfers** – Moving from one seating/reclining area or position to another.

**Mobility** – Moving including assistance with ambulation, including use of a wheelchair. Mobility does not include providing transportation for a recipient.

**Positioning** – Including assistance with positioning or turning a recipient for necessary care and comfort.

**Toileting** – Bowel/bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area and inspecting skin and adjusting clothing.

**Health-related Procedures and Tasks** – Health related procedures and tasks according to PCA policy. Examples include: range of motion and passive exercise, assistance with self-administered medication including bringing medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, interventions, monitoring and observations for seizure disorders, and other activities listed on the care plan and considered within the scope of the PCA service meeting the definition of health-related procedures and tasks.

**Behavior** – Redirecting, intervening, observing, monitoring and documenting behavior.

**IADLs (Instrumental Activities of Daily Living)** – Covered service for recipients over age 18 years only, such as: meal planning and preparation, basic assistance with paying the bills, shopping for food, clothing, and other essential items, performing household tasks integral to the personal care assistance services; assisting with recipient's communication by telephone, and other media, and accompanying the recipient with traveling to medical appointments and participation in the community.

**Light Housekeeping** – Light housekeeping integral to personal care may include washing dishes, putting dishes in dishwasher, clearing tables, taking out garbage, making the bed and cleaning bathroom.

**Laundry** – Laundry integral to personal care, includes sorting clothes, putting clothes in washer and dryer, adding soap and/or dryer sheet, folding and putting away clothes.

**Other**

## Visit One

Documentation of the first visit of the day.

### Ratio of PCA to Recipient –

**1:1** = One PCA to one recipient

**1:2** = One PCA to two recipients (shared services)

**1:3** = One PCA to three recipients (shared services)

### Circle the appropriate ratio of PCA to recipients for this visit

**Shared Care Location** – (Required for shared care only) Write a brief description of the location where you provided the shared care, examples include school, work, store and home.

**Time in** – Enter time in hours and minutes that you started providing care and circle AM or PM.

**Time out** – Enter time in the hours and minutes that you stopped providing care and circle AM or PM.

## Visit Two

This is documentation for the second visit of the day. Follow instructions for Visit One above.

## Daily Total

Add the total time in minutes that you spent with this recipient for the care documented in one column.

## Total Minutes This Time Sheet

Add the time in minutes for all visits on this entire time sheet and enter the total in the appropriate ratio box.

## Acknowledgement and Required Signatures

Recipient/responsible party prints the recipient's first name, middle initial, last name, and MA Member (MHCPID) Number or birth date (for identifying purposes). Recipient/responsible party signs and dates form. PCA prints his/her first name, middle initial, last name, individual PCA Unique Minnesota Provider Identifier (UMPI) (for identifying purposes). PCA signs and dates form.