MRCI CLIENT DIRECTED SERVICES
Phone: 1-800-829-7110
Fax: 1-888-800-7336

Phone Number: _____

PCA Time and Activity Documentation

Employee # _____

Week of: Sunday ____/____/____ Thru **Saturday** ____/____/____

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Dates of Service:							
Activities							
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behavior							
IADL's (only recipients age 18+)							
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	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	AM PM
Time out (circle AM/PM)	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	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	AM PM
Time out (circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Daily Total (Hours							

Wage	$	**Total Hours for the week**	

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.

Dates/Location of Recipient Stay In Hospital/Care Facility/Incarceration:

RECIPIENT NAME(First, Mi, Last)	MA MEMBER # OR BIRTH DATE	PCA (First, Mi, Last)	PCA PROVIDER NUMBER

RECIPIENT / RESPONSIBLE PARTY SIGNATURE	Date	PCA SIGNATURE	Date

Office Use Only: Spreadsheet _____ P.P.E _____