## INTERCOMMUNITY HOME HEALTH CARE

## 27 E. Franklin Ave Minneapolis MN 55404 Tel 612-435-0283 Fax 612-338-1493

## **Homemaking Time and Activity Documentation**

	Th	ursd	ay		Frida	ay	Sa	turda	ay	5	Sund	ay	M	lond	ay	Tu	esda	ay	Wed	nesd	ay
Activities Vacuuming				l			1			l			1						1		
																1					
Dust																					
Wash Windows (inside)																					
Clean Toilet																					
Clean Fridge																					
Clean Stove																					
Change Bedding																					
Empty Garbage																					
Prepare Food/Serve																					
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			AM			AM			AM			AM			AM			AM			AM
(circle AM/PM)			PM			PM			PM			PM			PM			PM			PM
Time out			AM			AM			AM			AM			AM			AM			AM
(circle AM/PM)			PM			PM			PM			PM			PM			PM			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			A B 4			A B 4			A B 4			A B 4			A B 4			A B 4			A B /
Time in (circle AM/PM)			AM			AM			AM			AM			AM			AM			AM
			PM			PM			PM			PM			PM			PM			PM
Time out			AM			AM			AM			AM			AM			AM			AM
(circle AM/PM)			PM			PM			PM			PM			PM			PM			PM
DAILY	Dail	y Hou	rs	Daily	/ Hou	rs	Daily	y Hou	rs	Daily	/ Hou	rs	Daily	/ Hou	rs	Daily	/ Hou	rs	Dail	y Hou	rs
TOTAL WEEKLY HOURS																					
Relationship I am related to recipie					follo	wing:	Parer	nt, Sib	oling, <i>i</i>	Adult	Child	, Grar	ndpare	ent or	Gran	dchild	(U1)	None	of the	e abo	ve
Acknowledgment and	Requ	ired S	Signat	ures																	

After 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 # OF	R BIRTH DATE	PCA NAME (Fist, MI, Last)	PCA PROVIDER NUMBER			
RECIPENT / RESPONSIBLE PARTY SIG	DATE	PCA signature		DATE			

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**Homemaking Time and Activity Documentation** 

Dates of service																					
Dates of Service	Thursday		Friday			Saturday			Sunday			Monday			Tuesday			Wednesday			
Activities	•••	ui Sui	шу		····ac	4 y	00	itui ut	4 у		Ouna	uy		iona	ч		icsac	4.9	· · · ·	icsu	4 у
Vacuuming																					
Dust																					
Wash Windows (inside)																					
Clean Toilet																					_
Clean Fridge																					
Clean Stove																					
Change Bedding																					
Empty Garbage																					
Prepare Food/Serve																					
																					_
Visit One	1						•						ı								
Ratio staff to recipient Shared care location	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:
Time in			AM			AM			AM			AM			AM			AM	1		Α
(circle AM/PM)			PM			PM			РМ			PM			PM			РМ			Р
Time out			AM			AM			AM			AM			AM			AM			A
(circle AM/PM)			PM			PM			PM			РМ			PM			РМ			Ρ
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:
Shared care location Time in			AM			AM			AM			AM			AM			AM			Α
(circle AM/PM)																					
			PM			PM			PM			PM			PM			PM			Р
Time out			AM			AM			AM			AM			AM			AM			A
(circle AM/PM)			PM			PM			PM			PM			PM			PM			Р
DAILY	Daily	y Hou	rs	Daily	/ Hou	rs	Dail	y Hou	rs	Dai	ly Hou	rs	Dail	/ Hou	rs	Dail	y Hou	rs	Daily	y Houi	S
TOTAL WEEKLY HOURS																			<u> </u>		
Relationship I am related to recipie	Requ	ired S	Signat	ures																	
After PCA has documer from the PCA. Review t medical Assistance pay specified in the PCA Ca	he cor ment. are Pla	nplete Your n.	ed time	sheet ure ve	for a	ccurad the tim	cy before and	ore siç I servi	gning. ces en	It is a tered	federal above	al crim e are a	e to p	rovide te and	false I that t	inform he sei	nation	on PC	CA billi	ngs fo	r
RECIPIENT NAME (Fire	st, MI,	Last)		MA	MEN	/BER	# OR	BIRTI	1 DATI	E	PC	A NAM	Л <mark>Е (F</mark> i	st, MI	, Last)		PCA	PROV	/IDER	NUMI	3EI
RECIPENT / RESPON	SIBLE	PAR	TY SIG	L SNATU	JRE			D	ATE		PCA s	signatı	ıre							DATE	