Dates/Location of recipient stay in hospital/care facility/incarceration

Dates of Service MM/DD/YY (month/day/year)	**Week 1** SUN	MON	TUE	WED	THUR	FRI	SAT	**Week 2** SUN	MON	TUE	WED	THUR	FRI	SAT
Activities (initial each box in which supports were provided by you for each shift)														
Dressing														
Grooming														
Bathing														
Eating														
Transfers														
Mobility														
Positioning														
Toileting														
Health Related														
Behavior														
IADL's														
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	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 services location														
Time in (circle 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	AM PM
Time out (circle 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	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	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 services location														
Time in (circle 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	AM PM
Time out (circle 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	AM PM
Daily Total (Hours)	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours

Total Hours (This time sheet)	**Total 1:1 Hours**	**Total 1:2 Hours**	**Total 1:3 Hours**

Acknowledgement and Required Signatures

After the PCA has documented his/her time and activity, the recipient must draw a line through any dates/times he/she did not receive services from the PCA. Review the completed contact sheet for accuracy before signing. **It is a crime to provide false information on PCA billings for Medical Assistance payment. By signing below you swear and verify the time and services entered above are accurate and that the services were performed by the PCA listed below as specified in the PCA Care Plan.**

Consumer / RP Name (print)	MA # or DOB	Consumer / RP Signature	Date

I certify and swear under penalty of law that I have accurately reported on this time sheet the hours I actually worked, the services I provided, and the dates and times worked.
I understand that misreporting my hours is fraud for which I could face criminal prosecution and civil proceedings.

PCA Name (print)	UMPI Number	PCA Signature	Date