ELITE NURSING SERVICES, INC.
2393 Coon Rapids NW
Coon Rapids, Minnesota 55433
Telephone: (763) 421-3613 Fax: (763) 374-5451

PCA Time and Activity Documentation

DATES/LOCATION OF RECIPIENT STAY IN HOPSITAL/CARE FACILITY/INCARCERATION	
NAME OF INDIVIDUAL PCA	RECIPIENT NAME

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

Activities

Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Health Related							
Behavior							
Laundry							
IADL's							

Visit One

Ration 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 Service 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

Ration 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 Service 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 (Minutes)	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes	Minutes

Total Minutes This Time Sheet	Total 1:1	Total 1:2	Total 1:3
	Minutes	Minutes	Minutes

Relationship

I am related to the recipient as: (use the appropriate modifier on the claim. For example: U1 if the individual PCA provider is the parent or adoptive parent of the recipient)

- ❒ Parent, Sibling, Adult Child, Grandparent or Grandchild (U1)
- ❒ None of the above

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 billing 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 DOB	Recipient/Responsibility Signature	Date
PCA Name (First, MI, Last)	PCA NPI/UMPI	PCA Signature	Date