


# In-Home Respite Time and Activity Documentation

**TIMESHEETS ARE DUE BY 4:30PM MONDAY AFTER WEEK 2**

WEEK 1 of pay period								WEEK 2 of pay period							
MON	TUE	WED	THU	FRI	SAT	SUN		MON	TUE	WED	THU	FRI	SAT	SUN	
Month/Day/Year								Month/Day/Year							
<b>VISIT ONE</b>								<b>VISIT ONE</b>							
TIME IN	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	TIME IN	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
TIME OUT	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	TIME OUT	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Visit 1 Hours:								Visit 1 Hours:							
<b>VISIT TWO</b>								<b>VISIT TWO</b>							
TIME IN	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	TIME IN	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
TIME OUT	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	TIME OUT	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Visit 2 Hours:								Visit 2 Hours:							
Total your daily hours in the boxes below								Total your daily hours in the boxes below							
Total Daily Hrs:								Total Daily Hrs:							
WEEK 1				Respite Wk 1 Total hours:				WEEK 2				Respite Wk 2 Total hours:			

Activities	MON	TUE	WED	THU	FRI	SAT	SUN	Activities	MON	TUE	WED	THU	FRI	SAT	SUN
Monitor Client								Monitor Client							
Redirect behavior								Redirect behavior							
Keep residence tidy								Keep residence tidy							
Assist w/meals								Assist w/meals							
Appropriate dress								Appropriate dress							
Personal Care								Personal Care							
Assist w /appointments								Assist w/appointments							
Other (note on back)								Other (note on back)							

**Acknowledgements & 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. 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.

<b>Print Recipient Name</b>	<b>MA Member # or DOB</b>	<b>You must initial cares provided. Do not pre-fill or pre-sign/date timesheets.</b>	
		Every date box must have month/day/year for entire timesheet & include AM/PM notation	
<b>Recipient/Responsible Party Signature:</b>	<b>Date:</b>	<b>Incomplete, incorrect, or illegible timesheets cannot be accepted for billing.</b>	
		<b>Total Hours</b> (office use)	
<b>Print PCA Name</b>	<b>PCA Provider # (office use)</b>		
<b>PCA Signature</b>	<b>Date:</b>		<b>Bemidji</b> <b>P: 320-233-0119</b> <b>F: 320-233-0129</b>
<b>Late timesheets will not be processed until the next payroll cycle (2 more weeks)</b>			

Dates & location of client stay in hospital or care facility or incarceration:

