TIME AND ACTIVITY DOCUMENTATION

METROPOLITAN COMMUNITY SERVICES

CLIENT NAME: _____

Type of Service: ☐ PCA ☐ HMK

DAYS OF SERVICE	MON	TUE	WED	THUR	FRI	SAT	SUN
DATES OF SERVICE (mm/dd/yy)							
ACTIVITIES (Document (R) if client refuses care)	Initials	Initials	Initials	Initials	Initials	Initials	Initials
Bathing							
Dressing							
Shampoo / Brush / Comb hair							
Shave							
Oral hygiene							
Skin / Foot care							
Nail care							
Grooming							
Bowel / Bladder program / Catheter care							
Exercise as directed							
Ambulation / Cane / Walker assist							
Positioning / Transfer							
Medication reminder							
Meal preparation / Assist							
Grocery shop							
Change linen/make bed							
Clean living room							
Clean bathroom							
Clean kitchen							
Laundry							
Dust / Vacuum / Sweep / Mop floors							
Accompany client / Socialization							
Safety							
Specific orders							

VISIT INFORMATION

DATE	DAY	VISIT 1		VISIT 2		Daily Total
		Time In	Time Out	Time In	Time Out	
	Mon	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	
	Tue	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	
	Wed	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	
	Thu	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	
	Fri	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	
	Sat	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	
	Sun	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	
					WEEKLY TOTAL	

ACKNOWLEDGEMENT AND REQUIRED SIGNATURES

After the caregiver has documented his/her time and activity, the client must draw a line through any dates he/she did not receive services from the caregiver. Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on client billings for any Federal/Medicaid insurance payment. Your signature verifies the time and services entered above are accurate and that the services were performed as specified on the Client Care Plan.

CLIENT NAME (FIRST, LAST)	PMI # OR DOB	CLIENT/RESPONSIBLE PARTY SIGNATURE	DATE
EMPLOYEE NAME (FIRST, LAST)	**PCA NPI/UMPI**	**EMPLOYEE SIGNATURE**	**DATE**

NOTE: If more than two visits worked in a day, please use another timesheet. See other side for complete instructions.

ADMIN (Initial)	RN Sup (Initial)

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INSTRUCTIONS FOR PCA TIME AND ACTIVITY DOCUMENTATION

This form documents time and activity between one PCA and one recipient. Document up to two visits per day on this form. Use additional forms if you do more than two visits per day. The Agency has additional instructions or documentation requirements (see employee manual).

USE BLACK PEN ONLY

Work week is MONDAY through SUNDAY.

Type of Service

Check appropriate service

Dates of Service

Dates of service must be in consecutive order. Enter the date in mm/dd/yy format for each date you provide service. The recipient must draw a line through any dates and times PCA services were not provided.

Activities

For each date you provided care, write your initials next to all the activities you provided. Your initials indicate you provided the service as described in the Care Plan. If you provide a service more than once in a day, initial only once. Each employee MUST use Universal Precautions with every client. This includes frequent Hand Washing and using Personal Protective Equipment. The client must draw a line through any dates and times services were not provided. Document (R) if client refuses any type of activity. The following are general descriptions of activities of daily living and instrumental activities of daily living.

Bathing: Starting or finishing a bath or shower, transfers, mobility, positioning, using soap, rinsing, drying, inspecting skin, and applying lotion.

Dressing: Appropriate clothing for the day, includes laying-out of clothing, actual applying and changing clothing, orthotics, prosthetics, transfers, mobility, positioning to complete this task.

Shampoo/Brush/Comb Hair

Shave

Oral Hygiene: Set up/Assist brushing teeth, using glycerin swabs, cleaning dentures, and floss teeth.

Skin/Foot Care: Prepare foot soak, inspect skin, lotion, massage.

Nail Care: File only

Grooming: Applying cosmetics, deodorant, caring for eyeglasses, contact lenses, hearing aids and applying orthotics.

Bowel/Bladder Program/Catheter Care: Bowel/bladder elimination and care, catheter care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, and inspecting skin and adjusting clothing.

Exercise as Directed: Follow exercise program in client's Care Plan including Range of Motion.

Ambulation/Cane/Walker Assist: Moving from one place to another, including using a cane, walker, or wheel chair.

Positioning/Transfer: Moving the client's body for necessary care and comfort or to relieve pressure areas. Moving from one sitting/reclining area or position to another.

Medication Reminder: Remind client to take medications.

Meal Preparation/Assist: Getting food into the body, transfer, mobility, positioning, hand washing, applying of orthotics needed for eating, feeding, and preparing meals.

Grocery Shop: Make grocery list, shopping, return grocery items, receipt and change to the client.

Change Linen/Make Bed: Clean the bedroom.

Clean Living Room: Dust/Vacuum/Sweep/Mop Floors.

Clean Bathroom: Disinfect toilet, sink, tub/shower, and refill toilet paper.

Clean Kitchen: Disinfect stove, fridge, sink, microwave, wipe counters, empty trash, clearing tables, washing dishes, putting dishes in dishwasher, drying and putting away dishes.

Laundry: Laundry integral to personal care, includes sorting clothes, putting clothes in washer and dryer, adding soap and/or dryer sheet, iron as needed, folding and putting away clothes.

Dust/Vacuum/Sweep/Mop Floors: Do Not Move Heavy Furniture. Accompany Client: to MD visits, stores, or errands as needed.

Safety: Test smoke alarms, clear walkways, report frayed electrical cords, check handrails, home security, emergency plan for fire/medical, cooking safety, and report safety or environmental concerns.

Specific Orders: Any additional orders the Nurse has listed in the client's Care Plan not included above.

Date

Enter the date in mm/dd/yy format for each date you provide service.

Visit One

Documentation of the first visit of the day.

Time In: Enter exact time in hours and minutes that you started providing care and check AM or PM.

Time Out: Enter exact time in hours and minutes that you stopped providing care and check AM or PM.

- IF YOUR SHIFT IS 8 HOURS OR MORE, YOU MUST DOCUMENT
  A MINIMUM OF 30 MINUTES FOR LUNCH BREAK.

Visit Two

Same as visit one.

Daily Total

Add the total time in hours and minutes that you spent with this client for the care documented in each row.

Weekly Total

Add the time in hours and minutes for all visits on this entire timesheet and enter the total in the appropriate box.

Acknowledgement and Required Signatures

Client/responsible party prints the client's first and last name, and PMI # or DOB (for identifying purposes). Client/responsible party signs and dates form. Employee prints his/her first and last name, and if applicable individual PCA Provider ID Number (for identifying purposes). Employee signs and dates form.