# TIMESHEET

**PCA Choice 1:1**
**Care Services**

- Complete legibly in **BLUE or BLACK** ink.
- Timesheets are due every other **Tues.** by **1:00 PM**.
- Any incomplete, conflicting or erroneous timesheets will NOT be processed until the next pay period.

Pay Period End Date: / /


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Ability Care Partners, Inc.
PCA Choice Provider

**Web: www.abilitycare.com Email: staff@abilitycare.com**


**Consumer Name:** **Consumer MHCP ID#:**

**PCA Name:** **PCA MHCP ID#:**

**PCA Relation to Consumer:** *Indicate Below (Required)*
**Relation is defined by blood or through legal adoption.**

- ☐ **Parent**
- ☐ **Grandparent**
- ☐ **Adult Child**
- ☐ **Adult Grandchild**
- ☐ **Sibling**
- ☐ **Not Related**

***Excludes:* Step-Child/Sibling, In-Laws and Non-Related Legal Guardian**

**Week 1 Total Hrs** ____ **Week 2 Total Hrs** ____ **Period Total Hrs** ____

| Wk 1 | Date | Shift 1 Time IN | Shift 1 Time OUT | Shift 2 Time IN | Shift 2 Time OUT | Shift 3 Time IN | Shift 3 Time OUT | Daily Total | Dressing | Grooming | Bathing | Eating | Transfers | Mobility | Positioning | Toileting | Cleaning | Laundry | Health (HRF) | Behavior | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sun | | | | | | | | | | | | | | | | | | | | | |
| Mon | | | | | | | | | | | | | | | | | | | | | |
| Tues | | | | | | | | | | | | | | | | | | | | | |
| Wed | | | | | | | | | | | | | | | | | | | | | |
| Thu | | | | | | | | | | | | | | | | | | | | | |
| Fri | | | | | | | | | | | | | | | | | | | | | |
| Sat | | | | | | | | | | | | | | | | | | | | | |

Indicate times as **AM** or **PM.** Draw a line through days **NOT** worked. List any Consumer hospitalization dates.

**PCA's _must_ initial services provided each day, as specified in care plan.**

| Wk 2 | Date | Shift 1 Time IN | Shift 1 Time OUT | Shift 2 Time IN | Shift 2 Time OUT | Shift 3 Time IN | Shift 3 Time OUT | Daily Total | Dressing | Grooming | Bathing | Eating | Transfers | Mobility | Positioning | Toileting | Cleaning | Laundry | Health (HRF) | Behavior | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sun | | | | | | | | | | | | | | | | | | | | | |
| Mon | | | | | | | | | | | | | | | | | | | | | |
| Tues | | | | | | | | | | | | | | | | | | | | | |
| Wed | | | | | | | | | | | | | | | | | | | | | |
| Thu | | | | | | | | | | | | | | | | | | | | | |
| Fri | | | | | | | | | | | | | | | | | | | | | |
| Sat | | | | | | | | | | | | | | | | | | | | | |

**Acknowledgement:** By signing this document, both parties verify the times/services provided are accurate and that the services were performed as specified in the Consumer's PCA Care Plan.
***It is a federal crime to provide false information on PCA billings for Medical Assistance payment. Ability Care Partners will investigate and report any suspected fraud.***

**Consumer (or Responsible Party) Signature** **Date** **PCA Signature** **Date**