3638 Central Ave. NE
Minneapolis, MN 55418
(612) 378-1474

CLIENT NAME: ______________________________

PERIOD COVERED: ______________ TO ______________

TYPE OF SERVICE: HHA PCA HM

| ACTIVITIES | MON | TUE | WED | THUR | FRI | SAT | SUN |
|---|---|---|---|---|---|---|---|
| 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 | | | | | | | |
| Safety | | | | | | | |
| Specific orders | | | | | | | |
| | | | | | | | |

Client observations: ______________________________

______________________________

**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.

| | | |
|---|---|---|
| **Print Client Name (First, MI, Last)** | **Client DOB or MA Member #** | **Ending Sunday Date** |

______________________________

**Client/Responsible Party Signature** **Date**

**Print Employee Name (First, MI, Last)**

**Employee #** **DHS PCA Provider #**

**TYPE OF SERVICE: HHA PCA HM**

______________________________

**Employee Signature** **Date**

| Date | Day | 1st Visit Time In | 1st Visit Time Out | 2nd Visit Time In | 2nd Visit Time Out | Daily Total | Client Initials |
|---|---|---|---|---|---|---|---|
| | M | AM PM | AM PM | AM PM | AM PM | | |
| | T | AM PM | AM PM | AM PM | AM PM | | |
| | W | AM PM | AM PM | AM PM | AM PM | | |
| | T | AM PM | AM PM | AM PM | AM PM | | |
| | F | AM PM | AM PM | AM PM | AM PM | | |
| | S | AM PM | AM PM | AM PM | AM PM | | |
| | S | AM PM | AM PM | AM PM | AM PM | | |
| | | | | | **Weekly Total** | | |

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

# Instructions for Time and Activity Documentation:

This form documents time and activity between one employee and one client. 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.) For shared care, you must use a separate form for each person for whom you are providing care.

**USE BLACK PEN ONLY**
Work week is **MONDAY though SUNDAY**
**Client Name:** Print client's name clearly

**Period Covered:** Print Monday – Sunday date

**Type of Service:** Circle appropriate service

**Activities:** For each date you provided care, write your initials next to all the activities you provided. Your initials indicate you provided the services 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:**

**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, care of 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 orthodics 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**
**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** – Doctor appt's, 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.

**Client Observations:** Caregiver's objective observations on client's health status. **DO NOT INCLUDE ANY OTHER INFORMATION.**

**Acknowledgement and Required Signatures:** Client/responsible party prints the client's first name, middle initial, last name and date of birth or MA Member Number (for identifying purposes). Client/responsible party signs and dates form. Employee prints his/her first name, middle initial, last name, Employee ID Number, and if applicable individual PCA Provider ID Number (for identifying purposes). Circle appropriate type of service and print ending Sunday date. **The client must draw a line through any dates and times services were not provided.**

**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 circle AM or PM.
**IF YOUR SHIFT IS 8 HOURS OR MORE, YOU MUST DOCUMENT A MINIMUM OF 30 MINUTES FOR LUNCH BREAK.**
**(Visit One: 8:00 AM – 12:00 PM; Visit Two: 12:30 PM- 4:30 PM)**
**Time Out:** Enter exact time in hours and minutes that you stopped providing care and circle AM or PM.

**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.

**Client Initials:** Client/responsible party must initial in the appropriate box after each visit.

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

**FOR EMPLOYEE**
I certify that the hours recorded on the reverse side are true and correct, was worked by me during the week ending as shown and were properly certified by the client or their responsible party.

I agree to notify the agency by mail or by phone within 5 days of termination of each assignment. If I fail to give such notice, the agency may assume that I am not available for employment and my unemployment benefits may be affected.

**FOR CLIENT**
Client certifies that the hours recorded on the reverse side are accurate and that the work was completed in a satisfactory manner. In the event of any claim under the agency fidelity bond, client agrees to notify the agency within 20 days of the incident and understands that the failure to notify the agency in writing within such time frame shall constitute a waiver of the claim.