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**PCA 1:1
 Services**

Pay Period End Date:

/ /

Week 1 Total Hrs

Week 2 Total Hrs

Pay Period Total Hrs

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

TIMESHEET INSTRUCTIONS: Complete legibly in BLUE or BLACK ink and indicate each time as AM or PM.
 Draw a line through any day(s) NOT worked. Timesheets are due TUESDAY by 1:00pm as listed on the payroll schedule.

Wk 1	Date	SHIFT 1		SHIFT 2		SHIFT 3		Daily Total
		Time IN	Time OUT	Time IN	Time OUT	Time IN	Time OUT	
Mon								
Tues								
Wed								
Thu								
Fri								
Sat								
Sun								

Dressing	Grooming	Bathing	Eating	Transfers	Mobility	Positioning	Toileting	Cleaning	Laundry	Health	Behavior	Other

Wk 2 Please call us if the Consumer was hospitalized, and indicate any dates/times on this timesheet.

Mon								
Tues								
Wed								
Thu								
Fri								
Sat								
Sun								

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

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. Break-Thru Home Care will investigate and report any suspected fraud.

Consumer (or Responsible Party) Signature _____ Date _____

PCA Signature _____ Date _____