Pay Period Dates | Clear Times | Clear Names | Clear Page | Reset All | Print

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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.

		SHIFT 1		SHIFT 2		SHIFT 3			Dressing	Grooming	Bathing	Eating	Transfers	Mobility	Positioning	Toileting	Cleaning	Laundry	Health	Behavior	Other
Wk 1	Date	Time IN	Time OUT	Time IN	Time OUT	Time IN	Time OUT	Daily Total													
Mon																					
Tues																					
Wed																					
Thu																					
Fri																					
Sat																					
Sun																					
Wk 2	Please call us if the Consumer was hospitalized, and indicate any dates/times on this timesheet.								PCA's must initial services provided each day, as specified in care plan.												
Mon																					
Tues																					
Wed																					
Thu																					
Fri																					
Sat																					
Sun																					

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**