Mail: 2965 Lone Oak Drive, Suite 160, Eagan, MN, 55121-1553 **Fax Toll-Free: 1-877-858-6957**

Lifeworks
PCA Time Card
(Do not use for shared care)

Employee ID: ☐☐☐☐☐☐ Client ID: ☐☐☐☐☐☐

Care Facility ○
Hospital ○

Facility Name and Date Admitted:

35418

Employee Name: _____ Client Name: _____

Employee Phone: _____ From: ☐☐ / ☐☐ / ☐☐ To: ☐☐ / ☐☐ / ☐☐

WK1	TIME IN	AM/PM	TIME OUT	AM/PM	TOTAL
Su					☐☐.☐☐
Mo					☐☐.☐☐
Tu					☐☐.☐☐
We					☐☐.☐☐
Th					☐☐.☐☐
Fr					☐☐.☐☐
Sa					☐☐.☐☐

ACTIVITY

Su	Dressing ☐	Grooming ☐	Bathing ☐	Eating ☐	Light Housekeeping ☐
	Mobility ☐	Positioning ☐	Toileting ☐	Transfers ☐	Health Related ☐
	Laundry ☐	Behavior ☐	Other ☐		
Mo	Dressing ☐	Grooming ☐	Bathing ☐	Eating ☐	Light Housekeeping ☐
	Mobility ☐	Positioning ☐	Toileting ☐	Transfers ☐	Health Related ☐
	Laundry ☐	Behavior ☐	Other ☐		
Tu	Dressing ☐	Grooming ☐	Bathing ☐	Eating ☐	Light Housekeeping ☐
	Mobility ☐	Positioning ☐	Toileting ☐	Transfers ☐	Health Related ☐
	Laundry ☐	Behavior ☐	Other ☐		
We	Dressing ☐	Grooming ☐	Bathing ☐	Eating ☐	Light Housekeeping ☐
	Mobility ☐	Positioning ☐	Toileting ☐	Transfers ☐	Health Related ☐
	Laundry ☐	Behavior ☐	Other ☐		
Th	Dressing ☐	Grooming ☐	Bathing ☐	Eating ☐	Light Housekeeping ☐
	Mobility ☐	Positioning ☐	Toileting ☐	Transfers ☐	Health Related ☐
	Laundry ☐	Behavior ☐	Other ☐		
Fr	Dressing ☐	Grooming ☐	Bathing ☐	Eating ☐	Light Housekeeping ☐
	Mobility ☐	Positioning ☐	Toileting ☐	Transfers ☐	Health Related ☐
	Laundry ☐	Behavior ☐	Other ☐		
Sa	Dressing ☐	Grooming ☐	Bathing ☐	Eating ☐	Light Housekeeping ☐
	Mobility ☐	Positioning ☐	Toileting ☐	Transfers ☐	Health Related ☐
	Laundry ☐	Behavior ☐	Other ☐		

WEEK 1 TOTAL: ☐☐☐.☐☐

Acknowledgement and Required Signatures: After the PCA had documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from the PCA. Review the completed timesheet for accuracy before signing. It is a federal crime to provide false information on PCA billings for Medical Assistance payment. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the PCA Care Plan. You are also assuring that your employees did not work any hours while the client was in the hospital or care facility.

Employee Signature _____ Date _____ Support Manager Signature _____ Date _____