Respite Time Sheet

(PLEASE PRINT)

PCA/RN NAME:_______________________________________ **CLIENT NAME:**___________________________________

MHCP (PCA) Provider #: _______________________________ **D.O.B.:** ____ or

Pay Period: ____ **MHCP (MA) ID** #: ____________________________________

*** This time sheet is NOT to be used for SHARED CARE ***

This timesheet is to be completed DAILY by each PCA or Supervising RN who has physical presence contact with the client. By signing below, the PCA or Supervising RN and CLIENT verifies that all of the information that has been completed on this form is accurate and truthful. All time and duties listed MUST have been actually worked/performed with/for the client. Listing any time or duties that was not worked/performed with/for the client is considered FRAUD and may result in termination of employment/services. Any FRAUD or suspected FRAUD will be reported to the Fraud Investigation Division of the Department of Human Services. <u>This timesheet must be in the AccuKare Inc. office by Tuesday after the pay period ends.</u> It is the responsibility of each individual to handle the sending/faxing of his or her time card.

Mail to: AccuKare Inc.
13750 Crosstown Dr NW, Suite L100
Andover, MN 55304
PH. (763) 862-3971

OR

Fax to: (763) 862-2135
(If you fax your time card, call and verify it has been received)

Email to: timecards@accukare.com

Date (Mo/Day/Yr)	Time In (Circle AM or PM)	Time Out	Daily Total Time	Safety	Grooming	Bathing	Skin Care	Dressing	Eating	Resp. Care	Toileting Needs	Transfers	Positioning	Mobility	Exercises	IADL	Behaviors	Seizures	Med. Assist.	Laundry	Cleaning Med. Equip.	Cleaning (Related to Cares)
	AM PM	AM PM																				
	AM PM	AM PM																				
	AM PM	AM PM																				
	AM PM	AM PM																				
	AM PM	AM PM																				
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	AM PM	AM PM																				
	AM PM	AM PM																				
	AM PM	AM PM																				
Total Time for Pay Period																						

*** More than one line may be used per day.**
*** More than one time sheet may be used per pay period, per employee, per client.**

Notes: ____

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****NOTICE: After the PCA has 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 time sheet 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. All unused lines are to be crossed out.**

PCA SIGNATURE: ___________________________________ **CLIENT SIGNATURE**: ____

Date: _______________________ **Date:** ________________________

All above information is to be considered confidential and is to be treated in accordance with agency policy.