HMI HOME HEALTH

1707 L St, NW, Suite 900, Washington, DC 20036

PCA/HHA TIME & ACTIVITY SHEET

Beneficiary Name: _____ **Beneficiary ID#**_____ **Place of Service**_____

HHA/ PCA Name: _____**HHA/PCA NPI#**_____

Week of _____/_____/_____ **Through** _____/_____/_____

Is Care Plan in Home: ☐ **Yes/** ☐ **No**
If no, contact the office to get a copy.

ALL TASKS MUST BE PREFORMED PER THE CARE PLAN FOR BENEFICIARY/CLIENT

HHA's must observe, document, and report beneficiary's physical condition, behavior, and appearance and report all services provided on a daily basis:

Beneficiary and aide must sign and date daily for all activities performed.

Date: (mm/dd/yr)							
Day of week	Sun	Mon	Tues	Wed	Thu	Fri	Sat
Time In:(also show:A=am, P=pm)							
Time Out:(also show:A=am, P=pm)							
Daily Total Hours:							
Activities of Daily Living - Cueing or Hands-on Assistance with the following functions							
Bathing: (T)Tub/(SH)Shower/(SP)Sponge/(PC)Perineal Care							
Hair-(SC)Shampoo/Condition/(CB)Comb/Brush							
Oral/dental care (D) clean dentures (S) Shave							
(D) Dressing (L) Layout Clothing							
(S) SkinCare/(F)FootCare/(N)NailCare-Clean & file							
Bathing Total Time:							
Toileting - Cueing or Hands-on Assistance with the following functions							
Toileting:(B) Bathroom/Commode Incontinence							
Assisting with Bowel and Bladder Elimination							
Assist with incontinence- Empty urinary drainage bag Y (yes) N (No) or NA (no catheter)							
Monitoring urine in/output according to POC Y (yes) N (No) or NA							
Toileting Total Time:							
Eating/Meal Preparation - Cueing or Hands-on Assistance with the following functions							
Meal/Snack preparation (per the dietary guideline)							
Assist with Feeding Cueing-setting up							
Eating/ Meal PreparationTotal Time:							
Mobility							
Range of Motion Exercise per PT/OT Care Plan							
Assist/Supervise Ambulating:(S)Self/(C) Crutch (AWC)Assist Walker/Cane (WC) Wheelchair							
Transfer-Bed/chair,wheelchair/commode/HoyerLift							
Position Change every 2 hours. Indicate which side L, R, back or sitting							
Mobility Total Time:							
Special Maintenance - Promoting Safe, Living Environment/Universal Precautions/Infection Control of areas occupied by and or used in the delivery of care to the beneficiary.							
Free of Clutter, trip hazards, rugs (BA) Bathroom (K) Kitchen (BD) Bedroom (LA) Living Area							
Practice Infection Control (Sanitize and Disinfect) (BA) Bathroom/(K) Kitchen/(BD) Bedroom (soiled linen/clothing)/(LA)Living Areas/(DME) Durable Medical Equipment (cane, walker, wheelchair etc.)							
Accompany to Medical/Dental appt. recreational/community activities according to POC. N (no) Y(yes) None (NA)							
Medication Reminder-Y(yes)/N(No) or R(refused)							
Assistance with telephone use							
Shopping for items related to beneficiary's meals according to dietary guidelines and /Errands related to health needs.							
Observe Beneficiary physical condition, behavior, and appearance *Complete Narrative on Page 2							
Special Maintenance Total Time:							

MON:
_____ _____
Beneficiary Signature **Date**
_____ _____
HHA Signature **Date**

TUE:
_____ _____
Beneficiary Signature **Date**
_____ _____
HHA Signature **Date**

WED:
_____ _____
Beneficiary Signature **Date**
_____ _____
HHA Signature **Date**

THU:
_____ _____
Beneficiary Signature **Date**
_____ _____
HHA Signature **Date**

FRI:
_____ _____
Beneficiary Signature **Date**
_____ _____
HHA Signature **Date**

SAT:
_____ _____
Beneficiary Signature **Date**
_____ _____
HHA Signature **Date**

SUN:
_____ _____
Beneficiary Signature **Date**
_____ _____
HHA Signature **Date**

Acknowledgments and Required Signatures

After the caregiver has documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive service. Review the completed time sheet for accuracy before signing. It is a federal crime for both the beneficiary and PCA to provide false information on billings for Medical Assistance payments. Your signatures verify the time and services entered above are accurate and that the services were performed as specified in the Care Plan. **PCA also attests that he/she does not work for another agency during the hours documented on timesheet.** ***Incomplete documents will result in time sheet not being processed.***

BENEFICIARY/RESPONSIBLE PARTY SIGNATURE_____ **DATE**_____

PCA/HHA SIGNATURE_____ **DATE**_____

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PCA/HHA TIME & ACTIVITY SHEET

Date Time	**Client Daily Condition (√ Check all that apply) Please document any changes regarding the client's physical condition, behavior, appearance and other changes that you may observe. Call Nurse/Office immediately for changes and incidents that occur with the client. If emergency, call 911 and notify office immediately.**
Sunday Date_____ Time_____	**A. Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforced wound dressing ❒ Yes ❒ No** **Comment(s):** _____ **B. Did you observe any change in the client's behavior? ❒ Alert ❒ Confused** **Comment(s):** _____ **C. Any redness, open sores, wounds on client's body? ❒Yes ❒ No. If yes is nurse aware? ❒Yes ❒ No. Did a Fall Occur?❒ Yes ❒ No** **Additional Comments:**_____
Monday Date_____ Time_____	**A. Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforced wound dressing ❒ Yes ❒ No** **Comment(s):** _____ **B. Did you observe any change in the client's behavior? ❒ Alert ❒ Confused** **Comment(s):** _____ **C. Any redness, open sores, wounds on client's body? ❒Yes ❒ No. If yes is nurse aware? ❒Yes ❒ No. Did a Fall Occur?❒ Yes ❒ No** **Additional Comments:**_____
Tuesday Date_____ Time_____	**A. Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforced wound dressing ❒ Yes ❒ No** **Comment(s):** _____ **B. Did you observe any change in the client's behavior? ❒ Alert ❒ Confused** **Comment(s):** _____ **C. Any redness, open sores, wounds on client's body? ❒Yes ❒No. If yes is nurse aware? ❒Yes ❒ No. Did a Fall Occur?❒ Yes ❒ No** **Additional Comments:**_____
Wednesday Date_____ Time_____	**A. Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforced wound dressing ❒ Yes ❒ No** **Comment(s):** _____ **B. Did you observe any change in the client's behavior? ❒ Alert ❒ Confused** **Comment(s):** _____ **C. Any redness, open sores, wounds on client's body? ❒Yes ❒No. If yes is nurse aware? ❒Yes ❒ No. Did a Fall Occur?❒ Yes ❒ No** **Additional Comments:**_____
Thursday Date_____ Time_____	**A. Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforced wound dressing ❒ Yes ❒ No** **Comment(s):** _____ **B. Did you observe any change in the client's behavior? ❒ Alert ❒ Confused** **Comment(s):** _____ **C. Any redness, open sores, wounds on client's body? ❒Yes ❒No. If yes is nurse aware? ❒Yes ❒ No. Did a Fall Occur?❒ Yes ❒ No** **Additional Comments:**_____
Friday Date_____ Time_____	**A. Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforced wound dressing ❒ Yes ❒ No** **Comment(s):** _____ **B. Did you observe any change in the client's behavior? ❒ Alert ❒ Confused** **Comment(s):** _____ **C. Any redness, open sores, wounds on client's body? ❒Yes ❒No. If yes is nurse aware?❒ Yes ❒ No. Did a Fall Occur?❒ Yes ❒ No** **Additional Comments:**_____
Saturday Date_____ Time_____	**A. Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforced wound dressing ❒ Yes ❒ No** **Comment(s):** _____ **B. Did you observe any change in the client's behavior? ❒ Alert ❒ Confused** **Comment(s):** _____ **C. Any redness, open sores, wounds on client's body? ❒Yes ❒No. If yes is nurse aware? ❒Yes ❒ No. Did a Fall Occur?❒ Yes ❒ No** **Additional Comments:**_____

Additional Comments: Date/Comments:

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Beneficiary/Client Name:_____
PCA/HHA Signature/Date:_____/_____

Instructions for Personal Care Aide (PCA) Time and Activity Documentation:

This form documents time and activity between one (1) PCA and one (1) beneficiary. Each Provider shall maintain adequate documentation substantiating the delivery of allowable services provided in accordance with the PCA service authorization and the beneficiary's plan of care for each service provided to the beneficiary.

Dates of Service: Enter the date in mm/dd/yy format for each date you provide service. The client must draw a line through any dates and times PCA services were not provided.

Time IN/Time OUT: Enter time you started/stopped providing care in hours and minutes. Indicate AM or PM next to the time.

Daily Total Hours: Add the time for all activities delivered daily to the recipient on this entire time sheet.

Activities: For each activity performed on the day of service, enter the total amount of time. The time for each activity must be shown in 15-minute increments. Round up or down to the nearest 15 minutes. The rounding rule example: if you spent 10 minutes on an activity, round it up to 15 minutes. If you spent 20 minutes, round down to 15 minutes.
Examples of time entries on the time sheet are as follows:

For 15 minutes – enter time as 15
For 30 minutes – enter time as 30
For 45 minutes – enter time as 45
For 1 hour and 15 minutes – enter time as 1:15
For 1 hour and 30 minutes – enter time as 1:30
..and so on.

If you provide a service more than once a day, document total time and indicate in your comments for the day the total number of times a service is delivered to the recipient.

Total Time: Add the total time per category that you spent with this recipient for the care documented.

The following are general descriptions of activities of daily living and instrumental activities of daily living.

Activities of Daily Living – Personal hygiene includes assisting the recipient with hair care, oral care, nail care, shaving hair, applying cosmetics and deodorant, care of eyeglasses, contact lenses, hearing aids and applying orthotics. Starting and finishing a bath or shower, using soap, rinsing, drying, inspecting skin, applying lotion. Assisting in the bathroom with transfers, mobility, positioning and removing all clothes and towels from the floor**.**

Toileting – Bowel/bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area and inspecting skin and adjusting clothing.

Eating/Meal Prep Personal care may include assisting the recipient with all activities as needed in the kitchen to include hand washing, applying of orthotics needed for eating, feeding, preparing meals and grocery shopping. Personal care may also include Universal Standard Precautions activities during the performance of meal preparation including sanitizing surfaces, dishes and utensils used during meal preparation and feeding.

Transfers/Mobility – Moving from one seating/reclining area or position to another, transfers, mobility, and positioning. Moving from one place to another, including using a wheelchair.

Positioning – Assisting or moving the person to a different position or turning the client for necessary care and comfort or to relieve pressure areas.

Range of Motion/Exercise – Assist with exercise program as prescribed by MD, PT, and/or OT.

Special Maintenance promoting safe, comfortable living environment/ Universal Precautions/Infection Control -. Performing tasks to promote a safe, sanitary and comfortable environment in locations occupied by beneficiary to prevent infection and falls. Including activities such as decontamination of soil surfaces and clothes. Maintaining an environment free of clutter, trip hazards and spills to prevent falls.

IADLs (Instrumental Activities of Daily Living) -Covered service for recipients, such as: Meal planning and preparation, basic assistance with paying the bills, shopping for food, and items related to health needs, integral to the personal care assistance services. Assisting with recipient's communication by telephone, and other media, and accompanying the recipient with traveling to medical/dental appointments and participation in the community activities.

Medication Reminder – Reminding the recipient to take medication as prescribed by physician.

Physical/Behavioral Observation and reporting: Describe any noticeable changes in the client, including bruises, swelling, discoloration, increased pain, decreased mobility, decreased appetite, any wounds, etc. and/or behavioral changes or activities such as redirecting, intervening, monitoring behavior. Document if changes were reported.

Other – If other activities were performed according to plan of care, and were not included above, PCA must complete a full narrative description of personal care services rendered to the recipient.

Hospitalization/Admission Dates: PCA services shall not be provided in a hospital, nursing facility, intermediate care facility, or other living arrangement, which includes personal care as part of the reimbursed service. List any dates the client spent in the hospital during the pay period.

Acknowledgement and Required Signatures: Recipient/responsible party prints the recipient's first name, middle initial, last name, and Recipient ID (for identifying purposes). Recipient/responsible party signs and dates form. PCA prints his/her first name, middle initial, last name, individual PCA NPI Number (for identifying purposes). PCA signs and dates. Remember, it is a federal crime to provide false information on billings for Medical Assistance payments. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the care plan.