Allegiance Ability Assistance LLC

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Saint Paul, MN 55104
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PERIOD COVERED ___/___/20____ **TO** ___/___/20____

CLIENT NAME: _____ **PCA NAME:** _____

WEEK 1	SAT	SUN	MON	TUE	WED	THUR	FRI
DATE:							
Time IN	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Time OUT	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Time IN	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Time OUT	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Time IN	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Time OUT	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Total Hrs:							
WEEK 1	Total Hrs:						
Activities (please Initial)							
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Behavior							
Health-Related							
Laundry							
Housekeeping							
Other							

WEEK 2	SAT	SUN	MON	TUE	WED	THUR	FRI
DATE:							
Time IN	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Time OUT	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Time IN	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Time OUT	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Time IN	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Time OUT	am pm	am pm	am pm	am pm	am pm	am pm	am pm
Total Hrs:							
WEEK 2	Total Hrs:		Total Hrs (Week 1 / Week 2):				
Activities (please Initial)							
Dressing							
Grooming							
Bathing							
Eating							
Transfers							
Mobility							
Positioning							
Toileting							
Behavior							
Health-Related							
Laundry							
Housekeeping							
Other							

Acknowledgements & Signatures: 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.

PCA Signature:	**PCA Provider #**	**Date:**	**Client Hospital Discharge:**
Recipient/Responsible Party Signature:	***MA Member # or DOB***	**Date:**	am pm Date: _____ Time: _____

Please make a copy of your time sheet to keep track of your hours the PCA can only work 275 a month

PAYROLL SCHEDULE 2018

Pay Period	Time Sheet Due	Pay Day
6-Jan - 19-Jan	24-Jan	2-Feb
20-Jan - 2-Feb	7-Feb	16-Feb
3-Feb - 16-Feb	21-Feb	2-Mar
17-Feb - 2-Mar	7-Mar	16-Mar
3-Mar - 16-Mar	21-Mar	30-Mar
17-Mar - 30-Mar	4-Apr	13-Apr
31-Mar - 13-Apr	18-Apr	27-Apr
14-Apr - 27-Apr	2-May	11-May
28-Apr - 11-May	16-May	25-May
12-May - 25-May	30-May	8-Jun
26-May - 8-Jun	13-Jun	22-Jun
9-Jun - 22-Jun	27-Jun	6-Jul
23-Jun - 6-Jul	11-Jul	20-Jul
7-Jul - 20-Jul	25-Jul	3-Aug
21-Jul - 3-Aug	8-Aug	17-Aug
4-Aug - 17-Aug	22-Aug	31-Aug
18-Aug - 31-Aug	5-Sep	14-Sep
1-Sep - 14-Sep	19-Sep	28-Sep
15-Sep - 28-Sep	3-Oct	12-Oct
29-Sep - 12-Oct	17-Oct	26-Oct
13-Oct - 26-Oct	31-Oct	9-Nov
27-Oct - 9-Nov	14-Nov	23-Nov
10-Nov - 23-Nov	28-Nov	7-Dec
24-Nov - 7-Dec	12-Dec	21-Dec
8-Dec - 21-Dec	26-Dec	4-Jan
22-Dec - 4-Jan	9-Jan	18-Jan
5-Jan - 18-Jan	23-Jan	1-Feb
19-Jan - 1-Feb	6-Feb	15-Feb
2-Feb - 15-Feb	20-Feb	29-Feb