

**Independence Plus, Inc. Time Card**

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Independence Plus, Inc

PO Box 116

Crookston, MN 56716

This color indicates items that must be filled in by order of the state of minnesota.

**Relationship of employee to client? (Circle one) Must have one circled to be considered for payment**

**Parent / Adoptive Parent, Sibling, Adult Child, Grandparent, Grandchild, No relations as defined here.**

**Employee Name print First, M.I., Last: Last 4 Social Security # Recipient's Name print First, M.I., Last:**

**Dates client was incarcerated, hospitalized or insitutionalized**

**WEEK 2 Pay Period**

**thru #REF!**

Activities	Date	SUN	MON	TUE	WED	THU	FRI	SAT
		MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Dressing								
Grooming								
Bathing								
Eating								
Transfers								
Mobility								
Positioning								
Toileting								
Lighthouskeeping								
Health Related								
Behavior								
Respite								
Other								
<b>*Client Initial Daily*</b>		x	x	x	x	x	x	x
Visit 1st PCA time in Circle AM/PM	In	AM	AM	AM	AM	AM	AM	AM
	Out	PM	PM	PM	PM	PM	PM	PM
Visit 2nd PCA time in Circle AM/PM	In	AM	AM	AM	AM	AM	AM	AM
	Out	PM	PM	PM	PM	PM	PM	PM
Visit 3rd PCA time in Circle AM/PM	In	AM	AM	AM	AM	AM	AM	AM
	Out	PM	PM	PM	PM	PM	PM	PM
Visit 4th Late PCA time in Circle AM/PM	In	AM	AM	AM	AM	AM	AM	AM
	Out	PM	PM	PM	PM	PM	PM	PM
Homemaking time in Circle AM/PM	In	AM	AM	AM	AM	AM	AM	AM
	Out	PM	PM	PM	PM	PM	PM	PM
Respite time in Circle AM/PM	In	AM	AM	AM	AM	AM	AM	AM
	Out	PM	PM	PM	PM	PM	PM	PM

**Total Daily Time**

**Acknowledgement and Required Signatures TOTAL WEEK 1 TOTAL Both Sides**

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.

RECIPIENT/RESPONSIBLE PARTY SIGNATURE Date Date of birth or MA# Employee Provider ID #

Employee signature Date

**OFFICE USE ONLY**  
P A I D  
CK # DATE

**Total All Time Sheets**

\*Time card is not to be used for shared care