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 & Date Admitted, or Location of Service:

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: I certify that time shown above is accurate and includes all time actually worked up through the last work date shown on this card. A line must be drawn through any dates and times when recipient did not receive services from the PCA. All work hours have been pre-authorized by support manager. It is a federal crime to provide false information for billing Medical Assistance. Your signature assures these statements: Services were performed as specified in the PCA Care Plan. Hours were not worked while client was in hospital or care facility.

Employee Signature _____ Date _____ Support Manager Signature _____ Date _____