

Complete only if client was hospitalized:

Date	Time	Admit	Date	Time	Discharge
<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	

No hours can be claimed if Client is in the hospital, nursing home or out of home placement.



**SINCERE HOME CARE**  
REAL PEOPLE. SUPREME SUPPORT.

# PCA TIME REPORT

Fax: 763 – 208 – 6089 or Scan and Email to: [timecards@sincerehomecaremn.com](mailto:timecards@sincerehomecaremn.com)

Client Name: \_\_\_\_\_ Client DOB: \_\_\_\_\_

PCA Name: \_\_\_\_\_ PCA#: \_\_\_\_\_ Pay Period Start/End Date(s): \_\_\_\_\_

**\*\*\*PLEASE READ\*\*\*: This time report must be received by no later than Tuesday, of the non-pay week, no later than 5 PM. Please see your time report example or call the office if assistance is needed.**

**Complete time reports DAILY, White – out is Not Allowed, Picture Submissions are Not Allowed, Do not write X marks or ✓marks; Initials Only, Use Blue or Black Pen Only, Complete time report in its entirety, Incomplete and Incorrect time reports will be returned for resubmission, Late time reports will be paid the following pay period.**

Week One	Mo/Day/Yr.	Time In/Out Indicate AM or PM	Time In/Out Indicate AM or PM	Total Hrs.	Dressing	Grooming	Bathing	Eating	Transfers	Mobility	Positioning	Toileting	Light House- Keeping	Laundry	Health- Related Assistance	Behaviors
Mon																
Tues																
Wed																
Thu																
Fri																
Sat																
Sun																
<b>Total Time for Week One</b>																

Week Two	Mo/Day/Yr.	Time In/Out Indicate AM or PM	Time In/Out Indicate AM or PM	Total Hrs.	Dressing	Grooming	Bathing	Eating	Transfers	Mobility	Positioning	Toileting	Light House- Keeping	Laundry	Health- Related Assistance	Behaviors
Mon																
Tues																
Wed																
Thu																
Fri																
Sat																
Sun																
<b>Total Time for Week Two</b>																

**\*\*\*NOTICE\*\*\*: Your signature verifies the times and services entered above are accurate and that the services were performed as specified in the PCA Care Plan. It is a Federal Crime to provide false information for Medical Assistance payment.\*\***

PCA Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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