State of Alaska
Dept. of Health & Social Services
Senior & Disabilities Services

PCA WEEKLY TIMESHEET

PCA Agency Name:
PCA Agency Provider Number:

PCA Name:		**PCA Renderer #:**	
Recipient Name:		**Recipient Medicaid #:**	
Recipient Address:		**Recipient City, Zip:**	

Activity Code: 1=Body Mobility, 2=Transfer, 3=Locomotion (single level), 4=Locomotion (multi-level), 5=Locomotion (med appt), 6=Dressing, 7=Eating, 8=Toilet Use, 9=Personal Hygiene, 10=Washing Hair, 11=Bathing, 12=Light Meal Prep, 13=Main Meal Prep, 14=Shopping, 15=Light Housework, 16=Laundry, 17= Medication Assistance, 18= Medication Reminders, 19= Dressing changes, 20= Wound Care, 21= Equipment Maintenance, 22= Escort, 23= Passive Range of Motion

Use military time: 0000 to 2400 for each day worked

	SUN	MON	TUE	WED	THU	FRI	SAT
Date of Service (month/day/year)							
Service Location:							
Time In:							
Time Out:							
Activity Code(s):							
Time In:							
Time Out:							
Activity Code(s):							
Time In:							
Time Out:							
Activity Code(s):							
Time In:							
Time Out:							
Activity Code(s):							
Daily Total Hours:							

I hereby certify that the employee has completed the work tasks as authorized in the service level authorization and worked the recorded hours and all hours submitted comply with the regulations governing the Personal Care program (see 7 AAC 125.010 to 7 AAC 125.199) . **Misrepresentation of the time worked, activities actually performed, or the provision of services not authorized by the service level authorization constitutes fraud and can be criminally prosecuted as an unsworn falsification under AS 11.56.210 or as Medical Assistance Fraud under AS 47.05.210.** A conviction for making a false statement on a medical record or Medicaid Fraud can result in a barrier from performing services for Medicaid recipients or being employed or licensed. This medical assistance record must be maintained in accordance with 7 AAC 105.230.

Recipient/Legal Representative Printed Name	Recipient/Legal Representative Signature	Date
PCA Printed Name	PCA Signature	Date

PCA Agency
Quality Assurance Verification

Printed Name: _____ Signature: _____ Date: _____