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

PCA DAILY CASE NOTES

PCA Agency Name:
PCA Agency Provider Number:

NOTE: THIS FORM MUST ACCOMPANY EVERY TIMESHEET THAT IS SUBMITTED FOR PAYMENT

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

Service Level Authorization Chart Reviewed: YES/NO
Date Service Level Authorization Chart Reviewed: _____
Prior Authorization #: _____

Dates of Service: from: _____ to: _____
mm/dd/yy mm/dd/yy

TO BE COMPLETED BY THE PERSONAL CARE ATTENDANT:

Describe how the recipient has responded to your care:
Sunday: _____
_____
Monday:_____
_____
Tuesday:_____
_____
Wednesday: _____
_____
Thursday:_____
_____
Friday:_____
_____
Saturday:_____
_____

Identify any changes, improvements, or decline in the recipient's health, safety, or welfare. Including changes in the recipient's physical or mental condition:
_____
_____
_____

Additional Comments:
_____
_____
_____

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.

_____ _____ _____
PCA Printed Name PCA Signature Date

PCA Agency Verification

Printed Name: _____ Signature: _____ Date: _____