Independence Plus, Inc. Time Card

HOMEMAKING ONLY

Fax # 218 281-3015 Ph # 888 481-3506

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.

Employee Current Phone Number

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

Dates client was incarenated, hospitalized or insitutionalized

WEEK 1 Pay Period **thru**

Activities / Date	SUN MM/DD/YY	MON MM/DD/YY	TUE MM/DD/YY	WED MM/DD/YY	THU MM/DD/YY	FRI MM/DD/YY	SAT MM/DD/YY
Clean stove/Oven							
wash & dry puy dishes away							
clear counters/table & wash							
Clean microwave							
Mop Kitchen floor							
Clean refigerator							
Stack all papers on tables							
sweep and vacumm floors							
Dust all furniture							
Clear bathroom facilities							
Wash all mirrors							
Put clean sheets on							
Make bed							
Do laundry fold/hang							
Put away laundry							
Make a list of supplies							
Other							
Client Initial Daily	x	x	x	x	x	x	x
Homemaking time in Circle AM/PM — In	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Out	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Total Daily Time							
Check Box if incident has been reported							
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 #
x		

Employee signature Date	OFFICE USE ONLY P A I D
x	CK # / DATE

Total All Time Sheets

*Time card is not to be used for shared care

please fax correction to 1218-281-9929

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Emploee Current Phone Number

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

Dates client was incarenated, hospitalized or insitutionalized

WEEK 2 Pay Period **thru**

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
Clean stove/Oven								
wash & dry puy dishes away								
clear counters/table & wash								
Clean microwave								
Sweep/Mop Kitchen floor								
Clean refigerator								
Stack all papers on tables								
sweep and vacumm floors								
Dust all furniture								
Wash inside of windows								
Clear bathroom facilities								
Sweep/Mop bathroom floors								
Wash all mirrors								
Put clean sheets on								
Make bed								
Do laundry fold/hang								
Put away laundry								
Make a list of supplies								
Other								
Client Initial Daily		x	x	x	x	x	x	x
Homemaking time in Circle AM/PM		In AM PM	In AM PM	In AM PM	In AM PM	In AM PM	In AM PM	In AM PM
		Out AM PM	Out AM PM	Out AM PM	Out AM PM	Out AM PM	Out AM PM	Out AM PM
Total Daily Time								
Acknowledgement and Required Signatures				**TOTAL WEEK 2**			**TOTAL Both Sides**	
Check Box if incident has been reported								

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 #
x		

Employee signature Date	OFFICE USE ONLY P A I D
x	CK # DATE

Total All Time Sheets

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