LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

SPAS OFFICE STAFF ONLY

Total Amt. of Hrs. Approved for Payment:

Hrs.: _____ Staff Initial_____

State Personal Assistance Services (SPAS)

Personal Care Attendant (PCA) Timesheet

CONSUMER NAME: _____
ADDRESS: _____
PHONE NUMBER: _____

PCA EMPLOYEE NAME: _____
ADDRESS: _____
PHONE NUMBER: _____

Day	Date	Time In	Time Out	Time In	Time Out	Daily Total
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
					Total Hours	

CONSUMER SIGNATURE

I, _____, certify that this is a true account of the services provided; I understand falsification of this document could result in immediate termination of my agreement and/or criminal penalties.

PCA EMPLOYEE /AGENCY SIGNATURE

I, _____, certify that I provided PCA services to the above-named participant and the recorded hours are true and accurate. I understand falsification of this document could result in immediate termination of my agreement and/or criminal penalties.

Please return all timesheets by: Email: SPAS@thearcla.org, Text: 225-308-1559, or Fax: 225-383-1092