Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of this service plan addendum is to document a change in services and establish agreement between the client, or client's representative, and the home care provider regarding services to be provided.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Nursing Supervision | Registered Nurse | A Nurse will perform monitoring visits:* For ongoing monitoring and reassessment via face-to-face visit or telecommunication
 | At least every 90 days | $\_\_\_\_\_/visit  |
| [ ]  Nurse Visit | RN/LPN | An RN/LPN will see client:* Coordination of Care
* Visits as needed
* Upon change of condition, requiring reassessment
 |       | $25/15 – minutes |
| [ ]  Medication Setup | RN/LPN | A nurse will setup medications for clients requiring medication management services. |       | $60/visit |
| [ ]  Medication Change | RN/LPN | If a medication(s) update is required before the regularly scheduled medication setup, a nurse will update medication. |       | $30/visit |
| [ ]  Scheduled HHA Visit | HHA | A home health aide will assist with one or more of the following:* Assistance with dressing, grooming, and bathing
* Toileting and incontinence care
* Verbal or hands-on medication assistance
* Assistance with transfers and exercise
* See Plan of Care for individualized tasks
 |       | $12/15-minutes |
| [ ]  Medication Assistance | HHA | A home health aide will assist client with taking medications by verbal cues (See Plan of Care) |       | $12/15-minutes |
| [ ]  Bathing Assistance | HHA | A home health aide may assist clients with bathing or showering |       | $24/30-minutes |
| [ ]  Escort-in-House or Meal Delivery | HHA | A home health aide will provide an escort to meals, activities, or other within the building |       | $12/round-trip |
| [ ]  Escort-in-Community | HHA | A home health aide will accompany a client outside of the building for MD visits, shopping, etc. |       | $50/hour |
| [ ]  Laundry | HHA | A Recover Care employee will assist client with laundry |       | $12/load |
| [ ]  Foot Care | RN | Client will be assisted with foot care |       | $25/visit |
| [ ]  INR Draw | RN | A Recover Care employee will complete INR Draw |       | $40/visit |
| [ ]  Unscheduled Service | HHA | When a HHA responds to a client need that is not scheduled, regardless of the service type. | As Needed | $15/15-minutes |
| [ ]  Pet Care | Any Role | Assistance with pets |       | $15/15-minutes |
| [ ]  Mileage | Any Role | If client requires transportation he or she will be billed an additional charge per mile traveled. |       | $1.15/mile |
| [ ]  Annual Assessment | RN |  |       | $100/visit |
| [ ]  Other:       |  |  |       |  |

If there is a significant increase in services to be provided**, Recover Care** reserves the right to request an updated Service Deposit of 50% the estimated monthly cost. If so, this will be discussed with client and/or client representative.

Based on the updated RN comprehensive assessment, I understand that my estimated monthly cost is: \_\_\_\_\_\_\_ per month.

**Service Cancellations**: I understand **Recover Care** requires any request for schedule change or cancellation, twenty-four hours in advance, or I will be billed for my scheduled service time.

Service Guarantee: The Recover Care Commitment. Recover Care will issue a credit for any inadequate service that is reported to a Recover Care employee, with report of service dates and times in which inadequate service was performed.

Permission to Communicate: I understand Recover Care will communicate about my health care needs, via email or voicemail. I understand these methods are not a secure form of communication. I give consent for Recover Care to communicate about my health care needs via email or voicemail messages.

**[ ]** Accept **[ ]** Decline Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge I have had the opportunity to participate in the development of this service plan and agree with the conditions stated herein and certify that I am the client or the client’s legal representative and am capable of executing the aforementioned conditions and accepting the terms. Further, I understand that this agreement can be revoked at any time by either party.

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Client Name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Recover Care** Witness |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Client or Legal Representative | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |

Client or Responsible Party may contact a Recover Care Representative by calling the local office at:

Office Phone Number: (608) 535-8000

Main **Recover Care** Phone Number: (952) 230-6332

**Recover Care** Website: [www.recovercare.org](http://www.recovercare.org)