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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Services Provided | Provided by | Description of Services | Frequency | Charge |
| Caregiving | Home Health Aide | 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 * Meal Preparation * Housekeeping * Shopping * Laundry * Companionship * Transportation * Staff will be supervised face-to-face by a nurse within 30 days of initial hire and periodically thereafter face-to-face or by telecommunication | Services can be provided 3-24 hours/day | $30/hour  (3-24 hours/day)  $70/visit (up to 2 hours/day) |
| Companion/Homemaker | Homemaker/  Home Health Aide | * Meal Preparation * Housekeeping * Shopping * Laundry * Companionship * Transportation * Staff will be supervised by a nurse face-to-face within 30 days of initial hire and periodically thereafter face-to-face or by telecommunication | Services can be provided 3-24 hours/day | $27/hour  (3-24 hours/day)  $65/visit (up to 2 hours) |
| Nurse Visit | Registered Nurse/ Licensed Practical Nurse | A licensed RN/LPN will work with client to provide direct nursing care including, but not limited to:   * Medication Management / Setup * Simple dressing changes * Injections |  | $160/visit  (up to 2 hours) |
| Nursing Supervision  (Required by policy for all clients) | Registered Nurse / Licensed Practical Nurse | A Nurse will see client:   * For monitoring and plan of care update via face-to-face visit or telecommunication *(required)* * Medication Management / Setup * Coordination of Care * Upon change of condition, requiring reassessment * Employee supervision and education * An additional 15 minutes will be billed per visit for RN commute time | * Within the initial 14 days of service * At least every 90 days thereafter | $120/hour  (15 – minute increments) |
| Mileage | Any Role | If client requires transportation and does not provide the vehicle, he or she will be billed an additional charge per mile traveled. |  | $1.15/mile |
| 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.

**Certification**:

I acknowledge I have had the opportunity to participate in the development of this service plan addendum 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 or Legal Representative | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Recover Care** Witness |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Client or Legal Representative | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |

Contact a Recover Care Representative 24 hours / day, 7 days / week at:

**Recover Care** Phone Number: (715) 832-4875

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