Client Name: _____ Effective Date: _____

SSN: _____ DOB: _____

Phone Number: _____ Email Address: _____

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

Release of information: I authorize any hospital, TCU, physician's office or other health agency where I have been a patient to disclose any part or all of my medical records, including any Health Care Directive to **Recover Care**. In addition, I authorize the release of part or all of my medical records to health care agencies and medical equipment vendors whose services may be required in conjunction with the services provided by **Recover Care**.

Contingency Plan in the Event Scheduled Services Cannot be Provided	
☐ Reschedule	☐ Client / Responsible Party will assume all cares
☐ Emergency primary contact will be contacted: Phone Number: _____	☐ Other
Additional Instructions	

Emergency Contact: The person(s) I have designated to be contacted by **Recover Care** in case of emergency, and to receive information, if any, are:

In case of emergency, please contact:

Name:	Relationship:
Cell Phone:	Home Phone/Other:
Email Address:	
Name:	Relationship:
Cell Phone:	Home Phone/Other:
Email Address:	
Name:	Relationship:
Cell Phone:	Home Phone/Other:
Email Address:	

Person who has authority to sign on my behalf in case of Emergency (POA):

Name:	Relationship:
Cell Phone:	Home Phone/Other:

Advance Directive

I understand that emergency services will be summoned during an emergency unless there is a signed physician's order in my record that reflects my wishes according to the Adult Health Care Decisions Act.

Current Declaration

☐ **Living Will / Health Care Directive** ☐ **DNR** ☐ **DNI** ☐ **NONE**

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.

Personal Belongings/Property: I understand **Recover Care** is not responsible for my valuables or personal belongings, and is not responsible for items that are lost or damaged while **Recover Care** is providing care in my home.

Safe Environment: I understand I am required to ensure a safe and clean environment for **Recover Care** staff. I understand I am responsible to provide supplies necessary for adherence to infection control (i.e. trash bags, alcohol based sanitizer and / or antibacterial soap and paper towels). If unable to fulfill responsibility to provide supplies, **Recover Care** can supply necessities and bill primary payer.

Photograph Consent: I authorize **Recover Care** to use and publish my likeness or photo to conduct business activities in print and/or electronically. I understand that I can revoke this authorization at any time.

☐ Accept ☐ Decline Initials: _____

Use of Employee's Car: In rare cases, I understand my serviecs may require a **Recover Care** employee to transport me in his / her car. In In the event there is an accident I agree to hold Recover Care harmless. If I require transportation in an employee's car, I understand I will be billed $1.15 / mile.

☐ Accept ☐ Decline Initials: _____

Termination of Services: I understand **Recover Care** may terminate this service plan if:

- I do not provide a safe and clean environment for **Recover Care** employees.
- I do not meet payment obligations as stated in this service plan.
- **Recover Care** cannot sufficiently or safely meet my needs.
- Other reasons as identified in the Home Care Bill of Rights.

If **Recover Care** terminates this service plan, and I continue to need home care services, **Recover Care** shall provide me or my representative with a written notice of termination including effective date of termination, reason for termination, and a list of known licensed home care providers in my geographic area. If necessary, **Recover Care** will coordinate transfer of care to another home care provider, health care provider, or caregiver, as required by the Home Care Bill of Rights.

Billing & Payment: I understand all **Recover Care** services will be billed directly to the primary payer outlined in this service plan, and understand **Recover Care** does not accept any third-party payers. **Recover Care** bills for services after they are provided. I understand I will receive an invoice monthly, following the services provided. Payment will be expected within 14 days of the invoice date.

Purchases on My Behalf: I understand **Recover Care** employees may purchase household good (groceries, cleaning supplies, medication, etc.) on my behalf. The employee will provide me with receipts for all transactions and purchases paid with my funds.

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: _____

Electronic Signatures: I understand that **Recover Care** staff use an electronic record system to document services rendered and that, from time to time, I may be asked to electronically sign documents in that system (e.g., to confirm the documented services were rendered). I consent to the use of my electronic signature in **Recover Care**'s system.

☐ Accept ☐ Decline Initials: _____

Permission to Enter Apartment: Recover Care is committed to respecting our clients' privacy. In an effort to ensure that our clients' privacy is protected, our employees will always knock on your apartment door prior to entering your apartment. However, if you do not answer your door when we come to check on you or when we have an appointment to provide services, we are requesting your written permission to enter your apartment with a key provided to us by the management of this site. If we do not have your written permission on file, we will only enter your apartment when you are able to open the door for us.

I give Recover Care staff permission to enter my apartment using a key in the event of an emergency or at times a staff member is scheduled to provide services.

☐ Accept ☐ Decline Initials: _____

Services Provided	Provided by	Description of Services	Frequency	Charge
☐ Initial Comprehensive Assessment	Registered Nurse	An individualized initial comprehensive assessment must be conducted, in person, by a registered nurse.	1 time at initiation of service	$125/visit
☐ 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 after initial	$_____/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 ▪ Toileting and incontinence care ▪ Assistance with transfers and exercise		$12/15-minutes
☐ Medication Assistance	HHA	A home health aide will assist client with taking medications by verbal cues		$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		$30/visit
☐ Homemaker Services	HHA	A Recover Care employee will assist with light housekeeping		$30/hour
☐ INR Draw	RN	A Recover Care employee will complete INR Draw		$30/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
☐ Other:				

Based on the RN comprehensive assessment, I understand that my estimated monthly cost is _____ per month.

I understand **Recover Care** requires a service deposit of 50% of my estimated monthly cost, totaling: _____. This will be reimbursed, or applied to outstanding balance, upon termination of services.

I will pay this via:

☐ **Check – Check # _____** ☐ **ACH** ☐ **Credit Card**

Primary Payer	
Name:	Relationship:
Phone:	Mailing Address:
Email Address:	

Secondary Payer	
Name:	Relationship:
Phone:	Mailing Address:
Email Address:	

Consent for care:
I authorize **Recover Care** staff to render home care services in my home as documented on my Service Plan. Services to be rendered by **Recover Care** have been fully explained to me. I understand that my Service Plan may change and that all changes will be discussed with me in advance. Instructions for my care have been explained to me and, as indicated in the Service Plan, will become my responsibility in the absence of home care staff.

☐ Accept ☐ Decline Initials: _____

Client rights and responsibilities:
I have read, received a copy, and acknowledge understanding of my rights under the State and Federal provisions in the Home Care Bill of Rights. I have received a copy of **Recover Care's** Client Handbook containing the Home Care Bill of Rights, contact information for the Office of Ombudsman and Compliant Process, information on Healthcare Directives, a copy of the HIPAA Privacy Notice and Statement of Home Care Services.

☐ Accept ☐ Decline Initials: _____

Certification:
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

Contact a Recover Care Representative 24 hours / day, 7 days / week at:
Recover Care Phone Number: (952) 230-6332
Recover Care Website: www.recovercare.org