

Effective Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

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**.

| <b>Contingency Plan in the Event Scheduled Services Cannot be Provided</b>   |   |
|--|---|
| <i>In the event of a natural disaster, such as flood and storms, or other emergencies that may disrupt <b>Recover Care's</b> ability to provide care or services, <b>Recover Care</b> will follow the below Contingency Plan</i> |   |
| <input type="checkbox"/> Reschedule  | <input type="checkbox"/> Client / Responsible Party will assume all cares |
| <input type="checkbox"/> Emergency primary contact will be contacted   | <input type="checkbox"/> 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:**

|                       |                         |
|-----------------------|-------------------------|
| Primary Contact Name: | Relationship:           |
| Cell Phone:           | Home Phone/Other/Email: |
| Name:                 | Relationship:           |
| Cell Phone:           | Home Phone/Other/Email: |
| Name:                 | Relationship:           |
| Cell Phone:           | Home Phone/Other/Email: |

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

|             |                         |
|-------------|-------------------------|
| Name:       | Relationship:           |
| Cell Phone: | Home Phone/Other/Email: |

**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**    **POLST**    **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. gloves, alcohol based sanitizer and / or antibacterial soap and paper towels). If unable to fulfill responsibility to provide supplies, **Recover Care** can supply necessities and invoice 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 my Car:** My requested services may require a **Recover Care** employee to drive my car. I agree that I have responsibility for my car and my car insurance. In the event there is an accident I agree to hold **Recover Care** harmless.

Accept    Decline   Initials: \_\_\_\_\_

**Use of Employee's Car:** My requested services may require a **Recover Care** employee to transport me in his / her car. 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.

**Billing Exceptions:** I understand if I request a **Recover Care** employee to work more than 40 hours per week, I will be billed time and one-half my regular hourly fee. Additionally, I understand if I request a **Recover Care** employee to work on any of the following holidays, I will be billed time and one-half my regularly hourly fee: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas Day.

**Permission to Communicate:** I understand **Recover Care** will communicate about my health care needs, via email, text 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.

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. I consent to the use of my electronic signature.

Initials: \_\_\_\_\_

| Services Provided   | Provided by                                    | Description of Services  | Frequency  | Charge   |
|---|--|--|--|--|
| <input type="checkbox"/> Initial Comprehensive Assessment<br>(Required by policy for all clients) | Registered Nurse                               | An individualized initial assessment must be conducted in person by a registered nurse.  | 1 time at initiation of service  | \$145/visit  |
| <input type="checkbox"/> Caregiving   | Home Health Aide                               | <p><b>A home health aide will assist with one or more of the following:</b></p> <ul style="list-style-type: none"> <li>▪ Assistance with dressing, grooming, and bathing</li> <li>▪ Toileting and incontinence care</li> <li>▪ Verbal or hands-on medication assistance</li> <li>▪ Assistance with transfers and exercise</li> <li>▪ Meal Preparation</li> <li>▪ Housekeeping</li> <li>▪ Shopping</li> <li>▪ Laundry</li> <li>▪ Companionship</li> <li>▪ Transportation</li> <li>▪ 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</li> </ul> | Services can be provided up to 24 hours/day  | \$30/hour (3-24 hours/day)<br><br>\$70/visit (up to 2 hours/day) |
| <input type="checkbox"/> Companion/Homemaker  | Homemaker/<br>Home Health Aide                 | <ul style="list-style-type: none"> <li>▪ Meal Preparation</li> <li>▪ Housekeeping</li> <li>▪ Shopping</li> <li>▪ Laundry</li> <li>▪ Companionship</li> <li>▪ Transportation</li> <li>▪ 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</li> </ul>   | Services can be provided up to 24 hours/day  | \$27/hour (3-24 hours/day)<br><br>\$65/visit (up to 2 hours)     |
| <input type="checkbox"/> Nurse Visit  | Registered Nurse/<br>Licensed Practical Nurse  | A licensed RN/LPN will work with client to provide direct nursing care including, but not limited to: <ul style="list-style-type: none"> <li>▪ Medication Management / Setup</li> <li>▪ Simple dressing changes</li> <li>▪ Injections</li> </ul>   |  | \$160/visit (up to 2 hours)                                      |
| <input type="checkbox"/> Nursing Supervision<br>(Required by policy for all clients)              | Registered Nurse /<br>Licensed Practical Nurse | <p><b>A Nurse will see client:</b></p> <ul style="list-style-type: none"> <li>▪ For monitoring and plan of care update via face-to-face visit or telecommunication (<b>required</b>)</li> <li>▪ Coordination of Care</li> <li>▪ Upon change of condition, requiring reassessment</li> <li>▪ Employee supervision and education</li> <li>▪ An additional 15 minutes will be billed per visit for RN commute time</li> </ul>   | <ul style="list-style-type: none"> <li>▪ Within the initial 14 days of service</li> <li>▪ At least every 90 days thereafter</li> </ul> | \$120/hour (15 – minute increments)                              |
| <input type="checkbox"/> 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  |

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:  |
| <input type="checkbox"/> <b>Check – Check # _____</b> <input type="checkbox"/> <b>ACH</b> <input type="checkbox"/> <b>Credit Card</b> |

| 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.

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 Wisconsin 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.

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 Name of Client or Legal Representative | <b>Recover Care</b> 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)