|  |  |
| --- | --- |
| 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: |
| 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. 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: My requested services 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. I consent to the use of my electronic signature.

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 *(Required by the State of MN for all clients)* | Registered Nurse | An individualized initial comprehensive assessment must be conducted, in person, by a registered nurse. The registered nurse must reassess within 14 days of start of services. | * 1 time at initiation of service
* Within initial 14 days of service
 | $125/visit |
| [ ]  Nursing Supervision***(Required by the State of MN for all clients)*** | 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 thereafter | $\_\_\_\_\_\_/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 and attached IMMP and ITP for individualized tasks
* 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
 |       | $12/15-minutes |
| [ ]  Medication Assistance | HHA | A home health aide will assist client with taking medications by either verbal cues or hands-on assistance* See Plan of Care and attached IMMP
 |       | $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 into the community. |       | $50/hour |
| [ ]  Laundry | HHA | A Recover Care employee will assist client with laundry |       | $12/load |
| [ ]  Foot Care | HHA | Client will be assisted with foot care |       | $25/visit |
| [ ]  Foot Care | RN | Client will be assisted with foot care |       | $35/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 |       | $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 client will be billed an additional charge per mile traveled. |       | $1.15/mile |
| [ ]  Emergency Response | Any Role | If Recover Care personnel stays with client until emergency personnel arrives |       | $25/15-minutes |
| [ ]  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 # \_\_\_\_\_\_\_\_ [ ]  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 Minnesota 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 at The Lodge** Phone Number: (651) 653-0848

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

## **INDIVDIUALIZED TREATMENT MANAGEMENT PLAN (ITP)**

**Subd. 3. Individualized treatment or therapy management plan.** For each client receiving management of ordered or prescribed treatments or therapy services, the comprehensive home care provider must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the client. The provider must also develop and maintain a current individualized treatment and therapy management record for each client.

|  |  |  |
| --- | --- | --- |
| **Type of Treatment Services to be Provided** | **Personnel Who Will Provide Treatment** | **Specific Client Instructions or Special Requirements Related to Documentation of Treatment** |
|   | * RN / LPN
* Home Health Aide
* Family
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | *Individualized details on the client plan of care.* |
|   | * RN / LPN
* Home Health Aide
* Family
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | *Individualized details on the client plan of care.* |
|   | * RN / LPN
* Home Health Aide
* Family
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | *Individualized details on the client plan of care.* |
|   | * RN / LPN
* Home Health Aide
* Family
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | *Individualized details on the client plan of care.* |
|   | * RN / LPN
* Home Health Aide
* Family
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | *Individualized details on the client plan of care.* |

### *All treatments must be documented within the client’s Plan of Care (POC)*

### *Home Health Aides are instructed to call the phone number posted in the agency office, in the facility, to reach a registered nurse with any questions or concerns regarding treatment administration*

### *The below Registered Nurse is responsible for monitoring the Individualized Treatment Plan and verifying treatment is current and being provided as prescribed; and monitoring of treatment to prevent possible complications or adverse reactions*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| ***Registered Nurse (PRINT)*** |  | ***Registered Nurse (SIGNATURE)*** |  | *Date* |
|  |  |  |
| ***Client/Client Representative Signature****This signature represents that client/representative has been provided a copy of the above ITP* |  | *Date* |

## **INDIVDIUALIZED MEDICATION MANAGEMENT PLAN (IMMP)**

**Subd. 5. Individualized medication management plan.** For each client receiving medication management services, the comprehensive home care provider must prepare and include in the service plan a written statement of the medication management services that will be provided to the client. The provider must develop and maintain a current individualized medication management record for each client based on the client’s assessment. ***The below individualized medication management plan (IMMP) will be individualized, current, and updated when there are changes.***

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Medication Management Services to be Provided** | **Personnel Who Will Provide Treatment** | **Medication Storage Location** *(based on client's needs and preferences, risk of diversion, and consistent with manufacturer’s directions)* | **Specific Client Instructions or Special Requirements Related to Documentation of Medication Management Service** |
| * Medication Setup
 | * RN / LPN
* Family
* Pharmacy
* Other \_\_\_\_\_\_\_\_\_\_\_
 |  | *Individualized details on the client plan of care.* |
| * Medication Reminders
 | * Unlicensed Personnel
* Family
* Other \_\_\_\_\_\_\_\_\_\_\_
 |  | *Individualized details on the client plan of care.* |
| * Medication Administration
 | * Unlicensed Personnel
* Family
* Other \_\_\_\_\_\_\_\_\_\_\_
 |  | *Individualized details on the client plan of care.* |
| * Other: \_\_\_\_\_\_\_\_\_\_\_
 | * RN / LPN
* Unlicensed Personnel
* Family
* Pharmacy
* Other \_\_\_\_\_\_\_\_\_\_\_
 |  |  |
| * Monitoring of Medication Supplies
 | * RN / LPN
* Family
* Other \_\_\_\_\_\_\_\_\_\_\_
 |  | *Individualized details on the client plan of care.* |
| * Ensuring Medication Refills are Ordered on a Timely Basis
 | * RN / LPN
* Family
* Other \_\_\_\_\_\_\_\_\_\_\_
 |  | *Individualized details on the client plan of care.* |

### *All treatments must be documented within the client’s Plan of Care (POC)*

### *Home Health Aides are instructed to call the phone number posted in the agency office, in the facility, to reach a registered nurse with any questions or concerns regarding medication management services*

### *The below Registered Nurse is responsible for monitoring the Individualized Medication Management Plan and verifying all medications are current and being administered as prescribed; and monitoring of medication use to prevent possible complications or adverse reactions*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| ***Registered Nurse (PRINT)*** |  | ***Registered Nurse (SIGNATURE)*** |  | *Date* |
|  |  |  |
| ***Client/Client Representative Signature****This signature represents that client/representative has been provided a copy of the above IMMP* |  | *Date* |