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:   * Meal Preparation * Housekeeping * Shopping * Laundry * Companionship * Transportation * 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 | Services can be provided up to 24 hours/day | $37/hour  (4-24 hours/day)  $47/hour  couples  (4-24 hours/day) |
| 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 |  | $180/visit  (up to 2 hours) |
| Nursing Supervision  (Required by the State of MN 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)* * 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 | $140/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: (952) 230-6332

**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 indicated on the client chart 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 indicated on the client chart 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* |