

**Independent Life at Home Services and Financial Agreement**

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

Client Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Phone #(Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Phone #(Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial Contact Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start of Service Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the client medically frail/medically compromised? 🞎 Yes 🞎 No

Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ongoing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eligible for other services provided by THA Group (Check all that apply):

🗆 Island Health Care (Home Health) 🗆 Island Hospice (Hospice) 🗆 Palliation Choices (Palliative Care)

**Please complete if bills should be sent to someone other than the client:**

|  |  |
| --- | --- |
| Party Financially Responsible for Client: | Relationship to Client: |
| Mailing Address (Street, City, State, Zip) | |
| Main Phone:  Alternate Phone: | Email: |

**Client/Client’s Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The following services, as requested by client/client’s responsible party, will be provided by a personal care attendant or RN/LPN according to the established schedule outlines:**

🞎 Nursing Services 🞎 Personal Care Services 🞎 Companion/Sitter Services (Supervisory every 62 days) (Supervisory every 92 days) (Supervisory every 122 days)

Description of specific services needed as stated in the client’s (or responsible party’s) own words: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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Number of days per week services will be provided: \_\_\_\_\_\_\_\_\_\_\_ Projected Hours of Service per Week: \_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **FREQUENCY** | **EXPECTED DURATION**  **(HOURS PER DAY)** | **PERSONAL CARE;**  **COMPANION/SITTER;**  **NURSING** | **SPECIFICATION;**  **EXPLANATION** |
| **SUNDAY** |  |  |  |
| **MONDAY** |  |  |  |
| **TUESDAY** |  |  |  |
| **WEDNESDAY** |  |  |  |
| **THURSDAY** |  |  |  |
| **FRIDAY** |  |  |  |
| **SATURDAY** |  |  |  |

**Client/Client’s Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Service Rate: Services will be provided at a rate of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/per hour Monday through Friday and at a rate of $\_\_\_\_\_\_\_\_\_\_\_\_\_/per hour Saturday and Sunday. Mileage Rate: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_/per mile**

**Cancelation: Please provide 24 hours-notice of cancellation or changes to avoid billing charges.** A charge of one half of the scheduled hours cancelled will be incurred for any services cancelled without appropriate notice as defined above. In the event services are canceled while an assignment is in progress, client will be charged the amount equivalent to the full shift.

**Mileage:** A mileage rate will be charged when an ILAH employee uses his/her personal vehicle for transporting a client.

**Overtime:** Overtime rates will be invoiced for ILAH employees working over 40 hours per week. Overtime hours will be invoiced at 1.5 times the regular hourly billing rate.

**Holidays:** Applies to hours worked during the following: New Year’s Day, Martin Luther King’s Day, St. Patrick’s Day, Christmas Day, Thanksgiving Day, Easter Day, Mother’s Day, Memorial Day, Father’s Day, Independence Day, and Labor Day. The holiday rate is 1.5 times the hourly rate. Beginning the day of the holiday at 12:00am and ending at 11:59pm.

**Rate Inclusions:** As an Accredited Standards of Quality requires a nursing assessment be completed every 92 days, the client will be charged a nominal fee of $35 to complete this required service. ILAH reserves the right to change pricing as deemed necessary and will provide proper 30-day notice of changes to the client.

**Security:** Client agrees to store all valuables and financial documents in a safe and secure location. If theft is suspected, the client must immediately report a claim to ILAH to ensure a proper and timely investigation. Under no circumstances, should money be loaned or given to ILAH employees. Any gifts provided to ILAH employees should first be approved through the office.

**Minimum Guarantee of Hours:** Client agrees to guarantee a minimum of 4 hours per assignment. Client may use the caregiver for less than four hours but will be billed a minimum of 4 hours.

**Referral Incentive:** Client will be issued a $50 credit for referring new clients that complete 90 days of service.

**Solicitation:** Client agrees to refrain soliciting caregivers to work privately that are employed by THA Group’s Independent Life at Home. ILAH incurs substantial recruiting, marketing, training and administrative expenses associated with employing caregivers. Any employee placed in the client’s residence is an employee of ILAH and may not be hired by the client. If the client insists on hiring an ILAH employee, the client will incur a fee of $5,000 for any employee who has provided services for the client for less than 6 months from the first day worked or $2,500 for a period of 1 year or greater from the first day providing services to the client.

**Replacement Staffing:** ILAH makes every effort to staff appropriately. Circumstances where all best efforts have been made to replace an absent caregiver and is unable to, a friend or family member may be asked to stay with the client.

**Billing:** Weekly bills will be sent to the person and address specified in this agreement. Payment is expected upon receipt of the bill. Please communicate any questions or concerns regarding your bill as soon as possible. A charge of 18% annum will be added to all outstanding amounts unpaid for 30 days or more. ILAH is committed to working with each client to work out satisfactory payment terms. Client must contact the office at 912-629-2727 to make special arrangements. Failure to pay invoices timely, could result in notification to a third-party collection agency. A collection fee of 33% will be added to any outstanding payments pursuant to Georgia statutory law “O.C.G.A.-13-1-11” or South Carolina law “O.C.S.C.A.-1-14-147”.

**Client/Client’s Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Transportation Authorization:** In the event a client or responsible party requests transportation for a client, the client/responsible party recognizes that Independent Life at Home agents/staff are not qualified licensed chauffeurs and are not insured as such. Therefore, I hereby release THA Group’s Independent Life at Home and their employees from all responsibility and liability for injury to person or damage to the client’s vehicle. It is the responsibility of the client/responsible party to maintain proper insurance and liability coverage on the client’s vehicle, as required by law**.**

**Initial: \_\_\_\_\_\_\_\_\_\_\_\_**

**Financial Responsibility:** I authorize THA Group, Independent Life at Home to have funds provided for the requested ancillary services that have a cost included in this Service Agreement e.g., groceries, meals, etc.

**Yes \_\_\_\_\_\_\_ Initial\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_ Initial\_\_\_\_\_\_\_\_**

I understand Medicare & Medicaid **do not** cover the services included under this agreement, and that some long-term care plans and many private insurance providers may not cover these services. ILAH will bill long term care insurance although the client remains financially responsible for all charges not paid for by long-term care insurance.

**Credit Card Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **\_\_\_\_Visa \_\_\_\_MasterCard**  **\_\_\_\_Discovery \_\_\_\_ Amex** | **Expiration:**  **(Mo./Yr.)** | **Name of Cardholder (Please Print):** | **Signature of Cardholder:** |

**Credit Card Number:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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**Agreement: The service and financial agreements have been discussed with me. All questions have been answered to my satisfaction. I have read the financial liability information and the rights and responsibilities of client/purchaser and agency listed on the reverse side. I understand that I am financially responsible for all charges specified above and may change the type, frequency, or duration of services or cancel services at any time by contacting the office at 1-912-233-2334. I agree to accept financial responsibility for any service charges incurred under this agreement and accept liability for any attorney’s fees or other incidental costs incurred because of non-payment of services.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_**

**Client/Responsible Party Signature/Initials Date ILAH Representative/Initials Date**

By my signature, I accept the terms of this Service Agreement. My signature also confirms that I have received the following information: Client Rights and Responsibilities, Transportation Assistance, Complaint Process, Contact Information for DCH, Healthcare Facility Regulation Division, Contact Information, Supervisor responsible for services.

**YOU HAVE THE RIGHT TO CANCEL THIS SERVICE AGREEMENT AT ANY TIME, FOR ANY REASON, AND WILL ONLY BE CHARGED FOR SERVICES ACTUALLY RENDERED. \*SOLICITATION AND CANCELLATION TERMS STILL APPLY.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client’s Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Responsible Party’s Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Independent Life at Home Director Date**

**It is the right and responsibility of the client to read and understand all terms and conditions of this service agreement. The client has the right to refuse to sign the agreement. THA Group, Independent Life at Home and the client or responsible party shall abide by this agreement.**