SERVICE AGREEMENT

Name of Client: ____ Date: ___________________

Address: ____

Date of Referral or Initial Request for Service: ___________ Date of Initial Contact: _________

Is Client MF/MC? Yes [ ] No [ ]

Client's description of Services needed/specific task: (What we will provide time and days and a list of each task to be performed on what days.)

____
____
____
____
____
____
____

Type of Private Home Care Needed: Please place an X next appropriate care/

Personal Care (if client will be touched) _____, Companion Sitter, _____, Skilled Nursing _____, Description of services to be provided:

____
____
____
____

Explanation of Charges for Services: A projected charge of $18/hour will be billed for services provided by Favored Healthcare to the client or client's responsible party.

Explanation of Billing: Bill's/invoices will be sent to the client or client's responsible party (monthly) at the end of every month. Bills are expected to be paid in full upon reciept. Payment can be made by checks, cash or credit card.

Method of Payment: Private Pay: Cash _________ Credit card _________ Check ___________

Medicaid: ____

Private Insurance: ________________________________ (HMO) (PPO) (POS)

Cancellation of Services: All clients' receving services from Favored Healthcare has the right to terminate or cancel the Service Agreement at any time.

Did the client receive a copy of client's "Rights and Responsibilities": ___ Yes ___ No

Please contact the Department of Community Health – Healthcare Facility Regulation Division at (404-657-5550 or 404-657-5728) for information, complaints or questions about Favored Healthcare Service that has not been resolved to the client's satisfaction.

1. Client Represents Self: [ ] Yes [ ] No

2. Designated responsibility party/relations to client: ____

3. Authorization from client or responsibility party for access to client's personal funds when home management services are to be provided: ____

4. Favored Healthcare's employees Shall [ ] Shall Not [ ] have access or use of any **client's funds**, including credit card(s) or clients care, if applicable.

5. Favored Healthcare's employees Shall [ ] Shall Not [ ] have access or use of any **client's vehicle.**

X ______________________	X ______________________
Provider's Representative	Date

X ______________________	X ______________________
Responsible Party's Signature	Date

PERMISSION TO OBTAIN EMERGENCY MEDICAL TREATMENT

Client Name: ____

Agency Name: **FAVORED HEALTHCARE SERVICES**

I give permission for the above mentioned/named service provider to get emergency medical treatment that I might need while the provider staff is rendering service. By giving my permission for this treatment, I agree to pay all costs related to the medical care, including the costs associated with emergency transportation. I understand that in case of emergency, the people I chose as "Emergency Contacts" will be notified immediately.

__________________________________ ______________

Client's Signature Date:

____ ______________

FAVORED HEALTHCARE SERVICES Title Date

AUTHORIZATION AND CONSENT FOR AUTOMOBILE RELEASE OF LIABILITY

[ ] Yes I Accept   [ ] No I Decline

Date: ___________________   Phone: ____________________________

Client: ____________________________________   DOB: ___________________

Medicaid # _____________________________

Address: ____

City/State/Zip: ____

I, ____ (client) do waive all liability from **FAVORED HEALTHCARE SERVICES**, as well as my appointed Home Care Worker(s) who provide services for me if I should ask them to transport me in my vehicle or their vehicle as part of the service I need.

I understand that I have the primary responsibility for my vehicle insurance and maintenance. I agree to hold **FAVORED HEALTHCARE SERVICES** harmless in the event that there is an accident in which there is damage to my vehicle or injury to me or its occupants.

I agree to inform my insurance company of my intention to allow my Home Care Worker(s) to drive my vehicle. *I understand that I have to provide **FAVORED HEALTHCARE SERVICES** a copy of my vehicle certification of insurance before the Home Care Worker(s) will be able to transport me.*

I also agree to hold **FAVORED HEALTHCARE SERVICES** and the Home Care Worker(s) harmless in the event that while I am being transported in the Home Care Worker's vehicle an accident occurs and I am hurt. I also understand that if I refuse to sign this agreement my Home Care Worker(s) will not be able to transport me in his/her vehicle.

____

____

Client/Responsible Party Signature   **Date**

Client Automobile Use Waiver

[ ] I Accept [ ] I Decline

I, ____, do hereby authorize ________________________________, an associate of Favored Healthcare Services, to operate my automobile in the normal course of his/her duties while providing supportive care services to____.

(Name of Client)

I hereby certify that the vehicle described below is properly licensed, registered, in safe and usable condition, and that the minimum insurance required by law is carried on it, which insurance covers such Favored Healthcare Services associate as a permissive driver.

I hereby certify to indemnify and hold harmless Favored Healthcare Services, and its officers, associates, and agents from any and all claims, suits and liabilities a reasonable attorney's fees and costs resulting from operation of automobiles, vehicles and motorized instrumentalities whether owned or rented. This indemnification shall extend to any and all claims, including damage to our vehicles, bodily injuries including third parties, and property damages.

Make of Vehicle:______________________________ Model: ________________________

Color of Vehicle:____________________________ License Number:_______________

Client Signature:_______________________________________ Date:____________

Favored Healthcare Services Rep.:_____________________________________ Title: ___________

Client Rights, Responsibilities & Complaints

Client Rights:

FAVORED Health Care SERVICES issues a written notice of rights and responsibilities to each client or responsible party. This written notice of Rights are as follows:

- The client has the right to be informed about plan of service and he/she shall participate in the planning.
- The client has the right to be fully informed of any changes in the plan of service.
- The client has the right to accept or refuse service plan
- The client has the right to be fully informed of the charges for services provided.
- The client has the right to know the name, business address, and business telephone number of the person supervising the services and how to contact that person.
- The client has the right to be informed of the complaint procedures and the right to submit complaints without fear of discrimination or retaliation.
- The complaint procedure provided shall include the name, business address and telephone number of the staff designated by FAVORED Health Care SERVICES to handle complaints and questions.
- The client has the right of confidentiality for his/her record.
- The client has the right to have his/her property and residence treated with respect.
- The client has the right to have a written notice of the address and telephone number of the state licensing authority.
- The client has the right to obtain a copy of FAVORED Health Care SERVICES most recent completed report of licensure inspection.
- The client has the right to advise or inform provider of any changes in client's condition or events that will affect service needs.

Client Responsibilities

- The responsibility to notify service provider(s) of any change in care
- The responsibility to treat provider staff in a courteous and respectful manner, as well as cooperate and respect the rights of the caregivers providing direct care
- The responsibility to be as accurate as possible when providing information on health history and personal care needs
- The responsibility to participate actively in decisions making regarding individual health care and service care plan
- The responsibility to comply with agreed-upon care plans
- The responsibility to notify the client's physician, service provider(s), and/or caregiver of any change in one's condition
- The responsibility to be available to service provider staff at times services are scheduled to be rendered at Favored Healthcare Services facility
- The responsibility to pay any cost share liability, if applicable.

Signature__________________________________ Date: ______________

Client/Client's Responsible Party

Signature_________________________________ Date: ______________
Favored Healthcare Services

Client Rights, Responsibilities & Complaints

To file a complaint, client/responsible party may follow these steps:

1. Client/responsible party may telephone, e-mail, write, or by other means of communication or obtain a "Complaint/Grievance Form" from **Favored Healthcare Services** office to file the complaint.
2. When the Supervisor receives the complaint/grievance, he/she will determine whether the complaint/grievance will be processed by **Favored Healthcare Services** or referred to HFRD or the law enforcement.
3. The Supervisor has 48 hours to get back to the complainant upon receiving the complaint and 10 working days to resolve the complaint. If the complainant is not satisfied with the supervisor's resolution he/she will be directed to the Administrator who will further investigate the matter and try to reach a satisfactory resolution.
4. If the complaint/grievance is not resolved by the Administrator to the client/responsible party's satisfaction he/she will be directed to the DCH for further investigation. The telephone numbers for HFRD is 404-657-5726, the complaint hotline is 404-657-5728.
5. The Administrator, the Supervisor and staff will work with the department to resolve the matter to the satisfaction of the client.

X ____

Client/Responsible Party Date

X ____

Authorize Representatives Signature Date

Admission Agreement

Client Rights, Responsibilities & Complaints

I acknowledge that I have received, reviewed, and understand the list of my rights as mandated and my responsibilities as given by an agency representative __________ (Initial)

Consent for Assessment and Treatment

I consent to assessment by and treatment from Favored Healthcare Services consistent with a plan of care. I have been informed and have participated in planning care and procedures to be carried out by Favored Healthcare Services and signed this consent willingly. I understand that this consent at any time by notice to Favored Healthcare Services, if I do so services will no longer be provided. I understand that admission and continuation of services are subject to Favored Healthcare Services policies and procedures__________ (Initial)
In case of a life threatening injury or illness I authorize Favored Healthcare Services care provider to seek and/or perform emergency treatment. __________ (Initial) __________ (date)

Additional Terms

Unanticipated Services Interruption: I understand Favored Healthcare Services uses its best efforts to provide uninterrupted services however, sometimes interruptions are unavoidable. During interruption of essential services, I agree to provide or arrange backup care from another agency. __________ (Initial)
I have received a copy of the client's rights and responsibilities. __________ (Initial)
I read & understand Favored Healthcare Services admission agreement __________ (Initial)

Cancellations

I understand that I have a right to cancel any service agreement at any time and staff only be charged for services actually rendered prior to the time that Favored Healthcare Services is notified of the cancellation.
I understand that a staff member may be cancelled up to 8 hours before arrival time and that any cancellations (4) hours of less Favored Healthcare Services may assess reasonable charge for travel and staff time when the staff member arriving at the home to perform the service. __________ (Initial)

Authorization to Release Information

I consent to the release of information and/or disclosure to Favored Healthcare Service of all or any part of my medical record by any physician, hospital, or other inability of which I have been a client checking my credit and financial rating and history with any person, film or credit bureau if I may have any self-pay responsibilities, and release of information by the agency to individuals acting in official capacities as my advocate representing government agencies or other health care providers. __________ (Initial)

____ ____________________________

Signature of Client/Legal Representative **Date**

____ _________________________

Signature of Agency Representative **Date**

AFTER HOURS COVERAGE/EMERGENCY PLAN

We have a nurse on call 24 hours a day, 7 days a week to ensure that you receive necessary home care services. We do not carry medications with us and cannot give anything unless ordered by the physician. After office hours and on weekends, an answering service will reach the nurse and he/she will return your call, answer any questions you may have, or come to see you if necessary.

Please call the nurse at 770-932-4932 you experience any of the items checked (associate with you

• **Heart/Lung Problems:** • New onset of a productive/frothy cough or new congestions • Change in color, thickness, odor of sputum • Increased shortness of breath • New onset of irregular or rapid heartbeat • Chest pain relieved by rest or medication • More swelling in your legs or feet • Weight gain of ___ pounds in 24 hours	o **Too Much Blood Thinner:** • Bleeding from the nose, mouth, gums, rectum, surgical site • Bruising • Leg pain • Black tarry stools • Blood in urine • ____________________________________
o **Signs of Infection:** • Increased redness • Wound gets bigger or more painful • Temperature of 100 degrees or more • Change in amount, color or odor of wound drainage	o **Urinary Problems:** • Foul odor to urine • Catheter not draining • Low back or flank pain: body aches • Unable to urinate: frequency of urination • Increased weakness • Bloody, cloudy, or change in urine color
o **Diabetic Problems:** • Sudden weakness • Uncontrollable thirst or hunger • Increased urination • Sweating spells • Sudden dizziness • Frequent headaches • Itching • Drowsiness • Blood sugar level greater than ____ or less than ____	o **Other Problems:** • No bowel movement in 3 days • New skin problems • Change in balance, coordination, strength • Fall with small or no injury • Change in mental status • Signs of high blood pressure or stroke: new onset headache, dizziness, nosebleeds, blurred vision, ringing in the ears, heart palpitations (fluttering)

current condition) or if you develop any other problems (unchecked) as follows:

Call 911 if you experience any of the following:

- **A fall with a broken bone or bleeding**
- **Unable to wake client**

- **Chest pain that medicine doesn't help**
- **Severe or prolonged bleeding**