CLIENT AGENCY SERVICE AGREEMENT FORM

Date service agreement completed: ____

This service agreement is between this (agency)____and ("Client")

____

WHEREAS "Client" seeks this agency provides home care services, with qualified dependable personnel whom remain under consistent direct supervision of the Administration of this agency.

Client Basic Information

Name:____Phone#: ________________________________

Client Address; Clients DOB:_______________

Client Emergency Contact Name and Number:

Client emergency contact Address:

Client Responsible Party Name and Contact Number:

Client Responsible Party Address:

Date of Referral:_________**Date of Initial Contact:**____________Source of Referral: ________________

Service Options: Personal Care________Companion Sitter______________Nursing________________

Description of Service Requested (in Clients Own exact words):

____

Written Description of services to be provided:

____

Client Name: ______________________________________

CLIENT AGENCY SERVICE AGREEMENT FORM

Frequency of requested services:________________________Duration of services: __________________

Release of Information/Reimbursement Consent

I hereby authorize Private Insurance/Other: to pay any or all-applicable benefits directly to this agency.

I authorize the agency to release any of my medical records necessary to secure payment of documented charge. I understand that I am financially responsible for charges not covered by my insurance as specified;

MECHANISMS FOR BILLING: Hour's client request per day____________________________________

Days per week client wants services: (CIRCLE ONE) Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, and Sunday. The service listed above will be provided at an hourly rate of $_____________per hour.

The Service listed above will be provided at a rate of **$**___________________________per day.

The service listed above will be provided at a rate of $___________________________per week

Cash, Credit Card, personal check, money order, cash. **(CIRCLE ONE)**

Method of Payment:____________________________by whom __________________________________

Agency will bill the client in the following ways: (1. weekly every Friday) (2. Semi-weekly on Friday) (Monthly) Friday) <u>or (3. monthly last day of each month)</u>

Financial payee of the agency services Name & address:

HOW AGENCY CONTRACT SERVICES WILL BE PAID BY CLIENT/ CLIENT FAMILY.

Check:____________________Cash:_______________________Private Insurance: ____________________

Billing Date:______________________________________How Often:______________________________

CLIENT NAME: ___________________________________

CLIENT AGENCY SERVICE AGREEMENT FORM

I acknowledge receiving a copy of client's rights and responsibilities as outlined at rule (111-8-65-.12 Client Rights,

Responsibilities) Client Initials here: (   )

To complain or express dissatisfaction about the agency, call the Administrator, or the supervisor at: **866-235-2448**

(Agency Contact Name:) EMMANUEL UGBAJA

Statement of Authorization:

Agency employees are: (CIRCLE ONE) 1. To have access 2. Are not to have access (Client Initials:

If there is any use of client funds by staff for clients, including credit cards, or of the client's cars. If so, there must be special written authorization for such use or access in the client's record and all agency staff must be bonded and ensured when handling client funds. Agency Director will refer to L0943 regarding the requirement for bonding for any provider whose
employees have access to client's funds or a vehicle.

Client requests Assistance with Bill paying, personal funds & handling of financial transactions; YES /NO (Client Initials:)
Client requests Assistance with providing transportation in their own personal vehicle; YES/NO (Client Initials:

** Transport and escort services for healthy individuals/families are not considered PHCP services.
Prior to the establishment of this agency should attempt to determine if the client has a Responsible Party and has executed any written document designating a Responsible Party or has had a legal guardian appointed by the court. If unable to determine if client has a responsible party or guardian, efforts made to determine the status should be
documented. It should be documented in the client's record whether the client represents himself or whether another designated responsible party represents the client for the purposed of authorizations.

Client's Independent Status:______Complete Independent_____Adjudicated Incompetent

I authorize this agency to provide services described in this Service Agreement. I understand that I have the right to cancel this agreement at any time.

Client Name: ____

CLIENT AGENCY SERVICE AGREEMENT FORM

I have had input into my Service Agreement, I understand my Service Agreement, and further understand who to contact and how if I have any question, concern, and/or desires to make changes in my Service Agreement. The Agency Administrator will be responsible for updated any changes to Service Agreement within 48-72 hrs.

I understand that any changes or amendments will be updated correctly, and I will receive a revised copy of the new service agreement within 48-72 hours after it's been changed by the Agency Adm.

For Department of Community Health Private Home Care Program licensing questions, you may call **404-657-5700.**

State Licensing Program for this Agency is located @ 2 Peachtree Street, Suite 31-447 Atlanta, Georgia 30303 404-657- 5700.
If the matter is not resolved, or you cannot solve your problems with the agency staff, the Health Care Facility Regulation Division/Department of Community Health hotline to lodge complaints about provider services is: **Complaint Line is: 404-657-5728 or toll free 1-800-878 6442**

Cancellation of services:

If the client cancels services with the agency, they can do so at any time and shall only be charged for services rendered prior to the time that the provider is notified of the cancellation.

Any outstanding balance that is owed to the agency for services previously rendered up until the day of cancellation will be required to be paid by client with 5 days after cancelation and final payment will be required to be paid in cashier's check, postal money order or cash only to the agency. A final receipt will be given to the client once payment is made.

Contacts for all Clients/client payees to be aware of:

Healthcare Facility Regulation
Division 2 Peachtree Street NW
Suite 31.447
Atlanta, Georgia 30303-3142
Main Licensing number 404-657-5700
Local Complaint Number 404-657-5728
Toll Free Complaint Number 800-878-6442

I have been helped in understanding and how to exercise my rights as a client.

Client's Signature____Date:_________________________

Representative Signature:__________________________________Date: ________________________

Agency Administrator:_____________________________________Date: __________________________