

Client Requested Services

Client Name: _____ Date: _____

Care Recipient (if other): _____

Street Address: _____ County: _____

Building/Apt #: _____ City: _____ State: _____ ZIP: _____

Community/Facility: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ E-Mail: _____

Emergency Contact Name/Relationship: _____

Emergency Contact Phone/Alternate Phone: _____

Responsible Party/Relationship: _____

Responsible Party Phone/Alternate Phone: _____

Responsible Party Billing Address: _____

Long-Term Care Insurance? Yes No

LTC Insurance/ Company Name: _____

LTC Insurance/ Address: _____

LTC Insurance/ Phone: _____ Policy #: _____

Pets in the home? Yes No If yes, describe: _____

Do you need the Home Health Aide to drive Care Recipient's vehicle in order to perform assigned duties? Yes No

Does the Home Health Aide will be required to be in possession of a copy of the Care Recipient's house key in order to perform assigned duties? Yes No

Emergency Telephone Numbers

Medical emergency: 911

SCHEDULE

DAYS	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
TIME							

Attending Physician Contact Information

Under Florida law, nurse registries can refer a client to a certified nursing assistant (CNA) or a home health aide (HHA) for contract to provide in-home care *only if* the client is under a physician's care.

Florida law further requires nurse registries to send written notice to the attending physician once the client receives a referral for a CNA or an HHA. Fla. Stat. § 400.506(6)(b). If you think you or the care recipient might want a referral for a CNA or a HHA, please provide the following information:

Physician Name: _____

Address: _____

Phone Number: _____

E-Mail/Fax Number: _____

Client or Responsible Party Name: _____

Client or Responsible Party Signature: _____

Date: _____



CLIENT AGREEMENT FOR REFERRAL AND ADMINISTRATIVE SERVICES

This Client Agreement for Referral and Administrative Services (“Agreement”) is by and between Home Care Plus Nurse. (“Registry”) & _____ (“Client”). The “Parties” means the Registry and the Client and, in the singular, refers to either of them, as the context makes apparent. The Parties agree as follows:

1. Nurse Registry Services. The Registry is a nurse registry licensed under Section 400.506, F.S. and offers referrals of care professionals who operate as self-employed independent contractors (“Caregiver” or “Caregivers”). The Registry conducts a background check for and verifies the professional credentials of each Caregiver before the Caregiver is eligible for referral to Registry Clients. The Registry also coordinates the provision of certain administrative services, including ongoing referral of Caregivers if requested by Client, billing and payment processing services, and certain other administrative services to facilitate Client’s receipt of care. The Registry provides no home care services and does not hold itself out to be a provider of home care services, as such services are exclusively rendered by the referred Caregivers. Client hereby engages the Registry to refer one or more Caregivers to provide home care services to Client.
2. The Registry Is Not the Employer of Referred Caregivers. **Client acknowledges and understands that the Registry is not the employer or joint employer of the independent contractor Caregivers and does not monitor, supervise, manage, train, or handle scheduling for Caregivers.** Should an employer of a Caregiver be deemed to exist, Client understands and agrees that Client may be found the sole employer of the Caregiver. When a Caregiver performs services for Client, Client acknowledges that the Caregiver performs such services solely on behalf of Caregiver, and not on behalf of or as an agent of the Registry. Client and the Caregiver are solely responsible for determining all aspects of their relationship, including the rate of pay for Caregiver’s services, the length of the engagement, and the care objectives. Client retains the right to accept or decline any referral and the right to negotiate directly with the Caregiver concerning all aspects of their relationship. The Registry has no right to interfere with such a relationship, other than to inform Client about a Caregiver’s background check and professional credentials and provide certain ongoing administrative services. The client acknowledges that the Registry has not made any assurance, guarantee, promise or representation with respect to the results and/or outcome of any services to be provided by Caregivers.
3. Registry Fee. Client agrees to pay the Registry’s fee for each hour of service provided to Client by a referred Caregiver (“Registry Fee”) during the term of this Agreement and pursuant to Section 10 below. The Registry Fee is separate from and in addition to the Caregiver’s fee. Client agrees to pay billing statements upon receipt and acknowledges that unpaid accounts will be considered in

default after thirty days, after which a default charge will be imposed at 1.5 percent per month, or the maximum legal interest rate, whichever is lower, on unpaid balances. Client agrees to pay the default charge, including all reasonable attorney fees and costs of collection. If the Registry institutes legal action to collect Registry Fees, the Registry shall be entitled to recover its legal fees and costs associated with instituting the action. Client assumes full responsibility for Registry Fees, irrespective of whether any portion of the charges for the Registry's or the care service is to be submitted to a third-party payor, including long-term care insurance. The client's account will be credited only when the Registry receives payment. This paragraph shall survive termination of this Agreement.

The client agrees to pay a \$_____ initial deposit. The Registry shall deposit this amount into an account separate from the Registry's operational funds and account. The Registry will apply the initial deposit to Client's last invoice for Registry Fees and any other unpaid balances owed pursuant to this Agreement then refund the balance, if any, to Client.

4. Billing Agent for Caregiver Payments. Client has requested that the Registry act as the billing agent for the services rendered by one or more referred Caregivers. Although the Registry may act as a liaison for negotiations between Client and Caregiver at their request, Client and Caregiver are responsible for determining the terms of their engagement, including the rate of pay for Caregiver's services. The Registry will attempt to refer one or more Caregivers within Client's preferred range of rates who also meets any other objective criteria specified by Client. If a Caregiver cannot be located to provide services within Client's preferred range of rates, the Registry will confer with Client about the market and the Registry's experience of typical pay rates in the area to serve as a benchmark for negotiations. Client understands and acknowledges that Client and a referred Caregiver can renegotiate the Caregiver's rate of pay at any time, and agrees to timely inform the Registry of any changes in the rate to ensure accuracy of payment. Client proposes the following range of rates for the services provided by a referred Caregiver:

- **HOURLY SERVICES** \$_____ per hour & also _____

Some Caregivers referred by the Registry require a premium payment of one and one half times their hourly rate of pay to provide services on certain holidays, typically New Year's Day, Easter, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas Day. If you need care services over a holiday, you agree to negotiate with the Caregiver about the potential payment of a premium rate for service hours logged on holidays and to notify the Registry of the agreed-upon rate for billing purposes.

Some Caregivers referred to by the Registry require premium payment of one and one half times their hourly rate of pay for providing services in excess of 40 hours per workweek. If you request coverage from a Caregiver who requires premium pay for providing services more than 40 hours per workweek, indicate whether you agree to pay that Caregiver's premium rate, plus the Registry Fee, for such services. Please note that the refusal to agree to premium payment for services provided more than 40 hours per workweek may reduce the number of Caregivers willing to provide services to you.

I agree to pay a premium rate of one and one half times the Caregiver's hourly rate of

pay for any services performed more than 40 hours per workweek.

I do not agree to pay a premium rate.

Client agrees to render payment for a referred Caregiver's services on a weekly basis upon receipt of a billing statement generated from Caregiver's Timecard, approved before submission by Client or Client's representative. The Registry will not review invoices for accuracy. Client's funds will be disbursed only as Client directs. Client understands that he or she is fully financially responsible to the Caregiver for charges billed for the Caregiver's services. If Client should fail to pay the Caregiver's fees in accordance with the terms of this Agreement, and it becomes necessary for the Registry, in its role as billing agent, to collect any outstanding balances through the judicial process or otherwise, Client agrees to pay costs of collection, including reasonable attorney fees. This paragraph shall survive termination of this Agreement.

The Registry will accept direct payment from Client's Long Term Health Insurance Company ("LTH") if Client assigns the payment of benefits to the Registry and the LTH carrier pays the initial claim and all subsequent claims within thirty days of billing. Client is responsible for any claims over thirty days old and any charges his or her LTH Carrier denies. This paragraph shall survive termination of this Agreement.

5. Indemnification Related to Caregiver Services and Vehicle Use. Client agrees to indemnify, defend and hold harmless the Registry and its officers, directors, members, employees, successors and assigns from any and all obligations, disbursements, losses, liabilities, deficiencies, penalties, interest, claims, damages, actions, proceedings, taxes, settlements, judgments, and costs and expenses (including reasonable attorneys' fees) arising out of, in connection with, or incidental to Client contracting with or employing referred Caregivers under any and all circumstances (including use of an automobile, regardless of ownership). This paragraph shall survive the termination of this Agreement.
6. Authorization for Physician Contact and Medical Record Information. Client gives consent for the Registry to notify Client's primary physician of the services provided to Client as required by Section 400.506(6)(b), F.S. Client hereby authorizes the Registry to view, furnish, obtain, and receive information from the medical record of the care recipient named in this document, including photographs or video taken of the care recipient, to any insurer, compensation carrier, health care facility, welfare agency, physician, or any health Caregiver for reasons of financial assistance or continuity of services. Regulatory and accrediting agencies also have Client's permission to review Client's service records. Personal health information will be kept confidential and will not be disclosed except for legitimate purposes stated in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996.
7. Substitute Caregiver Referral. If Client initials this section, Client authorizes and directs the Registry to refer a substitute Caregiver in the event a Caregiver who provides services to Client is not available. Client understands that the Registry does not monitor or supervise Caregivers and that Client is responsible for notifying the Registry when a substitute Caregiver referral is requested. **Initials:**

8. Availability of a Registered Nurse. Client acknowledges that, when a CNA or HHA Caregiver is

referred, a RN is available to make visits to Client's home for an additional cost. Section 400.506(6)(c), F.S.

9. Direct Hire of Caregivers. Client understands that the Registry has made a large financial investment in screening and referring one or more qualified Caregivers to provide care to Client. Client agrees to pay a lump-sum fee of \$5,000.00 per Caregiver, plus any collection and litigation costs and attorney fees and costs charged to the Registry, if Client directly or indirectly hires any referred Caregiver outside of this Agreement during the time the Caregiver is providing services under this Agreement and for one year following the end of services being provided by the Caregiver. Client understands that he or she is free to directly contract with or employ such Caregiver and that the fees above are reasonable given the services provided by the Registry. This paragraph shall survive the termination of this Agreement.
10. Termination. This Agreement may be terminated by either Party at any time by providing the other Party with prior notice of its intent to terminate the Agreement. Termination of this Agreement shall have no effect on Client's engagement with a Caregiver, as the Registry has no right to terminate or otherwise interfere with Client's engagement with a Caregiver, other than to inform Client about matters pertaining to a Caregiver's background checks and professional credentials as required by state law. If Client terminates the Agreement and continues to receive services from a referred Caregiver, Client agrees to pay the lump-sum referral fee set forth in Section 9.
11. Entire Agreement. This Agreement contains the entire agreement between the Parties, and supersedes all prior agreements and representations, contracts, understandings, warranties, guarantees, inducements, or conditions, express or implied, oral or written, among the Parties with respect to such subject matter, except as contained in the Agreement. The Parties state and acknowledge that, by entering into this Agreement, they forego and extinguish any rights existing in any such prior agreement. No change or amendment to this Agreement shall be valid unless it is in writing and signed by both Parties.
12. Choice of Law and Enforcement. This Agreement shall be governed by the laws of the state of Florida, without regard to choice of law principles. Any litigation shall be brought in the state or federal courts located in or covering Miami-Dade County, Florida. Each Party agrees to the exercise of personal jurisdiction by such courts to the full extent permitted by law. This paragraph shall survive termination of this Agreement.
13. Severability. Should any term or provision of this Agreement be found invalid or unenforceable, the remainder of this Agreement shall not be affected, and each and every term and provision otherwise valid shall remain valid. This Agreement shall be binding upon, and inure to the benefit of, the Parties and their respective successors, assigns, and heirs.
14. Responsible Party. This section shall not apply if Client has not authorized a third-party to bear responsibility for Client's performance under this Agreement ("Responsible Party") and if Responsible Party does not execute this Agreement. In consideration of the Registry's services and the Registry entering into this Agreement, which the Registry would not do but for this guarantee, Responsible Party agrees to guarantee Client's prompt and faithful performance of all terms and conditions of this Agreement, including without limitation payment of all amounts owed by Client

to the Registry and/or to Caregivers. Responsible Party's obligations shall be co-extensive with Client's obligations under this Agreement and all modifications thereof. This guarantee shall be binding upon Responsible Party's legal representatives, successors and assigns. This paragraph shall survive termination of this Agreement.

Client has read and fully understands the contents of this Agreement and agrees to its terms.

Effective this _____ day of _____, 20_____.

Home Care Plus Nurse Registry, LLC.

SIGNATURE

NAME

TITLE

DATE:

Client or Legally Authorized Representative

SIGNATURE

NAME

DATE

RESPONSIBLE PARTY

SIGNATURE

NAME

DATE

RELATIONSHIP TO CLIENT



PLEASE BE ADVISED OF THE FOLLOWING:

- 1) The caregiver referred is an independent contractor and Home Care Plus Nurse Registry, LLC. , is not obligated to monitor, supervise, manage or train the caregiver.

- 2) R.N.'S are available to make visits to the patient's home for an additional cost.

Home Care Plus Nurse Registry, LLC. Representative

(Signature) _____ Date: ____/____/____

CLIENT OR RESPONSIBLE PARTY

(Signature) _____ Date: ____/____/____



Consents and Acknowledgments

CONSENT FOR CARE AND SERVICES

I hereby authorize Home Care Plus Nurse Registry. (HCPNR), a licensed nurse registry, to provide care and services to me in my home or a long-term care location under a Plan of Care authorized by my physician and/or third-party payor. I consent to treatment by the caregivers referred by HCPNR as per my request, or as ordered by my physician, or as may be necessary in an emergency in order to save my life or to prevent permanent injury. This consent releases HCPNR from liability for any claim based on unauthorized treatment.

I understand that caregivers referred by HCPNR are independent contractors, and that they may be identified as a companion, homemaker, certified nursing assistant, home health aide, licensed practical nurse, registered nurse, or other designations. The independent contractor maintains control over the method and means of delivering the services provided and is responsible for the performance of such services. HCPNR may not monitor, supervise, manage, or train such caregivers.

I understand that the frequency of services provided to me may vary and change according to need. I understand that a replacement caregiver may provide services to me in the event that the regular caregiver is unable to fulfill his duties. I understand that a registered nurse will supervise all services. I agree to allow a registered nurse from HCPNR to make periodic visits, as needed, to my home to assess the quality of care provided and such may be billed as a separate fee. Per Florida Statute 400.506(6)(c)-I understand that when HCPNR refers a certified nursing assistant or home health aide to my home, registered nurses are available to make visits to the home for an additional cost.

I further authorize HCPNR to release my medical records and pertinent information concerning my care to health care providers, payment sources, or possible payment sources, and as otherwise required by law. By signing this form, I also authorize HCPNR to speak to my physician, family members, and my insurance carrier regarding my care, as well as authorize all other health care providers involved in my care to release any portion of my medical records in their possession or control to HCPNR upon request.

Definitions:

"I" refers to the patient/client and/or their authorized representative.

"Nurse Registry" means referral of independent contractors to provide health care related services to a patient or client in the person's home or place of residence. Fla. Ad min. Code R. 59A-18.002(1 o

ACKNOWLEDGEMENT OF NOTICES IN CLIENT INFORMATION BOOKLET

In accordance with conditions of license, HCPNR has provided me with the following information:

As a licensed nurse registry in the state of Florida Home Care plus nurse Registry abides by Title VI of the Civil Rights act of 1964 which prohibits denial of care based on race, color, or national origin, as well as Section 1557 of the Affordable Care Act which prohibits discrimination on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics), in covered health programs or activities.

I have received a HIPAA Notice of Privacy Practices and consent to the HCPNR's use and/or disclosure of protected health information for payment, treatment, and the registry's health care operations.

I have received a HIPPA Notice of privacy Practices and consent to the HCPNR's use and/or disclosure of protected health information.

I have been informed of and received a copy of my **Bill of Rights**.

I acknowledge that I have received the statement of Advanced Directives, and the information has been discussed with me to my satisfaction.

I have been informed about Emergency Preparedness and what to do in an emergency.

I have received information on how to report concerns regarding Abuse, Neglect, and Exploitation.

I have received information about how to make a complaint regarding the referred caregiver or the services I am or am not receiving.

I have received information about how to report suspected Medicaid Fraud.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I READ AND UNDERSTAND THE CONTENT OF THIS FORM AND AGREE TO AUTHORIZE SERVICES. I ALSO ACKNOWLEDGE RECEIPT OF A COPY OF THE CLIENT INFORMATION BOOKLET.

Client/Authorized Representative Signature

Date

Relationship to the Client



8095 NW 12TH ST suite 200, Doral Florida 33126
PHONE (786) 636-6039

**Informed Consent:
Assistance with Self Administration Medication by Non-Licensed Personnel**

I _____ (client, client's surrogate, guardian or attorney in fact), is herein referred to as "the client", hereby state that I have been informed of the following's facts:

That the client will receive assistance with self-administration of medication from an unlicensed person; i.e. home health aides.

That the home health aides are independent contractors in agreement with Home Care Plus Nurse Registry, LLC.

Trained with respect to assisting with the self-administration of medications as provided in rules promulgated by the Agency of Healthcare Administration.

That Home Care Plus Nurse Registry, LLC. encourages patients who are capable of self-administrative their own medications without assistance to do so.

That Home Care Plus Nurse Registry Inc. provides unlicensed personnel who, consistent with a dispensed prescription label or the package direction of an over the counter medication, helps the clients who needs assistance and whose condition is medically stable, with the self-administration of routine, regularly schedule medications that are intended to be self-administrative and as needed medication.

Additional information on the State Regulations refer to the other side.

I hereby state that I have read and been fully informed of the above facts and that I hereby request and consent to have home health aides assist me with my self-administered medications.

_____ The above-named services are not required at this time. I will notify Home Care Plus Nurse Registry, LLC. when such service is required.

Client, Client's Surrogate, Guardian or Attorney in Fact

Date

Registry Representative

Date



8095 NW 12TH ST suite 200, Doral Florida 33126
PHONE (786) 636-6039

In cases where a Home Health Aide or a C.N.A. will provide assistance with self-administered medications as described in Section 400.488, F.S., and paragraph (e) below, a review of the medications for which assistance is to be provided shall be conducted by a Registered Nurse or Licensed Practical Nurse to ensure the C.N.A and Home Health Aide are able to assist in accordance with their training and with the medication prescription. The patient or the patient's surrogate, guardian, or attorney in fact must give written consent for a home health aide or C.N.A. to provide assistance with self-administered medications, as required in Section 400.488(2), F.S.:

(e) The trained Home Health Aide and C.N.A may also provide the following assistance with self-administered medication, as needed by the patient and as described in Section 400.488, F.S.:

1. Prepare necessary items such as juice, water, cups, or spoons to assist the patient in the self-administration of medication;
2. Open and Close the medication container or tear the foil of prepackage medications;
3. Assist the resident in the self-administration process. Examples of such assistance include the steadying of the arm, hand, or other parts of the patient's body so as to allow the self administration of medication;
4. Assist the patient by placing unused doses of solid medication back into the medication container.



**APPENDIX D
Emergency Health Services**

Name: _____ SOC: _____

Address: _____ Telephone: _____

GENERAL PATIENT INSTRUCTION ABOUT THIS FORM:

This information is provided to you as a quick reference source in case any emergency occurs. Keep this document where it can easily be found, preferably in your Registry folder or on your refrigerator door. Inform other persons close to you such as relative or neighbor of its location.

1. Home Care Plus Nurse Registry, LLC. has an On-Call Person after hours, weekends and Holidays. You can reach the On-Call person by calling our office number: 768-636-6039.
2. In case of a serious medical emergency, you should call 911 and be taken to a hospital. Home Care Nurse Registry, LLC. does not operate an emergency service; therefore, valuable time may be lost by contacting the Registry for a serious emergency such as a severe chest pain, unusual bleeding, unconsciousness, etc.
3. Ambulance/ Emergency number is 911
4. Doctor: _____ Telephone: _____
5. Name of close relative _____ Telephone: _____
Relationship _____ Address: _____

6. In the event of a Hurricane or other natural disaster, I plan to take the following actions:

- Remain in my place of residence.
- Go to a local shelter (Already Registered with the county or need registration).
- Evacuate to a safe area (will inform the Registry of my location).
- Go to a relative's home or other location.



Classification
Please circle correct classification of patient

D-1 Category 1

Patients who cannot safely forgo care, highly unstable patients with high probability of inpatient admissions if home care is not provided. Infusion Therapy, highly skilled wound care, with no family or caregiver able to assist during an emergency, requires life sustaining medication or equipment.

D-2 Category 2

Patient whose conditions recently worsened or requires moderate level of skilled care: A visit may be postponed until emergency situation improves. Clients with untrained families or caregivers who would provide basic care in an emergency. Patient may require a Special Need Shelter designated to care for people who required assistance with activities of daily living; or need assistance monitoring their medical conditions or administering medication.

D-3 Category 3

Patients who can safely forgo care or a schedule visits including Aides visits or patients receiving routine visits or have competent family member/ caregiver. The Registry will hold visits will be on hold during a hurricane. Visits will be resumed when a clearance is given by the National Hurricane Center to the public and conditions permit a safe entry to the affected areas.

PLAN OF ACTION

Document the patient's emergency plan and evaluate.

Patient plans to stay with: _____ Relationship: _____

Located At: _____ Telephone: _____

Application for Emergency Evacuation Assistance Prog. Completed: _____

Signature & Date

Confirmation letter verifying received by patient: _____

Signature & Date

RECURRING PAYMENT CREDIT CARD AUTHORIZATION FORM

CLIENT NAME: _____

HERE'S HOW RECURRING PAYMENTS WORK:

You authorize regularly scheduled charges to your Visa, MasterCard, and American Express. You will be charged each billing period (weekly) for the total amount due for that period for services rendered to the above-named client. A receipt will be emailed to you upon request and the charge will appear on your credit card statement. I understand and accept the following conditions:

1. Weekly charges will recur for as long as the services are rendered or until I give Home Care Plus Nurse Registry LLC. written notice to discontinue automatic credit card billing.
2. In the event that my financial institution rejects charges to my credit card by Home Care Plus Nurse Registry LLC. for any reason, I will pay the charges due immediately and no later than 72 hours after the rejection.
3. I agree to notify Home Care Plus Nurse Registry LLC. immediately if there are any changes to my credit card.
4. I agree to address any disputed charges directly to the Home care plus Nurse Registry LLC. office *before* disputing the charges with my financial institution.

PLEASE COMPLETE THE INFORMATION BELOW AS IT APPEARS ON CARD (PRINT):

I _____ authorize Home Care Plus Nurse Registry LLC. to charge my credit card.

CC NUMBER: _____ EXP DATE: _____ SECURITY CODE: _____

TYPE OF CARD: VISA MC AMEX

CREDIT CARD BILLING ADDRESS (PRINT): _____

TELEPHONE: (_____) _____ EMAIL: _____

SIGNATURE OF CARDHOLDER: _____

RELATIONSHIP TO CLIENT: _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. There is a credit card processing fee of 3%. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization. This payment authorization is for the type of billing dictated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Dade: 8095 NW 12th ST # 200 Doral, FL. 33126

305-266-7142