Grace Home Care Provider, LLC

SERVICE AGREEMENT

Client's Last Name_____ First Name _____M.I._____ DOB _____

Address _____ Phone _____

Responsible Party _____ Relationship _____

Date of initial client contact _____ Date of referral _____

EMERCENCY CONTACT

Name_____ Phone_____

I, the undersigned, hereby make the following acknowledgement and agreements regarding services to be provided by Grace Home Care Provider, LLC hereinafter The Agency. I agree to enter into an agreement for:

□ HHA □ Personal Care □ Companionship/Sitter □ Nursing Services

I, _____ have requested services to include:
_____
_____
_____
_____
_____
_____

Notify the office if you would like to make any change to the care identified above. A staff member will contact you and an addendum will be added. In addition, your customized care plan will also be updated, and your caregiver will be notified.

SERVICES PROVIDED BY THE AGENCY

The agency agrees to provide the following services:
Start Date_____
Frequency _____ Time _____-_____ Duration _____
Frequency _____ Time _____-_____ Duration _____

ENTRY TO RESIDENCE

Procedure to entry residence, i.e. gate code etc.
_____

FEE FOR SERVICE(S)

The Agency rates for services are listed below. The agreed upon rate(s) is/are:
Personal Care Hourly $____ Companion/Sitter Hourly $ _____

Live-In requires a minimum of (8) hours of sleep. If your level of care does not permit, The Agency will bill you at the hourly rate and may provide (2 or more) employees for your level of service requested based on the required hours.

REVISION TO SERVICE AGREEMENT

Subsequent revisions to the initial service agreement may be handled by the provider noting in the client's record the specific changes in service (e.g. addition or deletion of service, changes in frequency, or duration, or charge for services, etc.) that will occur and that the change was discussed with and agreed to by the client and/or responsible party, as appropriate, who signed the initial agreement prior to the change in services occurring.

HOLIDAY PAY

I understand that The Agency will bill at a rate of **1 ½** times the hourly rate for service(s) provided on the following holidays: New Year's Eve (after 5pm), New Year's Day, Memorial Day, Easter Sunday, Independence Day, Labor Day, Thanksgiving Day, Christmas Eve (after 5pm), and Christmas Day.

INVOICING FOR SERVICE(S)

I understand that The Agency will invoice every (Monday) (1) week in advance for live-in service(s). Hourly care will be invoiced on Monday for the previous week. Due to billing in arrears, the undersigned agrees to submit payment within (1) calendar day. Payments can be made online through The Agency's website, PayPal, or by authorizing The Agency to withdraw/charge the undersigned Visa or MasterCard, or check. The undersigned will be legally responsible for all collection activity fees; legal fees incurred by The Agency for collecting on delinquent invoices/monies owned to The Agency. The Agency will apply a 2% fee on all outstanding invoices which are not paid in full within 3 business days. If a third party is utilized for payment of services, it is still the sole responsibility of the undersigned to ensure The Agency receives payment on-time.

Invoices should be mailed to the client/responsible party for payment at the following address:
Name: _____ Email: _____
Address: _____ _____ _____, _____
_____

*The undersigned agrees to respect the rights of The Agency and will not directly employ any staff provided by The Agency or agrees to pay a liquidation fee equal to (12) weeks of service at (40) hours a week. Initials _____

Banking/Account Information on File

I understand that The Agency will debit via ACH for services rendered within (24) hours after the invoice has been generated. I authorize payment(s) to be withdrawn from my checking or savings account until I provide in writing to stop payments (*1-week advance written notice required*).

Bank Name: _____ Routing #: _____
Account #: _____
Billing Address_____
Card Holder's Signature: _____ **Date:**
_____

INSURANCE REIMBURSEMENT

The Agency's care management team will assist you with verifying benefits via insurance company, submitting claims and providing required home care service documents; however, The Agency does not accept assignment of benefits. Initials _____

CANCELLATION POLICY

A client has the right to cancel the service agreement at any time and shall only be charged for services rendered prior to the time that the provider is notified of the cancellation. If one week's notice is not given to the office, initial deposit will be forfeited. The provider may assess a reasonable charge for travel and staff time if notice of the cancellation service agreement is not

provided in time to cancel the service prior to the provider's staff member arriving at the client's house to perform the service.

CONSENT TO CARE

I authorize the employees of The Agency to render care/services as requested by myself and or family member. If required, I understand that I will be fully informed of the anticipated benefits, possible discomforts, and potential side effects prior to the performance of any treatment, and I release The Agency from liability that may arise as the result of such treatment, unless due to sole negligence of its staff.

GEORGIA STATE MANDATED REPORTERS

The Agency and its employees are mandated reporters of suspected elder abuse and will report concerns as required by Ga. State law.

ADVANCE DIRECTIVES AND DNR ORDERS

Do you have an Advance Directive? □Yes □No If yes, please provide a copy.

Do you have a DNR Order? □Yes □No If yes, please provide a copy.

PROVISION OF SERVICES

I understand that The Agency assigns staff based on client needs and considerations related directly to the care/services provided. I understand that services and employees are provided regardless of race, ethnicity, religion, sex, age, and veteran or handicap status.

RELEASE OF INFORMATION/PRIVACY RIGHTS

I have been provided with a Notice of Privacy Rights that details the various ways that information about me may be disclosed for treatment, payment, healthcare operations and other purposes permitted or required by law as applicable.

OBSERVATION/REVIEW CONSENT

I understand that surveyors and representatives of any other certification/accreditation/professional bodies may observe employees of The Agency perform prescribed care. I understand the purpose is to provide a learning experience or for the evaluation of the quality of care and that all information will be kept confidential in accordance with the Notice of Privacy Rights. I hereby grant permission for the above individuals to observe The Agency employees performing prescribed care. I am aware that I may revoke permission for observation verbally or in writing at any time.

GENERAL INFORMATION

This is to give access to client's personal funds when home management services are to be provided and when those services include assistance with bill paying or any activities, such as shopping, that involve access to or use of such funds; similarly approved authorization for use of client's motor vehicle when services to be provided include transport and escort services and when the client's personal vehicle will be used.

□ **Yes**, I give permission for The Agency's employee to access my personal funds. If yes, client agrees to provide a pre-paid card or petty cash account to manage transactions.
Initial here: _____
□ **No**, I do not give permission for The Agency's employee to access my personal funds.
Initial here: _____

□**Yes**, I give access to The Agency's employee to use my personal/rented vehicle for transportation services. (Must sign transportation waiver form)
Initial here: _____
□ **No**, I do not give permission for The Agency's employee to use my personal/rented vehicle for transportation services.
Initial here: _____

Client's/Payee Initials _____ Date _____

CLIENT RIGHTS
I have received a copy of Client Rights and Responsibilities. **Initial here**: _____

CUSTOMER SERVICES/GRIEVANCE PROCEDURE
Grace Home Care Provider, LLC is available 365 days a year. Their telephone # is 912 343-6454 Address;

The main number for the Department of Community Healthcare Facility Regulations Division is 404-657-5700 for information about licensing requirements. The number to lodge complaints about provider services is 404-657-5728 Local or 800-878-6442 Toll/Free.

Client Signature Date _____
_____

Phone Number _____

Address_____

Financial Responsible Party and/or Insured Party
Signature _____ Date _____ Phone Number_____

Address _____

Company Representative:
Signature _____ Date_____