Kenyon HomeCare Consulting

Smarter Solutions.
Better Outcomes.

Client File Forms Non-Skilled

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TABLE OF CONTENTS

INTAKE FORM **1**

CLIENT SERVICES AGREEMENT **2**

CLIENT BILL OF RIGHTS **4**

CLIENT DISCLOSURE STATEMENT **6**

ASSESSMENT (NON-SKILLED) **8**

SAFETY CHECK LIST **11**

EVACUATION PLAN **14**

MEDICATION PROFILE **15**

AIDE PLAN OF SERVICE **16**

CASE ASSIGNMENT ORIENTATION LOG **17**

SHIFT/VISIT REPORT **18**

NARRATIVE NOTE [MAY BE IN SOFTWARE] **19**

CLIENT SUPERVISORY NOTE **20**

DISCHARGE INFORMATION **22**

ORDER OF CLIENT FILE **23**

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INTAKE FORM

Date: _____

Client name:_____ Phone:_____

Address:

_____

Date of Birth: _____ Age: _____

Services requested:

_____

_____

_____

_____

Start date: _____

Medical diagnosis:

_____

_____

_____

_____

_____

Physician: _____ Phone: _____

Contact name: _____ Phone: _____

Referral source/person: _____ Phone:_____

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CLIENT SERVICES AGREEMENT

Client Name: _____

Client Rights and Responsibilities
I understand and have received the list of my rights and responsibilities: _____
(*Client Initials)*

Consent for Care
I consent to receive care from AGENCY as outlined in the plan of care and other services agreed to by AGENCY and me.

Services available through AGENCY	Services to be provided to you
Home Care Aide	Home Care Aide
Homemaker	Homemaker
Transportation	Transportation
Live-in	Live-in
Respite Care	Respite Care
	Other _____

Payment
I agree I am to pay all invoices within 14 days of receipt of the bill and a late charge of 12% may be assessed to bills that are later than thirty (30) days. I am liable for all charges, collection costs, and attorney fees regardless of the payor. I understand I am responsible for all charges. Further, I authorize payment directly to AGENCY of any insurance benefits payable to me for services provided and covered by my insurance plan.

Bill Rate and Deposit
The bill rate for Caregiver services is $_____ an hour/day. This rate is subject to change with a thirty (30) day notice.

I agree to pay $_____ upon signing of this agreement (cash, credit card, or check). This deposit for services will be applied to the last invoice for services.

Holidays
Holidays are Thanksgiving Day, Christmas Day, New Year's Day. You will be reminded of each holiday prior to the holiday. If you decide to have services on a holiday, you will be billed at a rate of one and one half for services provided starting at 7am of the holiday until 7am of the following day.

Service Interruption
I understand, from time to time, there may be an interruption of services due to circumstances that are unavoidable. AGENCY will make every effort to staff the shift and will notify me if they are unable to do so. During those times, I agree to provide or arrange for back-up care.

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Release of Liability
I release and hold harmless AGENCY its agents, and employees from any and all liability arising from transporting me in my vehicle or the employee vehicle, or agent of AGENCY **. I accept transportation at my own risk**. If transportation is provided in the employee car, I agree to pay 65 cents per mile, which will be billed with my monthly statement.

Hiring of AGENCY Employees
I understand that if I will not solicit or accept a solicitation from an employee or attempt to hire an employee of AGENCY for a period of one hundred and twenty days (120) following completion of services to me. Further, if I wish to hire the employee before the 120 days I will immediately pay AGENCY the sum of $15,000.

Termination
I understand I may cancel a shift or terminate this agreement with a four (4) hour notice. AGENCY may terminate this agreement by providing a seventy-two hour (3 day) notice. I understand that any cancellation with less than four hours' notice will be billed at the full shift.

Access to records
And I understand that I may have access to my records at any time upon request to AGENCY I can obtain a copy of my records. _____
(Client Initials)

Advanced Directives
I have received and reviewed the Advanced Directives Information statement. _____
(*Client Initials)*

Authorization to Release Information
I consent to the release of information to AGENCY any part of my medical record by a physician, hospital, AGENCY, or other facility of which I have been a client. I further authorize the checking of my credit and financial rating and history with any person, firm, or credit bureau. Release of information from AGENCY to individuals acting in an official capacity such as my guardian, individuals representing governmental or third party payors, or other health care providers involved in my care is also authorized.

I have read this agreement and received a copy of it and am the client or am acting in the client's behalf and accept these terms. ___ (*Client Initials*)

Signature: _____
Client or Representative Acting in Client's Behalf Relationship to Client_____

Printed Name:_____ Client Name _____
(Applicable only if Representative signs for client)

Form of payment: ☐ Credit Card ☐ Check ☐ Cash

AGENCY Representative/Title:_____Date: _____

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