

Southern Loving Care, Inc.

Service Agreement

This represents an agreement between Southern Loving Care, Inc., hereafter referred to as Agency and _____, hereafter referred to as "Client".

Services requested (type/day/time) _____

Rate of pay: \$28.00 hourly with a minimum of 20 hours weekly.

This agreement is effective from _____ to _____

TERMS OF AGREEMENT FOR AGENCY:

1. Assessment will be made to determine needs and wishes of client and care plan will be formulated based on information provided.
2. If an RN assessment is required it will be \$200.00
3. Open case packet/fee \$200.00
4. District Manager will monitor care to client.
- 5.* Itemized billing statements for services provided will be mailed/emailed to client and will be due upon receipt. (Provide name and address for billing invoices to be sent to. (SEE ATTACHED BILLING SHEET)
6. Refunds will be issued on a case by case basis.

TERMS OF AGREEMENT FOR CLIENT

1. Payment to Agency for services provided will be made by:
 Private Pay Other _____
2. Private Pay client will prepay for at least two weeks of service prior to start of care.
3. Payments to Agency for services provided will be due upon receipt of bill. Any amounts not paid, prior to the time frame on the invoice will be considered delinquent and may be assessed a "late fee" charge of 10% of unpaid balance. Staffing will be discontinued until payment is received.
4. Will advise Office Manager of any problems or special needs as they occur.
5. Understand Agency's holiday schedule and service limitations.
6. Agrees to not solicit agency staff nor discuss any payment arrangements made with said Agency.

Southern Loving Care, Inc. Representative

Date

Client/Responsible Party

Date

Southern Loving Care

BILLING INFORMATION

Name: _____

Address: _____

City: _____ State/Zip: _____

Contact Phone: _____ Alternate Phone: _____

DOB: _____ SS#: _____

Gender: _____ County of Residence: _____

Southern Loving Care Service Agreement Signed and Attached.

Medicaid Program Mandatory Information Needed: Service Authorizations: Attach Copy

Medicaid Waiver #: _____

Case Worker: _____ Phone Number: _____

Other Programs:

Insurance Company: _____

Billing Address: _____

Phone Number: _____

Billing Requirements: _____

Member ID: _____

Group Number: _____

Insured Name: _____

Private Pay Mandatory Information Needed:

Person Responsible for Payment: _____

Contact Phone: _____

Mailing Address: _____

Type of Service: _____

Billing Rate: _____

Billing information must be submitted and approved by Corporate prior to providing services.

Southern Loving Care Representative Signature/Date

Southern Loving Care, Inc.

Care Plan

Name: _____

Date: _____

Check the activities which the client can regularly accomplish alone. Where help is needed, describe the way in which assistance will be provided.

<u>Activity</u>	<u>Alone</u>	<u>Assist</u>	<u>Assistance to be provided by whom</u>
Bathing	_____	_____	_____
Grooming	_____	_____	_____
Dressing	_____	_____	_____
Elimination	_____	_____	_____
Self-administered meds	_____	_____	_____
Mobility(in home)	_____	_____	_____
(out of home)	_____	_____	_____
Food preparation	_____	_____	_____
Shopping	_____	_____	_____
Laundry	_____	_____	_____
Homemaking	_____	_____	_____
Transportation	_____	_____	_____
Managing Finances	_____	_____	_____
Care for Pets	_____	_____	_____

Patients hobbies or special interests (include family, friends, churches, senior centers or community organizations) _____

Southern Loving Care, Inc.

Client Information sheet

Date: _____ Allergies: _____
Name: _____ DOB: _____
Address: _____ Primary Diagnosis: _____

Location of current medications: _____

Does Patient have DNR orders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical Power of Attorney?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Healthcare surrogate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Emergency Information

Physician: _____ Phone #: _____
Emergency Contact: _____
Relationship to patient: _____
Phone #: _____

By signing below I am accepting responsibility for updating all the above information.

Patient/caregiver

Date

Southern Loving Care, Inc

Date

Southern Loving Care, Inc.

Client Profile

Name: _____ SS#: _____

Allergies: _____

Address: _____

Directions to home: _____

Phone #: _____ Sex: _____ Age: _____ DOB: _____

Name address and Phone # of responsible party: _____

Physician and alternate with address and telephone, in case of emergency:

Dietary needs (if any): _____

Does client take own medications? Yes NO

Does client need assistance? Yes NO

Restrictions by Physician: _____

Special health needs or concerns: _____

Name, address and phone of person/agency referring: _____

Southern Loving Care, Inc.

Patient acknowledgement Statements

Name:

DOB:

CONSENT FOR CARE AND SERVICES

I hereby give consent and authorize Southern Loving Care, inc., its agents and associates to provide care and treatment to me in my place of residence per program policy and/or prescribed by my physician. A representative of Southern Loving Care, inc. has explained services I will be receiving and all my questions have been answered satisfactory. I understand that the service/treatment plan may change and, if so these changes will be discussed with me.

CARE PLAN

I have reviewed and agree with the Care Plan prepared for me based on my review. I understand that I may request additional services or changes in my Care Plan in accordance with my Service Agreement.

RELEASE OF INFORMATION

Information from my records will be released only upon my written consent, which I may revoke at any time. Therefore, I give my permission to Southern Loving Care, inc. to release/obtain information in my records to/from the referring Agency, my Physician and persons who will perform related services. (For Medicaid patients only: I understand that the Long Term Care Ombudsman may review my records)

ADVANCE DIRECTIVES

I have received written information and explanation regarding advance directives from Southern Loving Care, Inc. and I understand the policy of Southern Loving Care, Inc. to respect individual choice to avoid discrimination based on whether or not I have advance directives. I understand and acknowledge that it is my responsibility to notify Southern Loving Care, inc. of any advance directives I have chosen.

PATIENT/CLIENT RIGHT AND RESPONSIBILITIES

I have received a copy and explanation of the Patient/Client Rights and Responsibilities. I understand that all information regarding myself or care is kept confidential.

Client/Patient Signature

Date

Clients/Patients Legal Guardian

Relationship

Agency Representative

Date

Revised: May 2007

Southern Loving Care, Inc.

106 SE White Ave. Ste B2
Live Oak, FL 32064
866-480-3277

Emergency Plan

Southern Loving Care, Inc. requires that clients have posted in plain view an emergency plan as specified by the family and/or client for staff reference.

Name: _____ Date: _____
Allergies: _____ Phone #: _____

In Case of an Emergency, call the following numbers:

_____	_____
_____	_____
_____	_____

Are you registered with special needs shelter? Yes No

If no, why not? _____

If the client is to be registered at a special needs shelter, how has Southern Loving Care, Inc. assisted? _____

In case of an evacuation to a special needs shelter, responsible caregiver to notify: Name _____ Phone # _____

Medications and equipment needed: (attach med sheet if needed)

Other instructions: _____

It is your responsibility to notify the office of any changes made to these instructions. Thank you.

*** Notify the office upon your return home so that services may be resumed.**

Southern Loving Care, Inc.

106 SE White Ave, STE B2

Live Oak, FL 32064

Emergency Management plan

Evacuation Priority Form

This patient is a priority #: _____

- #1 - Bed bound, Insulin dependent, IV therapy, O2, Beachside
- #2 - Lives in Mobile Home or known flood area, wheel chair bound
- #3 - Requires no special assistance, will evacuate with family/friend

_____ I have received information regarding emergency planning, special needs sheltering, shelter registration and understand the same.

_____ I require assistance with evacuation to the special needs shelter.

_____ I have my own evacuation plan.

My specific plan is as follows:

Relocating to:

Name of member/friend _____

Address _____

Phone _____

I understand that it is my responsibility to notify: _____

When I return to the area for resumption of services.

Patient Signature

Date

Agency Representative

Date

APPENDIX B: INFORMATION FOR NURSE REGISTRY PATIENTS

Insert copy on next page.

APPENDIX C: SUPPORT MATERIAL

List on this page and insert copies on following pages.

APPENDIX B: INFORMATION FOR NURSE REGISTRY PATIENTS

Please note: The special needs shelter should be used as a place of last refuge. The evacuee may not receive the same level of care received from independent contractors in the home, and the conditions in a shelter might be stressful.

(1) If the patient has a caregiver¹, the caregiver must accompany the patient and must remain with the patient at the special needs shelter.

(2) The following is a list of what special needs patients need to bring with them to the special needs shelter during an evacuation:

- Bed sheets, blankets, pillow, folding lawn chair, air mattress
- The patient's medication including the dose, frequency, route, time of day and any special considerations for administration, supplies and equipment list, including the phone, beeper and emergency numbers for the patient's physician, pharmacy and, if applicable, oxygen supplier; supplies and medical equipment for the patient's care; Do Not Resuscitate (DNRO) form, if applicable;
- Name and phone number of the patient's nurse registry
- Prescription and non-prescription medication needed for at least 5 to 7 days; oxygen for 5 to 7 days if needed.
- A copy of the patient's plan of care, if applicable
- Identification and current address
- Special diet items, non-perishable food for 5 to 7 days and 1 gallon of water per person per day
- Glasses, hearing aides and batteries, prosthetics and any other assistive devices
- Personal hygiene items for 5 to 7 days
- Extra clothing for 5 to 7 days
- Flashlight and batteries
- Self-entertainment and recreation items, like books, magazines, quiet games.

(3) Shelters need to know the following:

- If the patient has a caregiver, the caregiver must accompany all special needs shelters. A special needs shelter can accommodate one caregiver at a time, and other family members, friends, etc. should go to a regular shelter.
- The shelter caregiver will have floor space provided. The caregiver must provide his or her own bedding.
- Service dogs are allowed in the shelter. However, check with your local Emergency Management office to see if other pets are permitted.
- Bring personal snacks, drinks, and any special dietary foods for 72 hours. It is possible only sparse meals will be provided.
- Caregivers who regularly assist the patient in the home are expected to continue to do the same care in the shelter.

Signature

Date

FOR YOUR RECORDS

Important Phone Numbers

HOW TO FILE A COMPLAINT

If you wish to file a complaint against a licensed health care facility regulated by the Agency for Health Care Administration, please call 1-888-419-3456 or use the online complain form at <http://apps.ahca.myflorida.com/hcfc>

TO REPORT ABUSE

To report abuse, neglect, or exploitation, please call toll-free 1-800-962-2873 or 1-800-96-ABUSE. The Abuse Hotline investigates allegations of physical, sexual and mental abuse, neglect and exploitation of vulnerable persons. Report nurses and certified nursing assistants to the Department of Health by completing and submitting a complaint form at www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/forms.html

MEDICAID FRAUD

Medicaid fraud means an intentional deception or misrepresentation made by a health care provider or a Medicaid recipient with knowledge that the deception could result in some unauthorized benefits to to him or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law as it relates to Medicaid. To report suspected Medicaid fraud, please call toll-free 1-866-966-7226.

Southern Loving Care, Inc.

NOTIFICATION FORM

There are times when despite our best efforts, Southern Loving Care, Inc. staff will not be able to make a scheduled visit, including, but not limited to emergency situations beyond Southern Loving Care, Inc. control such as impassable road conditions or mandatory evacuation orders. Indicate below whom you would like for us to notify in the event staff are unable to make the visit. We will only call on these people after Southern Loving Care, Inc. has called other staff in the case and any relief people available.

Client/Patient name: _____ DOB: _____

Notify: _____ in the event
Southern Loving Care, Inc. staff are unable to make a scheduled visit.

Home Phone number: _____ Cell number: _____

Alternate contact: _____ Phone #: _____

Cell #: _____

FOR YOUR RECORDS

SOUTHERN LOVING CARE, INC. SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES FORM

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law.
- A patient has the right to know when the care giver being referred is a private contractor.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.
- To be free of physical and psychological abuse and have means to report abuse.

Southern Loving Care, Inc.

Pet policy Form

The client/patient has been informed on the pet policy established by Southern Loving Care, Inc. The client understands that at any time a staff member requests that their pets be secured while they are in the home, the clients obligated to secure the pets in either the back yard or a separate room prior to the staff's arrival. The client has been briefed that it is their responsibility for cleaning up the mess and caring for the pet. It is not the responsibility of Southern Loving Care, Inc staff to clean up unsanitary conditions caused by any pets, nor is it their responsibility to feed and water the clients pets.

If the client refuses to secure the pets or if the pets cause unsanitary conditions because of feces, urine or fleas to such extent that the workers ability to keep the home sanitary is jeopardized or the living environment poses a health hazard for staff coming into thome, the client understands that services will be put on hold and established procedures for terminating services will be implemented.

I understand my responsibilities as a pet owner and agree to adhere to the established pet policy as described to me by a member of Southern loving Care, Inc.

Pets description: _____

Pets name: _____ Number of pets: _____

Pet/pets reside: Indoors Outdoors

Problems that my pet may pose: (ie. Aggressive, excessive hair, etc.)

Client/Patient signature

Date

SLC, Inc. Representative

Date

Revised: May 2007

Southern Loving Care, Inc.



Transportation Release of Liability

I, _____ ("Releasor") understand that there are certain risk and dangers traveling in general. These risks include, but not limited to: vehicular traffic, weather conditions, illness, injury or death caused by accidents while being transported; negligence of others; accidents and/or illness in remote areas without immediate evacuation or medical facilities, or other agencies known or unknown.

I am aware that such risks may be present during traveling and at any time during the trip I am participating under the agreement of Southern Loving Care, Inc. in consideration, and as part payment for, the right to participate in the trip. I have and do fully assume all risks of injury or damage to my person or property, arising out of these risks and dangers. I've been given notice that Southern Loving Care, Inc., it's owners, agents and employees, act only as a means for transportation from facility to facility.

I have read and fully understand this agreement and it's terms and conditions and I agree to be bound by them. Every passenger must sign this agreement, and if a passenger is under 18 years of age a parent or guardian shall sign on his/her behalf.

Patient/guardian/responsible Party

Date

Southern Loving Care, Inc. Staff

Date

Witness

Date

Southern Loving Care, Inc.

Name: _____

DOB: _____

Patient/Client Understanding of Liability

I, _____ understand that there is no monetary liability on the part of, and no cause of action for damages arises against, a licensed home health agency, licensed nurse registry, or companion or homemaker service registered under s. 400.509, that, upon notice that the employee or contractor has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under s. 435.03 or under any similar statute of another jurisdiction, terminates the employee or contractor, whether or not the employee or contractor has filed for an exemption with the agency in accordance with chapter 435 and whether or not the time for filing has expired.

Patient/Guardian Signature

Date

Southern Loving Care, Inc. Witness

Date

Southern Loving Care, Inc.

Assistance with self-administration of medications

In reference to the assistance of self-administration of medications by independent contractor (CNA/HHA) under a Nurse Registry providing private duty work in a patient's home or place of residence: CNA/HHA's who are independent contractors for nurse registries may provide assistance with self-administration of medications, providing they have completed the training as required by Section 400.488(1)(b), F.S. (2002).

"Patients who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over the counter medication, assist a patient whose condition is medically stable with the self administration of routine, regularly scheduled medications that are intended to be self administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a patient or patient's surrogate, guardian, or attorney in fact. For purposes of this section, self administered medications include both legend and over the counter oral dosage forms, topical dosage forms and topical ophthalmic, otic and nasal dosage forms, including solutions, suspensions, sprays and inhalers."

I, _____ give consent for the CNA/HHA from Southern Loving Care, Inc. to assist with self-administration of medications for _____

Patient's signature

Date

Patient's representative

Date

Southern Loving Care, Inc. Representative

Date