Life Changes Home Care, LLC

SERVICE AGREEMENT

Period of Service: 0	Start of Care: enter start date

Client: enter clients name	PAYER: Medicaid
Address: enter clients address	Address: 615 Howerton Court
City/State: enter city/ state	City/State: Jefferson City, MO
Zip: enter client zip code	Zip: 65102-6500
Phone: enter clients number	Tel #: 573-751-3425
Client #: enter 4 digit code from spectrum	Relationship: Insurance Provider

SERVICE	DAYS/WK	UNIT	RATE	COST
CDS	Enter number of days per week	Enter units	$20.00 PER HOUR	Enter dollar amount

DESCRIPTION OF SERVICES

PAS SUPERVISORY VISITS WILL BE MADE QUARTERLY UNLESS OTHERWISE NOTED

TASKS Personal Care Attendant will assist with Activities of Daily living as needed.

I understand that mileage or car fare may be charged if an employee uses his/her personal vehicle to transport or run errands for me. I understand rates are subject to change and updated rates will be mailed out to me or I may receive them by contacting the Agency.

I will notify the Agency 4 hours in advance to cancel scheduled services. If an employee of the Agency arrives and is not needed and I have not notified the Agency

NOTE: Hourly services may be subject to a four (4) hour minimum charge. A monthly administration fee may be charged if medication management, basic care, or hourly services are not provided. All charges are due and payable in advance of services rendered. Initial payment may be prorated. Ongoing service requires payment be the 25th of the month prior to the month of service.

Method of Payment

Payment will be made by: State of MO_____

I, the undersigned, understand that services delivered on Holiday's will be billed at one and one half (1.5) times the normal rate. Holidays include: New Year's Eve, New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving, Christmas Eve, Christmas Day. Overtime billed at one and one half (1.5) times the normal rate. I, the undersigned, accept this service agreement and understand that I am fully responsible for the payment for services, supplies, and equipment provided by **Life Changes Home Care, LLC**

I understand that services are provided and billed monthly. Payment is due twice a month on the second and fourth Friday of each month for services to be rendered the following month. Short-term services are billed in advance of service rendered. I may cancel services at any time, however I remain responsible for the full amount due. Refunds will be prepared at the discretion of **Life Changes Home Care, LLC, Non-payment will result in cancellation of service.** I agree to respect the agency's right as an employer, and will not directly employ any staff provided by the agency, or I agree to pay a liquidation fee equal to four (4) weeks of service at (40) hours per week.

Client / Responsible Party Signature: _____ Date: _____

Agency Representative Signature: _____ Date: _____

Request for Services/ Inquiry			
Date:	Enter referral date	Employee:	Law, Jeremy
Signature		Title:	CDS Coordinator

Life Changes Home Care, LLC

Client Information			
Client Name:	Enter clients name	Social Security No:	Enter clients SSN
Address:	Enter clients address	City:	Enter city
State:	Enter state	Zip Code:	Enter zip code
Birthday:	Enter date of birth	Gender:	☐Male ☒Female
Home #:	Enter phone number		
Primary Physician			
Physician Name:	Enter physician name	M.D orders needed	☐Yes ☒ No
Hospital of Choice:	Enter hospital name		
Insurance Information			
Primary Carrier:	Medicaid	ID/ Policy #:	Enter dcn number

Billing Information			
Bill to:	State of MO	Relationship:	Insurance Provider
Billing Address:		615 Howerton Court, Jefferson City, MO 65102-6500	

Permission for service to begin given by: _____ Date:

Permission for service to begin received by: _____ Date:

Life Changes Home Care, LLC
Home Care Assistance Plan of Care

Goals

BATH	ASSIST WITH DRESSING	CARE OF ENVIRONMENT

☐ Bed bath	☐ Total assist	☐ Clean client's bedroom
☐ Sponge bath	☐ Minimal assist/reminders	☐ Clean client's bathroom
☐ Shower		☐ Do client's laundry
☐ Tub bath	**DIET**	
	☐ Meal preparation	
ORAL CARE	☐ Feed	
☐ Brush teeth	☐ Assist	**MEDICATIONS**
☐ Denture Care	☐ Nothing by mouth	☐ Medication reminders
☐ Swabs		☐ Family assists with meds
	TRANFER/ASSIST	
HAIR CARE	☐ Support	**ELIMINATION**
☐ Shampoo	☐ Assist	☐ Check voiding
☐ Comb	☐ Confined to bed	☐ Check bowel movement
	☐ Reposition	☐ Change diaper/pad
	☐ Fall risk	☐ Incontinent of urine
		☐ Foley catheter
		☐ External catheter
SHAVE		☐ Suprapubic catheter
☐ Electric	**EQUIPMENT/SUPPLIES**	☐ Incontinence

☐ Face	☐ Gait belt
☐ Underarm	☐ Walker ☐ Nutritional
☐ Legs	☐ Wound supplies ☐ Cane
	☐ Wheelchair ☐ Hearing Aid

	☐ Bedside commode	**SAFETY**
BEDMAKING	☐ Hospital bed	☐ Side rails
☐ Occupied	☐ Hoyer lift	☐ Pathways clear
☒ Unoccupied		
☐ Linen change		

FOOTCARE	SKIN CARE	TRANSPORT
☐ Clean nails	☐ Lotion	☐ Client Car
☐ Soak feet	☐ Powder	☐ Employee car
☐ Paint nails	☐ Deodorant	☐ Accompany client
	Special instructions	
	Pets ☐ Yes ☒ No	
	Communication:	
	Mental Status	**Physical Status**
	☐ Alert/ Oriented	☐ Ambulatory
	☐ Disoriented	☐ Needs Assistance to walk
	☐ Anxious/ Agitated	☐ Bedfast
	☐ Forgetful	☐ Wheelchair

Employee Signature/Title_____Date:

Life Changes Home Care, LLC

SERVICE REQUEST FORM

Referral Date: **enter referral date**	Referral taken by: **Law, Jeremy**
Referred By:	
Client Name: enter clients name	**Payer Name: Medicaid**
Address: enter clients address	**Address: 615 Howerton Court**
City/State: enter city / state	**City/State/Zip: Jefferson City, MO, 65102-6500**
Zip: enter zip code	**Relationship: Insurance Provider**
Tel # enter clients phone number	**Emergency Status: Full Code**

Client SS# enter client ssn	**Power of Attorney: None**
Medicare #	**Physician Name: Dr. Carol Stanford**
Medicaid # enter clients Medicaid nymber	**MD Tel #:**
Date of Birth: enter clients date of birth	**MD Fax #:**

Services CDS	Days Per Week Enter Number of Days	UNIT Enter Units	☐ **BATHING** ☐ **CLEANING** ☐ **DRESSING** ☐ **LAUNDRY** ☐ **EXERCISING** ☐ **MEAL PREP** ☐ **FEEDING** ☐ **ESCORT** ☐ **GROOMING** ☐ **SHOPPING** ☐ **TOILETING** ☐ **MED ASSIST** ☐ **SKIN/HAIR CARE** ☐ **TRANSFER** *ASSIST ONLY

COMMENTS: Please make sure that your personal care attendant uses spectrum voice technologies to clock in and out for their shifts daily.

HCSS or Provider Agency: Life Changes Home Care, LLC
Contact Name: Nashaunda Evans_
Address: 9504 E 63rd ST Suite 100, Raytown, MO 64133
Telephone: (816)737-9540

Life Changes Home Care, LLC

SERVICE CONSENT FORM

I hereby grant permission to **Life Changes Home Care, LLC** to provide **HOME CARE SERVICES** to:

Client Name:	Enter Client Name	DOB:	Enter Birth Date
Street Address:	Enter Client Address	City/Sate/Zip:	Enter City, State Zip

Personal Assistance Service (Primary Home Care, Community Based Alternatives, Self-Pay)

HIPAA: The Notice of Privacy Practices provides information about how the Agency may use and disclose health information about my care in accordance with new federal privacy regulations. Specifically, the Agency may disclose information regarding my health care to the following family members / caregivers.

I acknowledge that I have received the agency's Notice of Privacy Practices_____

Clients Initials

Authorization is hereby given for the release of any and all medical information from my record, while I was a patient of a hospital, nursing home, private physician or other social services organizational to Life Changes Home Care, LLC It is understood that the exchange of such information is necessary to effect a comprehensive health plan on my behalf.

Living Will

☐ Yes ☐ No

☐ Copy Obtained ☐ Wants to execute one

Medical Durable Power of Attorney

☐ Yes ☐ No

Name/Phone: Enter Name and Number_____

☐This is to certify that I have received the Client Information Handbook that contains the following:

- Facts about Home Care Services
- Statement of Patient Rights and Responsibilities
- Rights of the Elderly (if applicable)
- Attendant Service Information
- Drug Testing Policy
- Home Safety Assessment
- Policy on Abuse, Neglect and Exploitation
- Advanced Medical Directives
- Handling of Complaints
- Emergency Plan
- Disposal Tips / Infection Control
- Guidelines for Identifying and Reporting Victims of Abuse and Neglect
- Other: _____

Client Signature: _____Date: _____

Agency Representative Signature**:** _____Date: _____

Life Changes Home Care, LLC
ADMISSION EVALUATION

Start of Care Date: Enter Date Services Will Start
Client Name: Enter Client Name Caregiver: Enter Care Giver Name
SSN: Enter Client Social D.O.B: Enter Client Birth Date
Address: Enter Client Address
City: Enter City State: Enter State Zip: Enter Zip
Home Phone: Enter Client Phone Number Other Phone: Enter Other #

	ADVANCED DIRECTIVES
	Durable Power of Attorney ☐ Yes ☐ No
Emergency Contact	
Name: Enter Name	Name: Enter Name
Address: Enter Address	Address: Enter Address

City:	Enter City	State/ Zip:	Enter State and Zip	City:	Enter City	State/ Zip:	Enter State and Zip
Home Phone:		Enter Number		Home Phone:		Enter Number	
Relationship:		Enter Number		Relationship:		Enter Number	
May we contact this person: ☐ Yes ☐No				**May we contact this person:** ☐ Yes ☐No			

Emergency contact notified of responsibility: ☐Yes ☐ No
Client's Primary Physician: Enter Physician Name Living will: ☐ Yes ☐ No
Phone: Enter Phone # Location of will: Enter Location

Hospital of Choice Enter	Copy requested:	☐ Yes ☐ No
Hospital Address Enter	Copy received	☐ Yes ☐ No
Hospital Phone Enter	Do not Resuscitate Order	☐ Yes ☐ No
Type of service CDS	Copy in home	☐ Yes ☐ No

Life Changes Home Care, LLC

MEDICATION PROFILE

CLIENT Enter Name PHARMACY _____.
PHYSICIAN_____ADDRESS_
ALLERGIES_____PHONE _____
DOB: Enter Date of Birth HEIGHT: WEIGHT:

Date	**DRUG NAME**	DOSE	FREQ	ROUTE	**(N) New or (C) Change**	**COMMENTS**	**D / C Date**	Signature

Life Changes Home Care, LLC
New Client Processing Checklist

The following is a checklist of items required during processing:

Name Enter Client Name Service Date Enter Date Services Started

Title _____ Department CDS

Type of Ways to Pay (check one)

☐Private Pay
☐Medicaid Assistance
☐Private Insurance Provider
☐Payment Arrangements

Services Applied for (check one)

☐Non-clinical in Home Care
☐Non-clinical Private Duty
☐Skilled Clinical Services
☐Companion Care
☐Independent Contractor

Paperwork to be completed

☐Request for Service/ Inquiry
☐Service Request Form
☐Service Consent Form
☐Admission Evaluation
☐Client Profile 1
☐Client Profile 2
☐Emergency and Contact Info
☐Client Functional Assessment
☐Kansas City Local ID App
☐ 2643A Form MO Tax Withholding Form
☐SS-4 Form
☐MO Unemployment Tax Registration
☐Service Agreement Form
☐Medication Profile
☐Copy of Insurance Card
☐Copy of Social Security Card
☐Copy of Identification

Packets/ Information Given to Client

☐Home Fall Prevention Form
☐Infection Control Considerations
☐Client Handbook