Client Assessment

Hospice Y/N Home Health Y/N Dr. Office/ Home Y/N Placement Y/N Home Care Y/N

Other # _____ Deposit: _____ Rate: _____ SOC: _____

Client Name: _____ **Home #:** _____ **Cell #:** _____

Address: _____ City: _____ Zip Code: _____

DOB: _____ Height: _____ Weight: _____

POA ? : *YES /NO*

Name: _____ Relationship: _____ H#: _____ C#: _____

Address: _____

Emergency Contact: Relationship: H- C-

Emergency Contact: Relationship: H- C-

Private Pay Long Term Care Insurance Name:

Phone#: **Policy #:** **Claim #:**

Referral Name & #:

Diagnosis: Physician's Name & #:

Does client have pets? YES / NO If yes what kind of pets?

Does Client or anyone in the home smoke? Yes/No Is this person a DNR? Yes/No location:

Days & Times Service is Needed:

Sun._____ Mon._____ Tues._____ Wed._____ Thurs._____ Fri._____ Sat._____

Type of Services Needed: **Errands/Transportation Housekeeping Laundry ADL's Bathing Transfers Toileting Meal Preparation Medication "Reminders" Companion Care**

CLIENT'S MOBILITY:

○Ambulatory: ○Independent ○Supervise ○Bed Bound ○W/C Bound

○Ambulatory with Assist: ○Minimum ○Moderate ○Maximum

Assist Devices: ○Cane ○Hoyer Lift ○ Wheel Chair ○Walker ○Gait Belt

ALLERGIES: ○ **NKA**

Medication Allergies: _____ Food Allergies: _____

NUTRITIONAL STATUS:

Appetite: ○Good ○Fair ○Poor ○Special/ Restricted Diet: _____

Nutritional Risk: ○High ○Low ○Moderate ○Aspiration Precautions: *YES / NO*

FUNCTIONAL LIMITATIONS:

○Dentures ○Shortness of Breathe **Bladder**: ○Unable to Control **Bowels:** ○Regular ○Irregular

○Glasses ○Incontinence Care ○Unable to Control

○Hearing Aide ○Skin not intact ○Foyer Catheter ○Colostomy Care

MENTAL STATUS:

○**Oriented:** ○**Behavior Status WNL** ○**Able to Communicate**

○**Disoriented:** ○**Agitated** ○**Depressed** ○**Forgetful** ○**lethargic** ○**Unable to communicate**

Bill Client at Above Address?: ***YES / NO IF NO PLEASE FILL IN INFORMATION BELOW:***

Other Address: _____**City:**_____ **Zip Code:** _____

Phone: _____ **Relationship:** _____

Notes:_____

CLIENT ASSESSMENT NOTES

CLIENT/POA EMAIL ADDRESS:

12630 N 103rd Ave #244 | Sun City, AZ 85351
Office: 623-518-2280 | Fax: 623-518-3297

Credit Card Payment Authorization Form

I, _____, hereby authorize Arizona's Best Home Care to charge my credit card indicated below in the amount of $_____ on the _____ of _____, _____.

(Date) (Month) (Year)

Signature _____ Date _____

Billing Address_____ Phone # _____

City, State, Zip _____ Email _____

Account Type: □ Visa □ MasterCard □ AMEX □ Discover

Cardholder Name: _____

Account Number: _____

Expiration Date: _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

□ Authorization for Arizona's Best Home Care to make recurring charges to my Credit Card listed above on the due date printed on the invoice, and, if necessary, initiate adjustments for any transactions credited/debited in error.

Signature _____ Date _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am the authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated above in this form.

Arizona's Best Home Care
Licensed Bonded & Insured
12630 N 103rd Avenue, Suite 244
Sun City, AZ 85351
Phone: 623-518-2280 Fax: 623-518-3297

Client Service Agreement

Services: I (client or legal representative, herein after called client) agree to use the following services provided by Arizona's Best Home Care (herein after called ABHC), or independent contractors (herein after referred to as IC) at the rate(s) listed below, which may only be cancelled with a minimum of 24 hours notice:

Home Care Service: $ 15.00 /Hour or $225/day for a minimum of _____ hours/visit and or days.

Deposit: ABHC requires a deposit equal to 2 weeks of services paid by check or credit card, which will be applied to the final invoice with any credit balance returned to the client within 30 days of cancellation. Service Deposit of $ _____, paid by ***Check # or CC #***_____.

Billing: Service invoices are processed twice a month and must be paid by check or credit card. A late fee of $5.00/day will accrue on outstanding balances that are 14 days past the due date of the invoice.

Scheduling: Client agrees to provide ABHC a minimum of 24 hour notice for any changes in scheduled service.

Transportation: ABHC does not screen caregivers driving abilities, request written reports from the DMV or verify caregiver's car insurance. Client agrees to hold ABHC harmless and indemnify the provider, ABHC, its caregivers and principals in connection with any liability in the event of an accident in which the client is injured or property is damaged. If client allows caregiver to drive client's vehicle, client agrees to have adequate vehicle insurance that covers third party drivers. There will be a charge, as set forth by IRS, for transportation or errands in the caregiver's vehicle.

Release of Information: The client hereby authorizes direct payment for services to ABHC from an insurance or other third party benefits made on the client's behalf and permits ABHC to release any or all clinical information, including records to these payment sources on their request. Client authorizes ABHC representative's access to medical records for the purpose of providing care, if necessary.

Client Agreement: Client understands that ABHC is a placement agency and workers placed by ABHC may be independent contractors and work for client in an exclusive arrangement with ABHC, requiring that workers not render services for client or any family member independent of ABHC, in any capacity, contracted directly or through another agency. Client must immediately cease all contact with any past or present ABHC worker upon request by ABHC and includes phone calls and visitation. Client must report to ABHC any offer made by any worker to provide service independent of ABHC. I fully understand, hold harmless and indemnify ABHC, its independent contractors, and principals in connection with any liability in the event of injury or damage to myself or property caused by an independent contractor placed by ABHC. If client should breach this contract in any way, client agrees to pay ABHC the amount equal to what ABHC would have profited over 1 year of providing service to client (with a minimum of $5,000.00). If any action at law or in equity is brought to enforce or to interpret the provisions of this agreement, ABHC shall be entitled to recover reasonable attorney fees, including litigation cost, in addition to any other relief to which it may be entitled.

The following signature herby indicates that the above agreement has been read and understood, and agreed upon by all parties involved. The parties hereto agree that facsimile signatures shall be as effective as if originals.

_____ _____
Client or Legal Representative (Signature) **(Date)**

_____
Client or Legal Representative (Print)

_____ _____
Client Name (Print) (ABHC Representative

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Client or Legal Representative (Signature) **(Date)**

_____
Client or Legal Representative (Print)

_____ _____
Client Name (Print) (ABHC Representative