



Thank you for seeking our services for in-home living assistance. We provide referral and placement of home care companions (“Caregivers”) and on-going case management for Care Recipients for the duration of our services.

Services performed by our Caregivers generally include anything within reason to assist with the promotion of a positive quality of life for you or your loved one.

Services for the Care Recipient can include:

- light housekeeping and laundry
- general shopping and running errands
- meal planning, preparation and clean-up
- companionship and conversation
- reading, letter writing
- assistance with entertainment
- visiting neighbors and friends
- clothing selection assistance
- appointment reminders, picking up prescriptions, providing escort to appointments
- providing escort to lunch or dinner
- answering telephone or the door, overseeing home deliveries
- providing medication reminders, assistance with self-administration of medication
- personal care such as assistance with bathing, dressing, grooming, eating
- assistance with ambulation, physical transferring
- other assistance to help cope with the routines of everyday life

We have Registered Nurses available to make home visits.

Enclosed is an agreement between you and our Agency for services which includes our Privacy Policy and Patient/Client Bill of Rights. Please do not hesitate to call us if you have any questions about our services or the enclosed information.

Please fax the signed agreement and signed Predetermined Weekly Caregiving Schedule to us at 954-768-0158. We appreciate this opportunity to prove we are worthy of your trust.

Sincerely,

*Michelle Kain*

Owner and Administrator

FL License #: 30211310 & 229050

Visiting Angels ♦ 900 SE 3<sup>rd</sup> Ave ♦ Ste 205 ♦ Fort Lauderdale ♦ FL ♦ 33316

Local Phone 954-527-8888 ♦ Toll Free Phone 888-527-8882 ♦ Fax 954-768-0158

Website [www.BrowardCaregivers.com](http://www.BrowardCaregivers.com) ♦ Email us at [info@BrowardCaregivers.com](mailto:info@BrowardCaregivers.com)



## CAREGIVER PLACEMENT AGREEMENT

This letter is an agreement between you (our client) and our agency, VABC, Inc. db/a Visiting Angels for caregiver referral, placement and case management services for \_\_\_\_\_ (the "Care Recipient").

**OUR ROLE:** We will refer a caregiver (each and every referred caregiver referred by our agency is hereafter a "Referred Caregiver") to you who will provide home care services ("Services") on a schedule that will be predetermined and agreed upon by you and the Referred Caregiver in consultation with us in advance of each week of service ("Schedule"). In the event that you do not contact us to advise of a change in the Schedule set between you and the Referred Caregiver in advance of any week, we will assume that the Schedule is the same as it was for the most recent week of service. Our assurance to you is that we will, at all times, exert every reasonable effort to have the Care Recipient attended to during this Schedule. We will be available to you by telephone to address any needs or concerns that may arise during the time that a Referred Caregiver is providing Services. Our fee for the Services is earned for the referral and placement of one or more Referred Caregiver(s) and our continued availability to you during the period that any Referred Caregiver provides these Services.

**SERVICES:** We are licensed by the State of Florida Agency for Healthcare Administration as a Nurse Registry and as a Homemaker & Companion Services Agency. We refer and place Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nursing Assistants (CNA), Home Health Aides (HHA), Homemakers and Companions ("Caregivers") in accordance with the rules, regulations and statutes applicable to each of our licenses under Florida law. The Referred Caregiver we refer and place is an independent contractor of our agency.

**Attached to this Agreement are the Patient Bill of Rights and Notice of Privacy Practices.**

**CAREGIVERS & THEIR TASKS:** The tasks provided by our Referred Caregivers are those that are permitted to be performed under the applicable Florida rules, regulations and statutes. We have RN's available to make visits to your home for an additional fee.

**OUR FEES & TERMS OF PAYMENT; DEPOSIT:** Our fees are set and agreed to in advance and are determined by the Services provided and the Schedule. The fees paid to our agency, VABC, Inc. d/b/a Visiting Angels, are called Registry Fees. The Registry Fees are payable to us for each visit/hour/daily/shift/24-hour live-in period that a Referred Caregiver provides Services (make checks payable to "VISITING ANGELS"). **We require a deposit equal to one week of the total amount of services to be provided by a Referred Caregiver as set forth on the Schedule. We reserve the right to require an additional deposit if the number of hours increases during the term Services are provided. Any remaining balance of the deposit will be remitted to you after final payment. Any amount not covered by the deposit will be billed to you and prompt payment of such amount will be expected. We will**

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**require a credit card on file with an authorization to charge that credit card for any Registry Fees that are more than 15 days past due.**

**INVOICES; FEE INCREASES AND BILLING:** You will be invoiced weekly and payment will be due upon receipt. Late fees of 1.5% per month on any unpaid balance will be assessed if not paid within 15 days of the due date and Services may be terminated for non-payment. You agree that if our fees are not timely paid we have the right to charge the credit card on file for these fees without any further written approval by you. In the event that you wish to reduce or otherwise change the number of hours/shifts/days to be worked by the Referred Caregiver on the Schedule for a given week, you must contact us at least 48 hours in advance of any day for which you wish to change the Schedule. In the event that you change the Schedule or terminate Services as described below without contacting us at least 48 hours in advance (other than during the trial week as described below), you will be billed for the full amount of the Schedule. In the event that a Referred Caregiver fails to arrive at your home and/or the home of the Care Recipient or alters the Schedule in some way, we will adjust the amount that you are billed accordingly.

**HOLIDAYS:** The Registry Fees are all-inclusive (excluding auto expenses if the Referred Caregiver uses her/his own vehicle) with the exception of the following paid holidays: Referred Caregivers will be off on each of Easter, Memorial Day, the 4th of July, Labor Day, Thanksgiving, Christmas Eve (after 5:00 PM), Christmas Day, New Year's Eve (after 5:00 PM) and New Year's Day unless you/Care Recipient arrange otherwise directly with the Referred Caregiver(s) with advance notice to us. If you require that we fill in on any of those seven (7) holidays with our on-going Referred Caregiver or with substitute personnel referred by us (for which we will make reasonable efforts to place but cannot assure) upon the Referred Caregiver's request, you agree to pay us an additional 50% per hour or, in the case of a live-in Referred Caregiver, one and one-half times the current daily Registry Fee.

**RELATIONSHIPS:** The Referred Caregiver is an independent contractor of our agency as required by law. You hereby release VABC, Inc. d/b/a Visiting Angels from liability and responsibility for any events that may be harmful to the Care Recipient in the course of receiving services from the Referred Caregiver, including but not limited to any harm to property and/or persons and third parties that may result from the Referred Caregiver's use of the Client/Care Recipient's vehicle or Referred Caregiver's vehicle in the course of receiving Services from the Referred Caregiver. You agree to maintain homeowner's insurance, medical insurance, automobile insurance and/or other insurance as necessary to provide protection for the Care Recipient and third parties. You agree that you will abstain and you will cause others related or affiliated with you to abstain from directly or indirectly making or accepting any offers whereby any of the Referred Caregiver(s) would provide any services other than as sanctioned by us, whether or not you still have an ongoing relationship with us, for a period of two (2) years following the date that the final Registry Fees are paid in full.

**TRIAL PERIOD; NOTICE OF TERMINATION; FINDER'S FEE:** The first week a Referred Caregiver provides service is a trial week and cannot be terminated unless you contact us no less than 48 hours **in advance of the commencement** of Services for the first week. Subsequent to the trial

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week, this Agreement remains in effect until you provide us with at least 48 hours advance notice of termination. We will require the same notice of termination under all circumstances. If Services are terminated for any reason, either by you, the Care Recipient or us, the Referred Caregiver will no longer be able to provide Services to you and/or the Care Recipient as of the date of termination. As set forth above, you will abstain and you will cause others related or affiliated with you to abstain from directly or indirectly making or accepting any offers whereby any Referred Caregivers/personnel we have referred to you would continue to provide Services following any such termination for a period of two (2) years following the date that the final Registry Fees are paid in full. You agree that if you breach this provision of the Agreement you will pay us \$5,000 as a finder's fee for such breach as consideration for the time, effort and money spent by us to recruit, screen and orient the Referred Caregivers/personnel. Any claim or dispute arising out of, connected with, or in any way related to this Agreement which results in litigation shall be solely in the federal or state courts for Broward County, Florida, and you consent to the personal jurisdiction of and venue in such courts without objection. You agree to pay our attorney's fees and related costs to collect our fees whether or not a lawsuit is filed. The invalidity or unenforceability of any term, phrase, clause, paragraph, restriction, covenant, agreement or other provision of this Agreement shall in no way affect the validity or enforcement of any other provision or any part thereof.

Once again, we thank you for your trust, and we assure you of our best effort at all times.

\_\_\_\_\_ Date: \_\_\_\_\_  
For VABC, Inc. d/b/a Visiting Angels

Client: \_\_\_\_\_ Date: \_\_\_\_\_

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## Schedule A

### Notice of Privacy Practices

**This notice describes how medical information about Care Recipient may be used and disclosed and how Care Recipient can get access to this information. Please review it carefully.**

Medical information, including health history, is collected from the Client/Care Recipient upon initiation and subsequent visits, and is then stored in the clients file.

- Medical information will be used in the assessment of the Care Recipient's condition and the need for health care or referral purposes.
- Some of the medical information will be transferred to a computer program for the purposes of retrieval, storage, billing and payment purposes.
- Medical information may be disclosed to health and disability insurers for the purpose of payment or reimbursement of services.
- The medical information contained in the medical record will be stored by Visiting Angels for a period of no less than six (6) years (or longer if state law mandates a longer period of record keeping).

Health care providers, for the purpose of referral, consultation or coordination of health care include:

- Health care insurers
- Disability insurers
- Business Associates
- Persons responsible for Care Recipient's health care, such as a parent or nurse
- Billing organizations
- Collection agencies

Law enforcement officials or agencies include:

- Correctional institutions
- Public Health authorities
- Research institutes
- Family members
- Workers' compensation insurers or state agency, if applicable

Examples of health care information use and disclosure include:

- For the purpose of diagnosis, assessment, referral, and/or treatment
- For the purpose of payment by a third party, such as a health insurer
- For the purpose of day to day health care operations
- Appointment reminder notices or messages

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## Schedule B Patient's/Client's Bill of Rights

- You have the right to report abuse, neglect or exploitation by calling the State of Florida toll-free abuse hotline at 1-800-962-2873.
- To report a complaint about the services you receive, please call (888) 419-3456.
- You have the right to report suspected Medicaid fraud. **To report suspected Medicaid Fraud by phone, please call toll-free 1-866-966-7226.** *Medicaid Fraud* means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit 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. The office of the Inspector General at the Agency for Health Care Administration accepts complaints regarding suspected fraud and abuse in the Florida Medicaid system by phone at 1-888-418-3456 or on the Agency website at [http://ahca.myflorida.com/Executive/Inspector\\_General/medicaid.shtml](http://ahca.myflorida.com/Executive/Inspector_General/medicaid.shtml)
- You have the right to receive care without condition or discrimination based on the execution of advance directives and to know that we will comply with your advance directives in accordance with Florida State Law including decisions to withhold resuscitation.
- You have the right to know that we will not refuse service to any patient or client because of age, race, color sex or national origin pursuant to Chapter 760, F.S.
- If you are receiving care by a licensed nurse under a medical plan of treatment, you have the right to be informed of, participate in and, if requested, have a copy of the medical plan of treatment.
- If you are not receiving care by a licensed nurse, be advised that registered nurses are available to make visits to the patient's home for an additional cost.
- You have the right to receive considerate and respectful care in the home.
- You have the right to have your property treated with respect.
- You have the right to voice grievances regarding treatment or care that is furnished, or regarding the lack of respect for property, without fear of discrimination or reprisal for doing so and to know that the agency will investigate any complaint. You have the right to report a complaint regarding the service you receive by calling the State of Florida toll-free hotline at 1-888-419-3456
- You have the right to be fully informed in advance and in writing about the care to be provided.
- You have the right to refuse care and services.
- You have the right to receive information about our policies and procedures.
- You have the right to request a change of caregiver.
- You have the right to confidentiality of client/patient records and information.
- You have the right to privacy.

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- You have the right to be fully informed regarding costs, orally and in writing, before care begins and to know that Medicare does not cover the charges for the services of the Caregiver or Visiting Angels.
- You have the right to know the agency maintains liability insurance coverage.
- You have the right to be informed of these rights, in writing, before care begins.

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## Client/Care Recipient Information

Care Recipient(s) \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_  
Street
City
State
Zip

Care Recipient Phone \_\_\_\_\_ D.O.B. \_\_\_\_\_ Start of Service \_\_\_\_\_

Client/Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work Phone \_\_\_\_\_

Power of Attorney  Yes (attach signed copy)  No

Other Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street
City
State
Zip

Medical Condition \_\_\_\_\_

Alzheimer's, dementia or other related disorders \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street
City
State
Zip

Specialist Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street
City
State
Zip

Special Diet / Food Allergies \_\_\_\_\_

Medication Reminder \_\_\_\_\_ Medication Allergies \_\_\_\_\_

Any Special Needs \_\_\_\_\_ Vision and/or Hearing Impairment \_\_\_\_\_

Advance Directives  Yes (attach signed copy)  No      Pets  Yes  No

Other Services / Special Instructions \_\_\_\_\_

**Schedule:**

\_\_\_\_\_ // \_\_\_\_\_ // \_\_\_\_\_ // \_\_\_\_\_ // \_\_\_\_\_ // \_\_\_\_\_ // \_\_\_\_\_  
**Monday      Tuesday      Wednesday      Thursday      Friday      Saturday      Sunday**

The above describes the duties I would like the Caregiver to perform.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

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