CLIENT SERVICES AGREEMENT

Client		**Date**
Last Name	First Name	Middle Initial
Address		
City	State	Zip
Telephone	Alternate Telephone	E-Mail

Contact (if different than Client)		
Last Name	First Name	Middle Initial
Relationship to Care Recipient		
Address		
City	State	Zip
Telephone	Alternate Telephone	E-Mail
Do you have power of attorney for the Care Recipient? □ Yes □ No Are you the Care Recipient's legally appointed guardian? □ Yes □ No		

Mercy Home Health Care is hereinafter referred to as the Agency.

Nature of the Agency Home Care Services: The duties of our Agency's caregivers may include but are not limited to the following: reminding Client to take medications, assisting with basic personal care and ambulation, providing companionship, and performing care-related light housekeeping tasks, e.g. tidying rooms in which Client spends time, tidying bathrooms after Client's use, and washing Client's dishes or laundry. Care-related housekeeping tasks do not include cleaning services for the general household, such as scrubbing floors, vacuuming, washing windows, dusting behind and under furniture, cleaning drapes or blinds, and washing laundry for members of the household other than Client. The Agency will provide personal care services under the supervision of a registered nurse (RN). The Agency will provide skilled services under the direct supervision of a director of skilled services who is a physician licensed by the Virginia Board of Medicine or a registered nurse. The Agency and its caregivers do not practice medicine, and make no recommendations concerning diagnosis, prognosis, treatment, medication, prescriptions, or other medical or health related services.

Emergency Procedures: The Agency is not an emergency care service. In emergencies, the caregiver will call 911 (unless DNR in place) and then will contact the Agency. The Agency will then contact the Contact stated at the beginning of this Agreement or, in the absence of a Contact other than Client, Client is next of kin.

Services to be Provided; Payment. Client authorizes our Agency to provide the services stated on the attached Schedule of Services and Fees.Client shall pay for such services in accordance with the Schedule of Services and Fees and this Agreement.

Client Must Submit for Third Party Payment. If Client is eligible for benefits from any third-party payor, such as insurance, Client must pay the Agency as stated in this Agreement and then seek reimbursement from the third-party payor. We will not submit claims to third party payors on Client's behalf.However, upon request, we will provide copies of timesheets and daily logs to Client to assist Client in Client's submission of claims to a third-party payor. Client acknowledges that the Agency has not given any assurance that any third-party payor will pay for the services it provides to Client.

Changing Services or Schedule. In the event Client wishes to alter the time or date of services during a single week, Client must notify the Agency of the requested change at **least twenty-four (24) hours** prior to the time the service is regularly scheduled to begin.Notice given to a caregiver and not to the Agency is not considered notice to the Agency.If Client does not provide the required 24-hour notice, Client must pay for the full scheduled hours.

To change the weekly schedule during more than a single week, Client must notify the Agency at least **seven (7) calendar days** prior to the week Client wants the new schedule to begin.Notice given to a caregiver and not to The Agency is not considered notice to the Agency.

In the event that the Agency agrees to the proposed change to the schedule of services, the Agency shall document the new schedule and the documentation will become a part of this Client Services Agreement upon Client's acceptance of the requested services.Client understands that any change in services requested and performed may result in increased fees. Client shall pay for the increased fees in the same manner as for the other payments due under this Client Services Agreement.

Changing Rates. The rates stated in the Schedule of Services and Fees may be changed from time to time by the Agency, giving Client at least **thirty (30) calendar days** prior to a written notice of the change.

Billing; Payment; Collection; Interest. >>>☐**USPS**☐**EMAIL** EMAIL ADDRESS:

Invoices will be sent to Client bi-weekly. Client shall pay the amount of an invoice **within ten (10) calendar** days after the date of the invoice. Any unpaid balance not paid within that ten (10) calendar day period shall accrue interest at the rate of 1.5% per month. Client shall reimburse the Agency for any fee charged by a bank due to insufficiency of check submitted to the Agency for payment. In the event the Agency is required to take action to collect any amounts due under this Agreement, Client shall pay the Agency's reasonable attorney fees and costs incurred in collecting those amounts.

Deposits. The Agency requires a deposit equal to the cost of **one (1) week** of service. An additional deposit amount may be required if Client later requests an increase in the services provided.This money will be held by the Agency and applied to any outstanding balance on the final invoice after termination of services. Any balance remaining after all outstanding invoices have been paid in full will be refunded.

Refund to Client. The Agency will return any payment received in excess of the amount due, regardless of whose error it was and regardless of who made the inadvertent payment within **thirty (30) business days** of discovery.

Notice of Termination; Trial Period. Prior to the start of service or within the first week of service, this Agreement may be terminated by the Client or The Agency for any reason with no requirement of advance notice. Subsequent to the first week, this Agreement shall remain in effect until either party gives the other not less than **seven (7) calendar** days prior written notice of termination. Such prior written notice is required under all circumstances, excluding hospitalization and/or death of the care recipient.The Agency may terminate services without such prior written notice if Client fails to pay for services as required by this Agreement and his/her account is more than **fourteen (14) calendar days** in arrears or if the health and safety of the Agency'scaregiver is at risk.

Hiring the Agency's Employees. Client shall not employ or receive services from the employee(s) assigned to Client by the Agency except as contemplated by this Agreement for a period of two (2) years following the last day the employee(s) rendered services to Client on behalf of the Agency pursuant to this Agreement.This prohibition includes but is not limited to:

1. Paying the caregiver directly for services during the caregiver's employment with the Agency;
2. Paying the caregiver directly for services after the caregiver's employment with the Agency is terminated;
3. Paying another agency, person, or entity for services provided by the caregiver after the caregiver's employment with the Agency is terminated; and,
4. Accepting services from the caregiver while the caregiver is employed by another agency or entity.

In the event that Client violates this condition, Client shall pay the greater of the following: $10,000.00 or 30% of yearly annual billing for each such employee to the Agency as liquidated damages and any reasonable attorney's fees and costs associated with collecting those liquidated damages. This amount reflects the costs of recruiting, screening, and training the employee(s). In addition to this remedy, the Agency shall be entitled to obtain injunctive relief against any violation of this Agreement, without notice to Client, without the necessity of proving actual damages and without posting a bond. These remedies shall be cumulative and not mutually exclusive.The Agency reserves the right to pursue any other or further remedies at law or in equity to enforce its rights under this agreement.

Transportation. No caregiver shall operate a vehicle to provide transportation for Client without prior written authorization from the Agency, regardless who owns the vehicle. Client shall pay the mileage fee stated in the attached Schedule of Services and Rates for transportation provided by the Agency's caregivers.Client acknowledges that the Agency's insurance covers loss or damage caused by caregivers' operation of any vehicle only after Client's insurance coverage is exhausted, and Client shall be primarily responsible for any and all claims, related to caregivers' operation of a vehicle to transport Client.

Securing Property. Client shall secure all cash and valuables in a secure place (such as a safe) or remove them from Client's premises. The Agency's caregivers shall be bonded, and Client shall file a police report in the event that any cash or valuable is found to be missing from Client's premises.In addition, Client shall maintain insurance coverage for the theft or loss of cash or valuables.

Jurisdiction & Venue. If it is necessary to litigate a dispute arising out of or relating to this agreement, Client agrees to jurisdiction in the State of Virginia.

Entire Agreement & Severability. This agreement contains the entire understanding of the parties regarding the subject matter of this agreement, and supersedes all prior and contemporaneous negotiations and agreements, whether written or oral, between the parties with respect to the subject matter of this agreement.If a provision of this agreement is determined to be unenforceable in any respect, the enforceability of the provision in any other respect and of the remaining provisions of this agreement will not be impaired.

Release of Liability: Client hereby releases the Agency from liability for any act of the Agency's caregiver that arises from the provision of services to Client pursuant to this Agreement, including those acts or omissions that arise from a caregiver's negligence. Client shall maintain homeowner's insurance, medical insurance and/or other coverage as may be necessary to provide protection for Client.

AGREED AND ACCEPTED

_____ _____

Signature of Client or Legal Representative Date

Note: *If you sign this Client Services Agreement on behalf of the Client, a copy of* ***the Power of Attorney or court order*** *appointing you as the Client's legal guardian must be attached to this Agreement.*

THE AGENCY: Mercy Home Health Care

_____ _____

Signature of Mercy Home Health Representative Date

FINANCIALLY RESPONSIBLE PARTY

Financially Responsible Party			**Date**
Last Name	First Name		Middle Initial
Address			
City		State	Zip
Telephone	Alternate Telephone	E-Mail	

By signing below, I, the above identified Financially Responsible Party, agrees to pay for any and all charges for services the Agency provides to the Client pursuant to this Client Services Agreement and the attached Schedule of Services and Rates, as both may be amended from time to time.

_____ _____

Signature of Responsible Party Date

SCHEDULE OF SERVICES AND FEES

This Schedule of Services and Fees is part of the Client Services Agreement between Client and the Agency dated the same date as this Schedule.

Services will be provided for:

Customer Name: _____

At (Address, City, State, Zip Code): _____

Beginning Date of Services: _____

Such services will be delivered based on a written plan of services developed by a registered nurse, in collaboration with the client and client's family. The plan is part of the client admission package and shall include at least the following:

- Assessment of the client's needs;
- Functional limitations of the client;
- Activities permitted;
- Special dietary needs;
- Specific personal care services to be performed; and
- Frequency of service

The plan is retained in the client's record. Copies of the plan will be provided to the client receiving services and reviewed with the assigned home attendant prior to delivering services.

The Agency will provide the following services the days and times stated below:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Rates: The rates for services are:

RATE		**TOTAL**	**LEVEL ONE**
1 hour	$55.00	$55.00	Feed
2 hours	$38.00	$76.00	Bath/Shower/Sponge
3 hours	$30.00	$90.00	Dress/Groom
4 hours	$25.00	$100.00	Ambulation with Cane/Walker
8 hours	$23.13	$185.04	Mild Dementia
12 hours	$22.50	$270.00	Toileting Urine Incontinence Fall Risk
RATE		**TOTAL**	**LEVEL TWO**
1 hour	$60.00	$60.00	Feeding Tube
2 hours	$40.00	$80.00	Wheelchair/Scooter
3 hours	$35.00	$105.00	Transfer/ Hoyer Lift Stool Incontinence
4 hours	$27.00	$108.00	Colostomy
8 hours	$26.25	$210.00	Advanced Dementia
12 hours	$25.00	$300.00	Wound Care Bedbound

Minimum Charge: A minimum charge of 4 hours per visit will be charged.

Weekend Rate: The weekend rate begins on Saturday at 12:00a.m. and ends on Sunday 11:59 p.m. Any service that begins during that period will be charged at the weekend rate.

Holiday Rate: The holiday rate is one-and-one-half times the weekday rate and will be charged for the company's holidays listed below. The holiday rate begins at 12:00 a.m. and ends at 11:59p.m.on the holidays listed below. Any service that begins during that period will be charged at the holiday rate. The Agency' holidays are:

- New Year Day
- Memorial Day
- July 4th
- Labor Day
- Thanksgiving
- Christmas

Overtime Rate: The overtime rate is one-and-one half the weekday rate and is charged for any hours worked over 40 hours in a workweek Monday through Sunday by a caregiver if the caregiver is not legally exempt from overtime pay. The Agency will not schedule any caregiver for more than forty (40) hours in a workweek without prior consent of the Client or Client's representative.

Cancellations; Refusal of Service: A full day of scheduled hours at the applicable rate will be charged if a cancellation is received less than 24 hours prior to the time scheduled for the caregiver to arrive at Client's residence. Any cancellation in service must be communicated by telephone to the Agency office at or at a provided cell phone number. A full day of scheduled hours also will be charged if Client refuses service or is not at his/her residence when the caregiver arrives to provide service.

DEPOSIT AMOUNT:

CHECK NUMBER:

_____ _____
Signature of Client or Legal Representative Date

Mercy Home Health Care

BY: _____ _____
Date

Payments should be submitted to the following Agency's address:

Name: Mercy Home Health Care

Address: 15608 William Baylis Ct, Woodbridge VA, 22191

I authorize the Agency to conduct direct debit_____
Signature of Client or Legal Representative

Provide **VOID** check and designate if it is checking or saving account or fill out below

Routing #: _____

Bank Account # _____

Account type - □ checking □ saving □ other _____ (specify)