JEWISH TRADITION HOME CARE

ADMISSION AGREEMENT FORM

CLIENT NAME: ______________________________ MEDICAL RECORD #:______

---

(1) ADMISSION:

Jewish Tradition Home Care (the Agency) has agreed to admit you (the Client) for private duty home health services. In consideration of the Client's agreement to pay for services as described below, the Agency will provide the following:

Billing Rate: (Hourly) (Live-In) (Mileage)

Billing is every two weeks. There is no mileage charge for HHA to drive client's vehicle.

Home Health Aide (HHA) service hours:

Method of Payment: Insurance________ Private Payment_______

Bill To:

Name: ____________________________________
Address: __________________________________
____
Phone #: __________________________________
E-mail: ___________________________________
Policy #: (if applicable) ______________________

Frequency of RN Supervisory Visits: 2______ 6______ months and as needed.

---

(2) ADDITIONAL CHARGES:

- There is a minimum charge of (4) four hours for services provided hourly.
  - When Holiday pay is in effect the holidays will be:
    New Years Day, President's Day, Memorial Day, July 4th, Labor Day, Thanksgiving and Christmas.
- Care for more than one person shall be charged at a higher rate per hour/day.
- I understand that from time to time rates may change. I understand that I will be notified of this change by the Agency.
- I understand that HHA's who live-in MUST be permitted to sleep eight (8) hours of uninterrupted sleep each night. If Live-In workers are not able to sleep at night the Agency will charge on an hourly basis. (Except in EMERGENCY situations)

Initials: ________

(3) CHANGES IN SERVICE:

- Changes in the services provided by the Agency require advance notice of at least twenty-four (24) hours. Although I have the right to refuse service at any time, if notice of change is not provided twenty-four (24) hours in advance for services to be refused / cancelled, regardless of the circumstances, the Agency will charge for such services until twenty-four (24) hours notice has been received.
- If the client is admitted to the hospital or other institution for longer than 24 hours, the Agency may be unable to provide services upon discharge.

(4) RESPONSIBILITIES OF CLIENTS WHO CAN CARE FOR THEMSELVES AND/ OR PRIMARY CAREGIVERS:

I, __________________ (Name of client), understand that the staff of the Agency completed an evaluation and determined that it is likely that I can meet all of my own needs when not receiving services from the Agency.

OR

I, ____________________ (Name of client), understand that the staff of the Agency completed an evaluation and determined that it is unlikely that I can meet all of my own needs when not receiving services from the Agency. I understand that I must have volunteer or paid caregivers who can meet my needs when not receiving services from the Agency.

The name(s) of my primary caregiver(s) is/are as follows:

Name :

____

My primary caregiver(s) and I understand that our responsibilities may change from time to time.
I/we agree in advance to fulfill such responsibilities as they may change.

(5) UNAVAILABILITY OF STAFF:

- If Agency staff members are unable to provide services as scheduled, I/we understand that I/we are responsible to provide/arrange for care as needed by me/the client.

(6) DISCONTINUATION OF SERVICES:

- I/we understand and agree that if I/we fail to fulfill my/our responsibilities, services may be discontinued at the sole discretion of the Agency.
- If the Agency determines, in its' sole discretion, that services must be discontinued to the patient for any reason, I/we agree to promptly assist the client to make alternative arrangements for care.
- If I/we decide to discontinue services from the Agency, I will give at least twenty-four (24) hours advance notice to the Agency.

Initials: ________

(7)__EMPLOYEE RECRUITMENT PENALTY:

- For a period of six (6) months from the date of termination of this agreement, I agree that I will not hire, contract, add/or receive services from an individual who provided services to me on behalf of the Agency. If I violate this provision, I hereby agree to pay the Agency the sum of ten thousand dollars ($10,000) immediately upon written demand.
- My signature(s) below are evidence of our agreement to fulfill the responsibilities included in this section of the Admission Agreement.

(8)_PHOTOGRAPHS:

- I hereby consent to the taking of photographs.

(9)__INSURANCE INFORMATION:

- The agency will submit claims to or bill insurance companies and other payors for these services AT ITS' SOLE DISCRETION.
- Clients and/or their legally authorized representatives are responsible for payment of all invoices from the Agency.
- If the Agency bills insurers at its' sole discretion, I hereby assign, transfer, and convey any and all rights to the payment and authorize said payments to be made directly to the Agency.
- I also consent to the release of any and all information that may be required by insurers.

(10)__AGREEMENT TO SIGN TIME RECORDS AND TO PAY FOR SERVICES:

- I agree to pay for services provided by the Agency.
- At the end of each week, and/or at the completion of each assignment, I will be presented with a record of time spent in the provision of services by staff of the Agency. My designee or I will sign the record.
- I agree to pay in full for services immediately upon receipt of invoices from the Agency. ALL PAYMENTS MUST BE SENT TO JEWISH TRADITION HOME CARE 5701 North Pine Island Rd., Suite #301, Tamarac, FL 33321.
- I understand and agree that services will be immediately discontinued and no further services will be provided if I fail to pay any amount due to the Agency.
- I further agree to pay all costs of collection and legal representation, including court costs and or costs associated with arbitration/mediation, incurred by the Agency. I also agree to pay interest to the agency at the maximum amount allowed by law. I hereby consent to the jurisdiction of the courts of Broward County Florida.
- I also agree to participate in mediation of any all disputes that may arise in connection with this Agreement and/or services rendered at the sole discretion of the Agency.
- I also agree to pay for all emergency services, i.e.: 911 calls.

(11) ADVANCED DIRECTIVES:

The client has the following advance directive(s):

1) Living will: yes_____ no_____ On File: yes_____ no_____

2) Health Care Surrogate: yes_____ no_____ On File: yes_____ no_____

Name: _________________________________

3) Do Not Resuscitate (DNR) Order: yes_____ no_____ On File: yes_____ no_____

4) Power of Attorney: yes_____ no_____ On File: yes_____ no______

Name:_________________________________

I agree to provide copies of any and all advance directives to the Agency. I understand that the Agency cannot honor advance directives unless I provide the Agency with copies of them.

(12) LEGAL DISCLAIMERS:

- I hereby authorize the Agency or any credit or investigation bureau utilized by the Agency to obtain any and all information requested by the Agency from any other person regarding my credit, employment, insurance coverage, or finances.

- The terms of this Agreement supersede the terms of any prior agreements between the parties, whether oral or in writing. This agreement is binding upon my heirs, executors, administrators, and assigns. Modifications to this agreement may be made only in writing signed by both parties. This Agreement shall be interpreted in accordance with the laws of the State of Florida.

- The signature(s) below acknowledge receipt of the Statement of Patient Rights and Responsibilities, Policy for Patient Comments/Complaints, Scope of Services and Visit Plan, 911 Emergency/Abuse Hotline/Complaint Hotline, Complaint form, Emergency Preparedness Information, Medication Information, Basic Home Safety Information, and Infection Control in the Home and community Resources Guide. All of my questions regarding these documents have been answered by Agency staff.

Patient Signature	Print	Date
Authorized Representative	Print	Date
Relationship to client		
Primary Caregiver, if different From Legally Authorized Representative	Print	Date
JTHC Representative Signature	Print	Date

Initials: ________