

EMPLOYEE: Leave original with client after faxing.
FAX TO 404-233-8098 (out of metro Atlanta area - 1-800-989-8098)
 Alternate FAX #: 404-261-3463



IMPORTANT INSTRUCTIONS - FAX ALL ADDITIONAL FORMS ALSO
 Each employee is responsible for copying a new individual weekly Home Care Note/Time Slip Sheet from the Master Home Care Plan as established by the Always Care (AC) RN Supervisor, which is left on the case. You must follow the Plan as written, and Chart Task Performed/Observed. If there is no plan yet established, check the appropriate boxes (or write in if necessary) the Task/Observation that you are asked/decide to Perform/Observe. If additional narrative notes are needed use Form #1073 "Home Care Notes Continues". RNs & LPNs, if additional Medications are given, use Form #1074 "Home Care Notes - Medications". Write with ball point pen on hard surface. Make sure all copies are legible/readable.

HOME CARE PLAN		YEAR	HOME CARE NOTES						
Chart and/or Perform Task and/or Observation, Noted in Left Column		___	SAT	SUN	MON	TUE	WED	THU	FRI
		DAY	MONTH / DATE						
<input type="checkbox"/>	APPETITE (G=good F=fair P=poor)								
<input type="checkbox"/>	PREPARE & SERVE MEALS								
<input type="checkbox"/>	SHOPPING FOR PT'S NEEDS								
<input type="checkbox"/>	INTAKE (Measure cc's-fluids)								
<input type="checkbox"/>	ELIMINATION (Urine)								
<input type="checkbox"/>	ELIMINATION (BM)								
<input type="checkbox"/>	BATH								
<input type="checkbox"/>	CLEAN PT'S BEDROOM & BATHROOM								
<input type="checkbox"/>	PT'S LAUNDRY								
<input type="checkbox"/>	PHYSICAL CONDITION (S=stable U=unstable)								
<input type="checkbox"/>	MENTAL CONDITION (N=normal D=depressed C=confused)								
<input type="checkbox"/>	ACTIVITIES AND DAILY ROUTINE								
<input type="checkbox"/>									
<input type="checkbox"/>									
<input type="checkbox"/>									
<input type="checkbox"/>									
<input type="checkbox"/>									
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<input type="checkbox"/>									
<input type="checkbox"/>	MEDICATIONS (see attached sheet) RN's & LPN'S Only!								

Remarks by _____
 Employee _____

OFFICE: (1) Photocopy Fax Received.(2) Then Check Client File (W) on it.
 (3) Then Check P.R. Copy (Y) on Photocopy just made. Distribute.

SUPERVISOR REVIEW	DATE	INITIALS	<input type="checkbox"/> RN <input type="checkbox"/> LPN
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HOME CARE - TIME SLIP

CLIENT NAME _____ CLIENT # _____

ADDRESS _____ CITY _____

TIME SLIPS ARE DUE IN ALWAYS CARE OFFICE BY 10:00AM THE MONDAY AFTER EACH FRIDAY WEEK ENDING DATE IN WHICH WORK WAS PERFORMED.

USE NEAREST QUARTER HOUR									
D A Y	DATE WORKED	TIME STARTED	am pm	TIME FINISHED	am pm	REG. HOURS	O.T. HOURS	DAYS LIVE IN	Trans/Day or Miles or Expenses
1									
2									
3									
4									
5									
6									
7									
Week Ending Date FRIDAY		TOTAL HOURS FOR WEEK TO NEAREST ¼ HOUR ▶							

EMPLOYEE: I certify that the hours shown above are true and accurate and were worked by me during the days in the indicated week and were properly certified by the client or client's representative at the bottom hereof. I also certify that I did not receive any injuries during this assignment. I understand that I am to contact immediately the local ALWAYS CARE office after completing the assignment to determine if there is further employment for me. I agree that if I do not contact ALWAYS CARE immediately upon completion of an assignment, ALWAYS CARE can assume that I am not available for employment and this will be considered to be a break in my employment and my resignation. All employees working home care cases are required to submit completed Home Care Notes along with Time Slip. Pay will be held if notes are not completed properly. In the case of a live-in situation, I agree that I will not work more than 8 hours in a 24-hour period nor more than 40 hours in a 7-day period without the written permission of ALWAYS CARE. Time Slips must be signed by both employee and client. Employees pay will be held until signatures are provided. This shall be the responsibility of the employee.

EMPLOYEE NAME _____
 PRINTED (CLEARLY) _____
Last, First, Middle Initial

Employee Classification _____ Employee Number _____

EMPLOYEE SIGNATURE **X** _____

CLIENT: In the case of a live-in situation, it is understood and agreed that, unless otherwise indicated above, the client will not require any ALWAYS CARE employee to work more than eight hours in any consecutive 24-hour period nor more than 40 hours in any consecutive 7-day period, unless prior written approval is obtained from ALWAYS CARE. Appropriate adjustments will be made in the charges for such excess hours. I certify that the ALWAYS CARE EMPLOYEE worked the hours indicated above and that the work was performed in a satisfactory manner. The client's exclusive remedy and ALWAYS CARE's sole liability for claims of any kind or nature as to the services rendered by the employee shall be limited to the amount of compensation to be paid ALWAYS CARE. Failure to give written notice of claim within 15 days after occurrence shall constitute a waiver by client. Client shall not authorize or cause ALWAYS CARE employees to operate any vehicle or machinery without first obtaining written consent from ALWAYS CARE. It is acknowledged, understood and agreed that insurance furnished by ALWAYS CARE does not cover physical loss or damage caused by the operation of anyone's vehicle or machinery. The client shall not entrust ALWAYS CARE employees with the handling of cash, jewelry or anything of value, or entrust them to be responsible for such valuables without first obtaining written permission from ALWAYS CARE. We also agree that ALWAYS CARE will not be responsible for claims made under ALWAYS CARE's liability bond unless we report such claims in writing to ALWAYS CARE within ten days from the last day of service rendered under this agreement and we agree to cooperate fully in the investigation and subsequent prosecution. No oral statement of any person shall modify or otherwise affect the above terms and conditions. In consideration of furnishing the ALWAYS CARE employee, the client/patient agrees that it shall not either directly or indirectly employ any ALWAYS CARE employee for a period of Ninety-two (92) days following the completion of services rendered to the client/patient. In the event that the client/patient violates the above condition, the client/patient will pay to ALWAYS CARE upon demand the sum of \$5,000.00 per employee, as a finders fee plus any attorneys' fees and all the costs of collection if necessary. The client agrees to pay for the services immediately upon receipt of an invoice for such services and to pay interest on the unpaid balance of any such invoice over 30 days old at the rate of 1.75% per month (ANNUAL PERCENTAGE RATE OF 21%), or the legal maximum interest rate, whichever is lower, together with reasonable attorney's fees plus all costs of collection.

FEEES: Are subject to change without notice. It is agreed that all fees for service will be billed at the prevailing rate for the level of service provided. The local ALWAYS CARE office can advise of the exact fee schedule.

CLIENT: WRITE TOTAL HOURS IN WORDS ▶ _____

CLIENT SHALL NOT PAY OR ADVANCE ANY MONEY TO EMPLOYEE AND MAY NOT ASSERT ANY SUCH PAYMENT AS A SETOFF AGAINST ALWAYS CARE.

AUTHORIZED CLIENT SIGNATURE **X** _____