CAREGIVER – HOMEMAKER – CLIENT – WORKSHEET
MASTER CONTRACT FOR CAREGIVER SERVICES

Caregiver's Name #: _____ Start of Care Date _____, 20_____
Position: CNA / HHA ☐ Companion/HM ☐ Weekending Date: _____, 20_____
Referred By: **The Community Network, a division of SCG FamilyCare** Florida License Nos.: **NR30210982**

Address: 300 S. Pine Island Rd #308 Plantation, FL 33324 Phone: (954) 382-1932 Fax: (954) 382-3882
Email: communitynetworkplantation@gmail.com
Website: thecommunitynetwork.us

Client/Patient Name _____

Client/Patient Address _____

CAREGIVER & CLIENT AGREE TO THE FOLLOWING CONTRACT TERMS:

SERVICES TO BE PERFORMED	SUN	MON	TUE	WED	THUR	FRI	SAT	TOTAL
DATE:								
STARTING TIME:								
FINISHING TIME:								
TOTAL:								
BED/SPONGE/BATH/TUB/SHOWER								
HAIR CARE/SHAMPOO								
PERSONAL HYGIENE/PERICARE								
ORAL HYGIENE								
FOOT CARE								
SKIN CARE								
SHAVE								
DRESSING/CLOTHING								
MEDICATION REMINDER								
DIET/FOOD PREPARATION/FEED PATIENT								
ENCOURAGE FLUIDS								
LIMIT FLUIDS								
AMBULATION (WALK)								
TRANSFERS								
TURN/POSITION								
EXERCISE/ROM								
RECORD I & O								
TPR								
ASSIST BATHROOM (Toilet/Commode)								
ASSIST DIAPER/CATHETER/OSTOMY								
ASSIST URINAL/BEDPAN								
RECORD BM								
DUST/CLEAN BATHROOM								
LAUNDRY								
STRAIGHTEN RM/BATH/BED/KITCHEN								
MAKE BED/LINEN CHANGE								

1) FEES: Hourly Rate/Live-in Rate_____(Incorporating Caregiver Cost Plus Company Fee)
Fees are consistent with the minimum wage and overtime rules of the U.S. Department of Labor and the State of Florida.
2) We agree to sign a Weekly Service Sheet for submission to TCN for invoices and insurance reimbursement. We agree that TCN is the exclusive Billing and Collection Representative for Caregiver and agree that all payments of fees shall only be made to TCN
3) Client/Patient and Caregiver agree to the foregoing terms which can be changed orally at any time. If above terms change, we agree to notify TCN and sign a new Contract. This Contract does not affect each party's agreement with TCN which Caregiver and Client each affirm.

Caregiver Signature: _____ Date: _____

Client/Patient Signature: _____ Date: _____

*****The office is to be notified of all hours for Payroll no later than Monday 5pm (unless otherwise specified). *****
If received after, you will be paid the following pay period.