TDNT Counseling Services Companionship Attendant Client Agreement

Confirm you consent to our service terms at TDNT Counseling Services' Companionship Care Services. Please read and sign this agreement. We will retain a copy on file. For questions, please contact us anytime: tdntcounseling@tdntsocialservices.org.

* Indicates required question

TDNT Social Services, Inc. (*TDNT Counseling Services Program*)

Introduction

Welcome to our In-Home & Remote Companionship Attendant Referral Service with TDNT Counseling Services Program at TDNT Social Services, Inc. Here with us, you will receive healthy support as well as emotional care to meet your daily living needs. We provide in-home and remote companionship attendant services. If you can't come in to us, we will meet with you at home or remotely online via the internet to be sure you receive proper services. This document contains important information about our professional services as well as our policies. After careful review, please contact us with any questions and we will discuss them further during our sessions. Signing this form constitutes an agreement between us.

In-Home & Remote Companionship Attendant Contract

This Agreement is entered between the undersigned Client and assigned Companionship Attendant at TDNT Social Services, Inc. (the Service Provider), 1445 Woodmont Ln NW #998, Atlanta, Georgia, 30318. The Client and the Service Provider shall be collectively known herein as the Parties.

WHEREAS, the purpose of this Contract is to set out the terms of services to be provided to the Client by Service Provider generally known as "Companionship Attendant Services,"

IN Consideration of the mutual promises and other valuable consideration exchanged, the Parties hereby agree and contract as follows:

1. AUTHORIZATION. The Client hereby grants the authority to the Service Provider to provide Companionship Attendant Services to the Client at the Client's home located at the Service Address shown below.

2. TERM. This grant of authorization to provide Companionship Attendant Services shall begin on the Initial Service Date (DOS) shown below, and shall remain effective for a period of 5 years or more, if renewed. This Contract may be terminated prior to this term by either party on giving a written notice of 30 days.

3. LICENSING. The Service Provider warrants that, Service Provider is licensed in the state where services are being provided (Florida, Georgia or another state) to provide the services mentioned in this Contract. Further, any employee, volunteer or representative of the Service Provider performing services under this Contract is licensed in the state where services are provided (Florida, Georgia or another state) as a Certified Nursing Assistant (CNA), a Certified Medical Assistant (CMA), a Home Health Aide (HHA) or a credentialed Sitter and is current on all training and certifications.

4. DESCRIPTION OF SERVICES. The Service Provider shall provide a Certified Nursing Assistant (CNA), Certified Medical Assistant (CMA), a Home Health Aide (HHA) or a credentialed Sitter to attend the Client.

The CNA, CMA, HHA or Sitter provided by the Service Provider shall have the power to:

- Administer medications when appropriate as shown below under Medication Instructions. This task is limited to Companionship Attendants credentialed and holding proper licensure as CNA's and CMA's Only.

- Provide emotional care, social engagement, emotional support, meaningful activities, companionship, assistance or support with general daily living needs, and related duties or tasks.

- _____
_____

Service Provider or its representative will assist Client to live at home and to have as much control over the home environment and life as possible.

Apart from performing the above tasks the Service Provider shall do similar related tasks to be mutually agreed upon by the parties.

5. CONTACT PERSONS. The Client's contact information is as shown below under Client Name, Address, Phone #, Email and Representative, if any:

In an emergency situation, the Service Provider should immediately contact the following person as shown below under Emergency Contact.

If that person is not available, please contact the following alternate choice as shown below under Representative or Additional Emergency Contact.

6. PAYMENT. The Client shall pay a weekly, bi-weekly or monthly contract price to the Service Provider at an amount based on the scheduled visits, the hours of all visits for the services provided, as well as the contracted hourly rate, which is currently set at a standard $50 per hour, unless otherwise stated here or below on this contract under Contract's Hourly Rate.

The weekly, bi-weekly or monthly fee constitutes payment for all services performed during the Service Providers normal working hours which are defined as follows below under Service Schedule, Service Type & Services Needed.

If any additional service is done outside the working hours or on holidays, the Client shall pay $75.00 per hour or the negotiated rate of $_____ as specified here or below under Service Contract's Hourly Rate, as additional payment. The amount of compensation to be paid to the Service Provider for the Services in this Contract shall be covered by either one or a combination of Private Self-Pay (Out-of-Pocket/Cash), Commercial or Private Health Insurance, Medicaid or Medicare.

Whenever health insurance, Medicaid, Medicare or any other third party payor does not cover payments for your Services, the Client shall be wholly liable and responsible for the entire cost of the Services. The Client may contact us to discuss payment arrangements and if we are able to further negotiate the costs or the balance due. The Client is however totally responsible for the entire costs of Services as agreed upon in this Contract.

Our in-home companionship attendant services include both in-home and online sessions as a stand-alone or an add-on option, if you'd prefer. Please view this form and our pricing plans online at https://tdntsocialservices.org/tdnt-counseling-services for more information. Be sure to click ***More*** in the menus and then Click ***Companionship Attendant*** to go directly to our page. Our direct link is https://tdntsocialservices.org/companionship-care . Prices are subject to change with notice. This notice is typically provided on our website where our prices are posted and publicly displayed.

We offer different shifts for this in-home care service. We offer 2-hour, 4-hour, 8-hour, 12-hour and 24-hour shifts depending on our Companionship Attendants' availability. You are encouraged to use your health insurance to help you pay for your home visits. Visit our site to see which insurance plans we may accept. Confirmation of coverage acceptance can only be provided after you've submitted your completed Companionship Care Service Agreement (with payment authorization) form.

Our Standard Plan is $50 per hour (plus processing) regardless of the shift. For Additional Hours or Holidays, it is $75/hour. These rates are negotiable and subject to change. We recommend you consider your own requirements and speak to us as well as your assigned professional to determine the best pricing plan for you. Please review and sign this Companionship Attendant Client Service Agreement for more information and different prices and service, schedules as well as service types we offer.

Payment is expected at least 7-14 days prior to your first session with us and is paid on a weekly, bi-weekly or monthly recurring frequency, based on your contract. You are expected to initiate payments at the time of scheduling your first appointment, which must be scheduled at least 7-14 days prior to your first appointment date. Please feel free to discuss special payment arrangements with us ahead of time. TDNT Counseling Services (TDNT Social Services, Inc.) holds the right to discontinue treatment if payments have not been made for prior sessions or are canceled. There is a $30 service charge on returned eChecks (NSF).

You must have your payment information on file to secure payments for sessions, whether that is your credit card number, your debit card number or your bank account information or a combination of both. Your card or account will only be charged, in accordance with your authorization, on a recurring basis based on the plan you selected. Please view and sign the payment authorization form sent to your email, online or under our Forms page.

7. PAYMENT AUTHORIZATION FORM. The Client shall complete the Payment Authorization Form below in order to Sign Up for Services. The Client is required to complete all sections including the Credit/Debit/FSA card Info as well as the Health Insurance information even if they are paying with health insurance and/or Medicaid/Medicare.

This is to cover any copays, co-deductibles or coinsurance you may be responsible for. You may also pay all out-of-pocket expenses using your credit/debit or FSA health card, if you are Self-Pay. Your insurance provider determines your copay or out-of-pocket responsibility, if you're covered. Please verify through them even though we will do a verification check on your behalf. For Cash, also select Cash and enter if paying via bills or checks.

8. DETAILS OF INSURANCE COVERAGE. The details of the plan which covers the home healthcare services in whole or in part are as described below under the Payment Authorization Form/Health Insurance Information.

9. CANCELLATIONS & MISSED APPOINTMENTS. Clients are requested to give notice as soon as possible when canceling an appointment so it will be made available for another client. We require a minimum of 72-hour notice to cancel your service appointment, which we will reschedule for you another day within that same week or within that same month or 30-day period from the original date it was scheduled. After that month has expired, you have forfeited funds paid for that session and it cannot be rescheduled into the next month.

You are responsible for making sure the Companionship Attendant is able to access you and your home to provide services during your scheduled home visits, as part of your Service Contract. Should you have an emergency and are not able to take home visits, you must notify us. Messaging us via e-mail (tdntcounseling@tdntsocialservices.org) is the best way to cancel your service appointments and reschedule, though you should also speak to your assigned professional as well. Your 72 hour notice to cancel must be sent to

tdntcounseling@tdntsocialservices.org; otherwise, it is a noncancellation claim and you are responsible for any related noncancellation fees that apply. Unpaid balances on your accounts are subject to collection efforts by us or by any other debt collection agencies we have contracted.

Payments made are only refundable 144 hours prior to your first service appointment for that charge. After this period, your payments become non-refundable and we can only reschedule you within the week or month (30-day period) at least 72 hours before your service appointment(s). Refunds are always partial; that is, the eligible amount minus any processing fees. Failure to keep scheduled appointments for 60 days or more without valid reasons and without prior notice may result in discharge from services. Clients must re-enroll in plans and sign new admission forms in order to resume or continue receiving services if a discharge is processed.

10. CONFIDENTIALITY. Service Provider understands that any and all private information obtained about the Client, Client's family, or other Signing/Responsible Parties and their relatives during the course of work, treatment or service, including but not limited to medical, financial, legal, career and assets are strictly confidential and may not be disclosed to any third party for any reason. The obligations of the Service Provider under this clause survive termination of this Contract.

11. FORCE MAJEURE. If performance of this Contract or any obligation under this Contract is prevented, restricted or interfered with by causes beyond either party's reasonable control ("Force Majeure"), and if the party unable to carry out its obligations gives the other party prompt written notice of such event, then the obligations of the party invoking this provision shall be suspended to the extent necessary by such event. The term Force Majeure shall include, without limitations, acts of God, plague, epidemic, pandemic, outbreaks of infectious disease or any other public health crisis, including quarantine or other employee/worker restrictions, fire, explosion, vandalism, storm or other similar occurrence, orders or acts of military or civil authority, or by national emergencies, insurrections, riots, or wars, or strikes, lock-outs, work stoppages or other labor disputes, or supplier failures. The excused party shall use reasonable efforts under the circumstances to avoid or remove such causes of non-performance and shall proceed to perform with reasonable dispatch whenever such causes are removed or ceased. An act or omission shall be deemed within the reasonable control of a party if committed, omitted, or caused by such party, or its employees, officers, agents, or affiliates.

12. SEVERABILITY. In the event any provision of this Contract is deemed to be void, invalid or unenforceable, that provision shall be severed from the remainder of this Contract. All remaining provisions of this Contract shall then continue in full force and effect. If any provision shall be deemed invalid due to its scope or breadth, such provision shall be deemed valid to the extent of the scope and breadth permitted by law.

13. AMENDMENT. This Contract may be modified or amended in writing, if the writing is signed by the party obligated under the amendment.

14. NOTICE. Any notice or communication required or permitted under this Contract shall be sufficiently given if delivered in person or by certified mail, return receipt requested, to the address set forth in the opening paragraph, or to such other address as one party may have furnished to the other in writing.

15. ATTORNEY'S FEES. In the event of any breach of this Contract, the party responsible for the breach agrees to pay reasonable attorney's fees and costs incurred by the other party in the enforcement of this Contract or suit for recovery of damages. The prevailing party in any suit instituted arising out of this Contract will be entitled to receive reasonable attorneys' fees and costs incurred in such suit.

16. APPLICABLE LAW. This Contract shall be governed by the laws of the State of Florida and the State of Georgia depending on where the professional is licensed and providing Services.

17. SIGNATURES. This Contract shall be signed by Client and the assigned Companionship Attendant at TDNT Social Services, Inc. as shown below.

1. Client First Name *

2. Client Middle Name

3. Client Last Name *

4. Client's Residential Address (Service Address - Street, City, Zip) *

5. Client Date of Birth *

Example: January 7, 2019

6. Social Security Number (Optional, EAP)

_____

7. Client's Gender/Sex *

Mark only one oval.

- ◯ Male
- ◯ Female
- ◯ Other: _____

8. Client Phone Number *

_____

9. Client's Email Address *

_____

10. Client's Mailing Address (if different from service address)

_____

11. Client's Emergency Contact *
First & Last Name, Phone, Email & Address (include Relationship to Client: spouse/partner, child/grandchild, parent/grandparent, neighbor/friend, caseworker/agency, other)

_____

_____

_____

_____

_____

12. Client's Primary Care Physician (PCP)/ General Physician (GP)/Doctor's Name, Office Phone, Email & Address *

13. Client's Contact for Services (Representative
- First & Last Name, Title; include Relationship to Client [eg. case worker, family member, agency, doctor, etc.]; Phone, Email & Address)

14. Instructions for Administering Medications, When Applicable, Under the Guidance & Supervision of Client's PCP/GP, doctors or other prescribing professionals:

(Enter the following) Name of medication: ; Amount to be given: ; Time to be given: ; Other instructions:

15. Service Contract's Hourly Rate (any negotiated contract rate less than the $50/hour standard rate MUST be entered here by the Service Provider) *

16. Service Contract's Hourly Rate for *Additional Hours Outside of Regular Scheduled Hours & Holidays* (any negotiated contract rate less than the $75/hour standard rate MUST be entered here by the Service Provider) *

_____

17. I agree to make Payments to TDNT Social Services, Inc and its Care Attendants for Services at the following frequency or pay period: *

Mark only one oval.

- ◯ Weekly
- ◯ Bi-Weekly
- ◯ Monthly
- ◯ On the 15th of Every Month
- ◯ Other: _____

18. I agree to make Payments to TDNT Social Services, Inc for Services using any of the following payment methods

Check all that apply.

	I am paying all fees Out-of-Pocket thru Self-Pay Only	I want my health insurance, Medicaid or Medicare to help me pay and I have included the information below
Credit, Debit & FSA Card as Provided & Authorized Below	☐	☐
Bank Account as Provided & Authorized Below	☐	☐
Cash in US Dollar Bills In-Person	☐	☐
Personal or Cashier's Check In-Person	☐	☐
Personal or Cashier's Check By Mail	☐	☐

Check By

Mail

19. **Credit, Debit, or FSA Health Card Information (Required)** *

Mark only one oval per row.

	Visa	MasterCard	American Express	Discover	Other
Card Type	◯	◯	◯	◯	◯

20. Cardholder Name (as it appears on card): *

21. Card Number (ex: 16-digit): *

22. CVV/CCV (ex: 3-4 digit): *

23. Expiration Date (MM/YY): *

24. Billing Address (Street, City, State, & Zip Code): *

25. **Bank Account Information (Additional Payment Option)**

Check all that apply.

	Personal	Business	Checking	Saving	Other
Account Type	☐	☐	☐	☐	☐

26. Accountholder Name (as shown on account):

27. Bank Name & Routing/ABA Number:

28. Account Number:

29. Billing Address (Street, City, State, Zip)

Health Insurance Information (Required for Insurance Billing)

Enter None if choosing Cash or Self-Pay.

30. Insurance Name: *

Mark only one oval.

- ◯ United Healthcare
- ◯ Oxford
- ◯ United All Savers
- ◯ United /Optum EAP
- ◯ Oscar Health
- ◯ Cigna
- ◯ Other: _____

31. Is Client/Patient (You) the Named Insured/Policy Holder on the Insurance Plan? *

Mark only one oval.

- ◯ Yes
- ◯ No

32. Member ID (ex: 12-digit): *

_____

33. Group Number (ex: 9-digit): *

_____

34. Expiration Date (MM/YY): *

_____

35. Plan Type (Individual, Family): *

36. Insured/Policy Holder Name (exactly as shown on card): *

37. Insured/Policy Holder Date of Birth (M/D/YYYY) *

Example: January 7, 2019

38. Insured/Policy Holder Address (Street, City, State, Zip): *

39. Insured/Policy Holder Sex: *

Mark only one oval.

- Male
- Female

40. Client/Patient's (Your) Relationship to Insured/Policy Holder: *

Mark only one oval.

- ◯ Self (Client/Patient) - I am the policy holder.
- ◯ Spouse (Husband/Wife/Partner) - The policy holder is my spouse.
- ◯ Dependent (Child) - The policy holder is my parent.
- ◯ Dependent (Grandchild/Other) - The policy holder can claim me as a dependent financially or on taxes.
- ◯ Other: _____

41. Insured/Policy Holder Phone Number & Email Address: *

_____

42. EAP Insurance Reference or Authorization Number (ex: 9-10 digits); Number of Sessions your EAP Authorization Covers/ Number of Sessions Left; Dates your EAP Authorization Covers (ex: 5/13/23-11/13/23); EAP Authorization Company & Phone Number; (enter None if not applicable) *

_____

_____

_____

_____

_____

43. Service Type Needed *

Check all that apply.

- [ ] 8 hour Shift Care
- [ ] 12 Hour Shift Care
- [ ] 4 to 7 Hour Shift Care
- [ ] 2 to 3 hour Shift Care
- [ ] 12/24 Hour Shift Care
- [ ] Elderly Care
- [ ] Daily Caregiver
- [ ] Other: _____

44. Services Needed *

Check all that apply.

- [ ] Standard Companionship Attendant Service (i.e., conversation, play games, support in activities, taking walks together, eating meals together, etcetera)
- [ ] Light Meal Preparation (i.e., taking food from refrigerator to hand to Client; time spent together during meals; mixing, serving, and heating up drink or food in the microwave or on the stove, etcetera)
- [ ] Light Tidying of living spaces where providing services as needed (i.e., wiping counters or tables where Attendant provided services, where Client will be eating during the Shift; straightening out the bed sheets or table cloth where Client is currently lying down or eating; placing/removing clothes in/from the washing machine/dryer to be washed/dried; etcetera)
- [ ] Light Errands (i.e., pick up medications from the drug store; pick up food from restaurant or store; drop mail in outgoing mailbox; pick up mail; etcetera)
- [ ] Shopping (i.e., grocery shopping together or alone, light shopping for clothes and shoes, etcetera)
- [ ] Other: _____

45. Service Hours (Schedule)

Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Sunday

Check all that apply.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
4-HR SHIFT	☐	☐	☐	☐	☐	☐	☐
1:00 am - 5:00 am	☐	☐	☐	☐	☐	☐	☐
5:00 am - 9:00 am	☐	☐	☐	☐	☐	☐	☐
9:00 am - 1:00 pm	☐	☐	☐	☐	☐	☐	☐
1:00 pm - 5:00 pm	☐	☐	☐	☐	☐	☐	☐
5:00 pm - 9:00 pm	☐	☐	☐	☐	☐	☐	☐
9:00 pm - 1:00 am	☐	☐	☐	☐	☐	☐	☐
Other 4hr (Comments)	☐	☐	☐	☐	☐	☐	☐
8-HR SHIFT	☐	☐	☐	☐	☐	☐	☐
1:00 am - 9:00 am	☐	☐	☐	☐	☐	☐	☐
9:00 am - 5:00 pm	☐	☐	☐	☐	☐	☐	☐
5:00 pm - 1:00 am	☐	☐	☐	☐	☐	☐	☐
Other 8hr (Comments)	☐	☐	☐	☐	☐	☐	☐
12-HR SHIFT	☐	☐	☐	☐	☐	☐	☐

1:00 am -

1:00 pm 1:00 am - 1:00 pm	☐	☐	☐	☐	☐	☐	☐
5:00 am - 5:00 pm	☐	☐	☐	☐	☐	☐	☐
5:00 pm 5:00 am - 5:00 pm	☐	☐	☐	☐	☐	☐	☐
9:00 am - 9:00 pm	☐	☐	☐	☐	☐	☐	☐
9:00 pm 9:00 am - 9:00 pm	☐	☐	☐	☐	☐	☐	☐
1:00 pm - 1:00 am	☐	☐	☐	☐	☐	☐	☐
1:00 am 1:00 pm - 1:00 am	☐	☐	☐	☐	☐	☐	☐
5:00 pm - 5:00 am	☐	☐	☐	☐	☐	☐	☐
5:00 am 5:00 pm - 5:00 am	☐	☐	☐	☐	☐	☐	☐
9:00 pm - 9:00 am	☐	☐	☐	☐	☐	☐	☐
9:00 am 9:00 pm - 9:00 am	☐	☐	☐	☐	☐	☐	☐
Other 12hr (Comments)	☐	☐	☐	☐	☐	☐	☐
Other 12hr (Comments)	☐	☐	☐	☐	☐	☐	☐
24-HR SHIFT	☐	☐	☐	☐	☐	☐	☐
24-HR SHIFT	☐	☐	☐	☐	☐	☐	☐
1:00 am - 1:00 am	☐	☐	☐	☐	☐	☐	☐
1:00 am 1:00 am - 1:00 am	☐	☐	☐	☐	☐	☐	☐
5:00 am - 5:00 am	☐	☐	☐	☐	☐	☐	☐
5:00 am 5:00 am - 5:00 am	☐	☐	☐	☐	☐	☐	☐
9:00 am - 9:00 am	☐	☐	☐	☐	☐	☐	☐
9:00 am 9:00 am - 9:00 am	☐	☐	☐	☐	☐	☐	☐
1:00 pm - 1:00 pm	☐	☐	☐	☐	☐	☐	☐
1:00 pm 1:00 pm - 1:00 pm	☐	☐	☐	☐	☐	☐	☐
5:00 pm - 5:00 pm	☐	☐	☐	☐	☐	☐	☐
5:00 pm 5:00 pm - 5:00 pm	☐	☐	☐	☐	☐	☐	☐
9:00 pm - 9:00 pm	☐	☐	☐	☐	☐	☐	☐
9:00 pm 9:00 pm - 9:00 pm	☐	☐	☐	☐	☐	☐	☐
Other 24hr (Comments)	☐	☐	☐	☐	☐	☐	☐
Other 24hr (Comments)	☐	☐	☐	☐	☐	☐	☐
2-HR SHIFT Type hours	☐	☐	☐	☐	☐	☐	☐
2-HR SHIFT in Type hours	☐	☐	☐	☐	☐	☐	☐
Comments							

in
Comments

46. Type in Comments for the Schedule Above

47. Select Your Assigned Companionship Attendant (*you may be assigned a different care attendant if the one you requested is not available, but you will be notified and can let us know how you'd like to proceed; review our policies for making changes to your appointments)* *

Mark only one oval.

- Marie Saintclair, CNA
- Vladimir Jude, CMA
- Claude Mirnadia, Sitter
- Flore Jean-Baptiste, HHA
- Other:

48. Initial Date of Service (DOS - also effective date of contract) *

Example: January 7, 2019

49. **Any suggestions, questions or concerns? When would you like to schedule your initial intake or your next appointment** (date mm/dd/yyyy & time 00:00 am/pm)**? After viewing our website, do you have and want to include the Care Attendant name you'd like to work with** (if posted and available)**?**

Client Consent & Payment Authorization

I have reviewed and understand TDNT Counseling Services' Companionship Attendant Services policies on the process, confidentiality, payments, insurance coverage, and cancellations and missed appointments. I agree to accept financial responsibility for payment of services received.

I, _____(payee/client name), date of birth _____(m/d/yyyy), authorize TDNT Social Services, Inc. and its parent and subsidiary agents to charge my credit card, debit card, bank account and/or health insurance card for recurring (monthly, weekly or yearly) and one-time payments for agreed upon services and purchases. I understand my information will be saved to file for future authorized transactions on my account. Should this information no longer be valid or be changed, I will immediately contact TDNT Social Services, Inc. to update my information to prevent suspended service. Below on the line is the payee/client name and date of birth.

50. ***Patient/ Client Name (First, Middle Initial, Last):*** *

51. Patient/ Client Date of Birth (M/D/YYYY) *

52. ***Patient/ Client Signature:*** *

53. Date (m/d/yyyy): *

Example: January 7, 2019

54. Parent, Guardian or Responsible Party Name (First, Middle, Last) [for minors etc]: *

55. Parent, Guardian or Responsible Party Signature [for minors etc]: *

56. Date (m/d/yyyy): *

Example: January 7, 2019

57. Companionship Attendant Signature & Date

58. Executive Officer/Secretary Signature & Date (https://tdntsocialservices.org/companionship-care 954-324-7843 tdntcounseling@tdntsocialservices.org)

59. **Donate to Help us Support Community Members & Earn Incentives**

Check all that apply.

- [ ] $1 Donor
- [ ] $10 Anytime Sporadic Blessings (Bronze)
- [ ] $10 per month My Heart's Desire (Silver)
- [ ] $20 per month Start Small (Gold)
- [ ] $50 per month Philanthropist (Platinum)
- [ ] $1000 per year Patronus Honoris (Diamond)
- [ ] $5000 per year Honore Patronis (Titanium)
- [ ] Other: _____

A copy of the official registration and financial information may be obtained from the Division of Consumer Services by calling toll-free within the State. 1-800-435-7352 FDACS.gov. Registration does not imply endorsement, approval, or recommendation by the State. #CH65486