FAMILY FIRST CAREGIVERS, INC

Request for Caring

This document provides important information about the services provided by a Family First Caregiver Provider and the Care Provider's qualifications to provide these services. This document should be reviewed carefully. You should ask any questions you have before signing the document.

I, _____,consent to receiving the following services from Family First Caregivers, Inc.

- ☐ Bathing/ Showering
  Notes: _____
- ☐ Hair Care
- ☐ Shaving
- ☐ Dressing and Undressing: assist or complete
- ☐ Oral Hygience and Denture Care
- ☐ Toilet Assistance
- ☐ Incontinence Care
- ☐ Pressure Sore Prevention
- ☐ Mobility Assistance
  (walking, transfers, range of motion exercises
- ☐ Meal Planning
- ☐ Food Purchasing
- ☐ Food Preparation
- ☐ Feeding Assistance
- ☐ Special Diet Preparation
  Notes: _____
- ☐ Care of Hearing Aids, Glasses, Prosthetic Devices
  (circle each that applies)
- ☐ Medication Reminders
  (electronic device or med container)
- ☐ Monitor Blood Sugar Levels
- ☐ Measure and Record In-take and Out-Put
- ☐ Maintaining a Clean Environment
- ☐ Make Beds/Change Linens
- ☐ Apply Non-Sterile dry dressings to intact skin surfaces
- ☐ Apply non-prescription topical creams, ointments, lotions, etc.
- ☐ Change Colostomy Bag/ Catheter Bag
- ☐ Empty Catheter
- ☐ Running Errands
- ☐ Comfort Care
- ☐ Other Activities
  Notes:_____

Caring Services to begin: _____

Family First Caregivers, Inc.
10850 Pearl Road, Albion Place D-7
Strongsville, Ohio 44136
www.familyfirstcares.com

I understand that these services are being provided by a care provider, not a licensened RN or LPN. I also undertand that Family First Caregivers, Inc. and its representatives only provide **non-skilled, non-medical home care**. I have had an opportunity to discuss the services that I have selected with a Family First Caregivers, Inc. representative and I understand all of the above, and I understand that I can discontinue or add services at anytime, at no additional cost to me.

Signature: _____ Date: _____

Client Name: _____

Family Address: _____

City:_____ Zip Code: _____

Responsible Party: _____

Relationship:_____

Address: _____

City:_____ Zip Code: _____

Home Phone:_____ Mobile:_____

Work Phone: _____

Email Address: _____

FAMILY INFORMATION

CLIENT

Date of Birth:_____ Married: Yes/No Spouse Name:_____

Veteran: Yes/No Branch:_____ Service #_____

SPOUSE (if applicable)

Date of Birth:_____ Married: Yes/No

Veteran: Yes/No Branch:_____ Service #_____

*Responsible Party Signature*_____ *Date:*_____

*Family First Caregivers, Inc. Signature*_____ *Date:*_____

Family First Caregivers

FAMILY FIRST CAREGIVERS, INC

Family First Caregivers

Invoice and Payment Option Selection for _____

1. Please select your preferred method of weekly billing:

Bi-monthly payment schedule requires a 2-week caring deposit

☐ Email:_____

☐ USPS with return envelope: _____
Address

_____
Address

2. Please select your preferred method of payment:

☐ Check or money order due upon receipt of invoice

☐ Credit card to be processed for the weekly balance due
(plus $14.00 bank fee for charges over $499.00)

_____ _____ _____
Card# Exp. Date CSV#

_____ _____
Name as it appears on card Billing Address of Card

*Deposit (1 week of caring)*_____

Received:_____ Date:_____ Payment:_____

I agree to the terms outlined in the options I have selected for invoices for my Caring services and how I wish to pay for these Caring Services. I understand there is a 3% late fee applied to any outstanding balance to appear on my next statement. I also understand that all Caring Services will be postpoined if my balance is over 5 days past due and a payment in full is required for services to be restored. I agree to pay my balnace in full if services are ever cancelled, by me or by Family First Caregivers, Inc.

*Responsible Party Signature*_____ *Date:*_____

*Family First Caregivers, Inc. Signature*_____ *Date:*_____

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