Safe N Steady Inc.

100 East Linton Blvd. Suite 201A
Delray Beach, Fl 33483
Tel: 561-237-5252 Fax 561-807-7859

Care Assessment Notes

Review and complete each page for each assessment period.
If there are no changes, then sign and date at the bottom of each page.
DNR must be reviewed and approved every three months (write in date last approved).

DEMOGRAPHICS ☐ More than 1 client home: See Client:			
Name: Last:	First:		DOB:
Address:			Phone:
City:	State:		Zip:
SS#:	Age:	Email:	
Sex:	Weight:		Height:
Caregiver or Guardian:			
Drivers License Info #:		State:	Expiration:
Restriction:			
EMERGENCY CONTACT/PRIMARY CAREGIVER: In case of serious illness, hospitalization or death, *NOTIFY*:			
Emergency Contact:		Phone:	
Address:		City/State:	Zip:
Relationship to Client:			
Primary Caregiver:		☐ Same as above	
Name:	Relationship:		Phone:
☐ Able Caregiver	☐ Willing Caregiver		
BILLING INFORMATION (see attached for detailed insurance information)			
☐ More than 1 client see attached			
Responsible Party:		Relationship to Client:	
Address:			Phone:
City:	State:		Zip:
Health Insurance:	Policy #:		Phone:
Long Term Insurance:	Policy#:		Phone:
Caregiver Limitation:			

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Care Coordination Assessment

RESPIRATORY

- ☐ No Problems Reported
- ☐ S.O.B. at rest / exertion (circle)
- ☐ Orthopnea
- ☐ Cough – Productive
- ☐ Productive of Sputum
- ☐ O2 Mask Nasal (Cannula)
- ☐ Tracheotomy (Describe site, suctioning) _____
- ☐ Tires easily
- ☐ Other: _____

Comments: _____

GASTROINTESTINAL / NUTRITIONAL ASSESSMENT

NUTRITIONAL STATUS:

- ☐ Eats 3 – 4 complete meals daily from the basic food groups; TPN/Enteral feedings that meet all requirements
- ☐ Eats 2 – 3 complete meals daily
- ☐ Never has a complete meal, eats < half of food offered
- ☐ Rarely has a meal, eats< 1/3 of food offered; NPO IV hydration > 5 days

HYDRATION STATUS:

- ☐ Skin warm, + turgor, no edema, 6 – 8 glasses fluid per day
- ☐ Lips cracked, dry mouth, flaking skin, tenting dependent edema, diaphoresis < 4 – 8 oz fluid a day
- ☐ NPO, no fluid intake; generalized edema, weeping fluid from the skin

WEIGHT GAIN / LOSS:

☐ Gain ☐ Loss _____ Lbs

NUTRITIONAL RISK LEVEL:

☐ No ☐ Low ☐ Moderate ☐ High Risk

NUTRITIONAL / FLUID REQUIREMENTS:

- ☐ Low Fat
- ☐ Regular Diet
- ☐ Soft
- ☐ Liquid
- ☐ High Fiber
- ☐ Force Fluids
- ☐ Low NA + _____ GM
- ☐ Fluid Restriction _____ CC / day
- ☐ ADA _____ cal / day
- ☐ Enteral _____
- Formula _____
- ☐ Other _____

Above Information was reviewed with Client & unchanged from last Assessment:
Re-assessment dates & Initials:
Client Name: Date:

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Care Coordination Assessment

MEDICATION

☐ No medication (s)		
☐ 1 – 2 medications	☐ Able to manage	☐ Difficulty managing
☐ Multiple medications	☐ Able to manage	☐ Difficulty managing

Comments: _____

_____

_____

_____

_____

MEDICATION LOG

PRESCRIPTION MEDS	DOSAGE / FREQUENCY	PURPOSE
1.		
2.		
3.		
4.		
5.		

OVER THE COUNTER	DOSAGE / FREQUENCY	PURPOSE
1.		
2.		
3.		
4.		
5.		

VITAMINS / MINERALS	DOSAGE / FREQUENCY	PURPOSE
1.		
2.		
3.		

LAXATIVES	DOSAGE / FREQUENCY	PURPOSE
1.		
2.		

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Care Coordination Assessment

- ☐ Hx of Substance Abuse
- ☐ Language Barriers
- ☐ Cultural Barriers
- ☐ Communication Barriers
- ☐ Home Safety
- ☐ Caregiver Not Functioning
- ☐ Lives Alone
- ☐ Multiple Caregivers in Home
- ☐ Client Coping Difficulties
- ☐ Other _____
- ☐ Altered Mood / Affect
- ☐ Signs of Neglect / Abuse
- ☐ Inadequate
- ☐ Family Coping Difficulties

Please describe answers: _____

FUNCTIONAL STATUS: (check all areas that apply)
Level of care key: **SB**=Standby Assist **Min**=Minimum Assist **Mx**=Maximum Assist **Ind**=Independent

SB	Min	Mx	Ind		SB	Min	Mx	Ind	
☐	☐	☐	☐	Ambulation	☐	☐	☐	☐	Feeding
☐	☐	☐	☐	Up in W/C	☐	☐	☐	☐	Dressing
☐	☐	☐	☐	Transfer Bed / Chair	☐	☐	☐	☐	Grooming
☐	☐	☐	☐	Negotiate Stairs	☐	☐	☐	☐	Housekeeper
☐	☐	☐	☐	Shopping	☐	☐	☐	☐	Bathing
☐	☐	☐	☐	Toileting	☐	☐	☐	☐	Medication
☐	☐	☐	☐	Meal Preparation	☐	☐	☐	☐	Safety

TRANSPORTATION:

- ☐ Has Transportation
- ☐ Uses public transportation ☐ Independent ☐ Escort
- ☐ Transportation needed: _____

ACTIVITIES PERMITTED: (check all that apply)

- ☐ Complete bed rest
- ☐ Up as tolerated
- ☐ Exercise prescribed
- ☐ No restrictions
- ☐ Standby assist
- ☐ Bed rest BRP
- ☐ Transfer bed / chair
- ☐ Partial weight bearing
- ☐ Independent at home
- ☐ Other: _____
- ☐ Crutches
- ☐ Cane
- ☐ Wheelchair
- ☐ Walker

Comments: _____

Above Information was reviewed with Client & unchanged from last Assessment:
Re-assessment dates & Initials:
Client Name: Date:

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Physician Notification

Physician Name: _____

Telephone Number: _____

Fax Number: _____

Safe N Steady Inc. has placed a caregiver with your patient for homecare services.

Patient Name: _____

Start Date: _____

The frequency of care will be _____ hours per day, _____ days per week.

Please contact our office if you have any questions.

Safe N Steady, Inc.
Phone: 561-237-5252
Fax: 561-807-7859

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PAYMENT AUTHORIZATION FORM

Billing Information:

Name: _____

Person Authorizing: _____

Billing Address: _____

City: _____

State / Zip Code: _____

Phone: _____

Fax: _____

CREDIT CARD AUTHORIZATION

Credit Card Type: **Master Card** ☐ **Visa** ☐ **Amex** ☐ **Discover** ☐

Issuing Bank: _____

Credit Card Number: _____

Enter CVC Number: _____

Expiration Date: _____

Please select one of the following payment options:

☐ Check - Payment upon Receipt of Invoice

☐ Weekly – Bill my credit card once per week for the amount of service provided weekly for all contracts with Safe N Steady Inc.

Authorized Signature: _____

Date: _____

Changes in the status of this card can be reported to Safe N Steady, Inc at gosafensteady@aol.com

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Assignment of Benefits

Please take notice that the undersigned insured policy holder hereby does assign, transfer and set over to Safe N Steady Inc., a Nurse Registry, the policyholder's right, title and interest in and to the payment and receipt of benefits, free and clear of any liens, claims or other encumbrances of any kind for the service provided by Safe N Steady Inc., a Nurse Registry, and further appoints and authorizes Safe N Steady Inc. to directly bill and collect payments of benefits for services rendered to the policy holder by Safe N Steady Inc. a Nurse Registry.

Please sign this Assignment of Benefits form which authorizes your insurance carrier to pay Safe N Steady Inc., a Nurse Registry, directly. You further agree that if the insurance company denies payment of benefits on this claim for any reason, you are responsible for payment in full as billed. In the event any lawsuit, action or collection is brought by Safe N Steady Inc. for the collection of any sums due or owing, in addition to any such sums owed, you will owe Safe N Steady Inc. the costs of collection, including reasonable attorney fees and costs as to be fixed by the courts.

Insurance Company: _____

Name of Policy Holder: _____

Signature: _____

Policy No: _____ Claim No: _____

Date: _____

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HIPAA Release of information
AUTHORIZATION FORM

I, _____ hereby authorize _____ and its affiliates, its employees and agents (collectively _____), to release to _____ **[Insert full name of person/organization]** my personal health information maintained by _____ (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) except the following information about me:

_____ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of _____ **[INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES]** or the date my coverage ends with _____.

I understand that I have a right to revoke this authorization by providing written notice to _____. However, this authorization may not be revoked if _____, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: _____

Signature of Member: _____

Date: _____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____

REQUEST FOR SERVICE/INQUIRY

SafeNSteady Inc.
100 East Linton Blvd
Delray Beach, FL 33483
561-237-5252
www.safensteady.com

Date	Time	Person Taking Request (print)

CLIENT INFORMATION

Client Name			Social Security No.		
Address		City	State	Zip Code	
Birthdate	Gender ☐ Male ☐ Female	Height	Weight	Home Phone	Other Phone
Referral Source		Relationship			
Emergency Contact		Relationship	Work Phone	Home Phone	Other Phone
Primary Physician		Work Phone	M.D. Orders Needed ☐ Yes ☐ No		
Hospital of Choice		Last Hospital Stay			

INSURANCE INFORMATION

Primary Carrier	ID/Policy No.	Phone
Secondary Carrier	ID/Policy No.	Phone

BILLING INFORMATION

Bill to		Relationship	Phone
Billing Address		City	State	Zip
Requested Start Date	Days of Service	Hours of Service	Ongoing ☐ Yes ☐ No

Type of Service (e.g. Home care assistant, companion, live-in, nurse)

Other Organizations Involved in Care (e.g. Medicare Certified Agency)

Payment Type ☐ Credit Card ☐ Check ☐ Insurance

GENERAL INFORMATION

Medical Equipment
- ☐ None
- ☐ Gait Belt
- ☐ Walker
- ☐ Cane
- ☐ Wheelchair
- ☐ BSC
- ☐ Urinal
- ☐ Hospital Bed
- ☐ Hoyer Lift
- ☐ Other _____
- ☐ Other _____

Mental Status
- ☐ Alert/Oriented
- ☐ Disoriented
- ☐ Anxious/Agitated
- ☐ Forgetful
- ☐ Other _____

Pets
- ☐ Yes
- ☐ No

Type of Pets _____

Physical Status
- ☐ Ambulatory
- ☐ Needs Assistance to Walk
- ☐ Bedfast
- ☐ Other _____

Elimination Status
- ☐ Normal Bladder
- ☐ Normal Bowel
- ☐ Bladder Incontinence
- ☐ Bowel Incontinence
- ☐ Diapers
- ☐ Catheter

Other

Primary language_____

Living arrangements_____

Smoking_____

Other_____

Other_____

Phone

Permission for Service to Begin Given by	Date
Permission for Service to Begin Received by	Date

AGREEMENT FOR SERVICES

SafeNSteady Inc.
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Delray Beach, FL 33483
561-237-5252
www.safensteady.com

1. Terms of the Agreement: This agreement (the "Agreement") is made and entered into by and between Client (defined herein) and Safe N Steady, Inc. ("Company"), as of _____, 20_____. By signing this Agreement, Client agrees to the terms and conditions contained herein. Client and Company sometimes referred to as the Parties.

2. Client Information:

Client Name ("Client"): Last Name:_____ First Name:_____ M.I.____ Phone:_____

Financially Responsible Person:_____ Relationship:_____ Phone:_____

Client's Insurance Company:_____ Policy:_____

Services to be provided (the "Services"): Service_____ Rate:_____

Service_____ Rate:_____

3. Services: Client has requested that Company provide the Services and Company agrees to provide the Services subject to the terms and conditions contained herein. The Company shall make every effort to fulfill the service requests of Client but cannot guarantee uninterrupted service. Client understands and agrees that despite all efforts, there may be an interpretation of services due to factors beyond the control of the Company. Client understands that a family member must be responsible for the care of the Client should the Company be unable to provide the Services. Client agrees to notify the Company no less that four (4) hours in advance to cancel scheduled services. In the event that Client fails to provide adequate cancellation notice to Company, Client shall be billed for four (4) hours of service.

4. Disclosures: All Caregivers are Independent Contractors registered with Safe N Steady Inc. Client understands and agrees that Client will be charged time and 1/2 for the following holidays: New Year's Eve, New Year's Day, Easter, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Eve, and Christmas Day (If other, insert here:_____). Further, Client understands and agrees that mileage or carfare may be charged if a caregiver uses his/her personal vehicle to transport/run errands for Client. Client agrees that Client will be charged_____ per mile. Client understands and agrees that rates are subject to change and updated rates are available by contacting the Company.

5. Financial Responsibility: The Client or financially responsible party (the "Guarantor") agrees that by signing below, Client/Guarantor shall be responsible for payment of services, including services not paid by Client's/Guarantor's insurance company, if applicable. In the event that it becomes necessary to collect this account, Client/Guarantor shall be responsible for all costs incident thereto, including late fees, interest, and reasonable attorney fees. The Company shall submit insurance claims as a service to me, but this does not relieve Client/Guarantor of financial responsibility.

6. Assignment of Benefits: Client hereby assigns to the Company any benefits due and otherwise payable to Client for services rendered by the Company. Client hereby requests that payment be made directly to the Company on Client's behalf and that Client shall cooperate in releasing records that may be necessary to effectuate the purpose of this provision. Further, Client understands that this Assignment applies only to eligible charges and that any charge not paid for by Client's insurer shall remain financial responsibility of the Client.

7. Verification of Service: Client hereby understands and agrees that each employee who renders service will request my signature on a time document which specifies the days/hours the services were provided. Client understands this document will be used to preparer invoices. Client agrees to review and sign the time documents when submitted on a timely basis and to retain a Client copy. By signing below, Client authorizes a waiver of the signature procedure in the event that Client is unable to sign the necessary documents. All invoices for Company's services and costs are due ten (10) days after receipt by Client. Client will be charged interest at a yearly rate of twelve percent on any remaining balance not paid within thirty (30) days from the date of the invoice. CLIENT UNDERSTANDS AND AGREES THAT ALL PAYMENTS SHOULD BE REMITTED TO COMPANY DIRECTLY AND CLIENT SHOULD NEVER PAY ANY CAREGIVER DIRECTLY, OR MAKE LOANS, GIFTS OR ADVANCES OF ANY MONEY TO ANY CAREGIVER.

8. LIMITATION OF LIABILITY: The Company shall not be responsible for consequential damages except as to such damages as may arise from the following: (a) willful acts; AND (b) gross or continuing negligence on its part. THE LIABILITY OF THE COMPANY, IF ANY, AS A RESULT OF THIS CONTRACT WHETHER IN CONTRACT, TORT OR OTHERWISE, SHALL NOT EXCEED THE TOTAL CHARGES PAID BY CLIENT TO COMPANY FROM THE DATE OF THIS CONTRACT. THE COMPANY WILL NOT BE LIABLE FOR DAMAGES WHICH ARE INCIDENTAL OR CONSEQUENTIAL DAMAGES. THE REMEDIES EXPRESSED IN THIS CONTRACT ARE THE SOLE AND EXCLUSIVE REMEDIES AVAILABLE.

9. Non-Circumvent: Withoutthe Company's prior written consent, Client will not for a period of twelve (12) months from the date the last services are rendered to the Client by Company: (i) recruit, solicit, or entice any current employee and/or contractor of Company, or offer any form of employment to any current employee or contractor of Company (or encourage any of Client's family members do the same). In the event Client violates this paragraph, Client agrees to pay the Company liquidated damages in the amount of $_____, which sum is agreed on as the proper measure of liquidated damages and this sum is not to be construed in any sense as a penalty.

10. Assignment: Client may not assign this Agreement without the prior written consent of the Company. Company may assign this Agreement to any successor of Company or any acquirer of Company's assets.

11. Captions: Captions and paragraph headings used herein are for convenience only, are not a part of this Agreement and shall not be deemed to limit or alter any provisions hereof or to be relevant in constructing this Agreement.

12. Authority: The person signing this document on behalf of Client represents (by such signature) that he or she has been duly authorized by Client to execute this document and that such signature creates a binding obligation of Client (and guarantor). Client represents that Client has the right and authority to enter into this Agreement.

13. Waiver of Jury Trial: THE PARTIES HEREBY IRREVOCABLY AND UNCONDITIONALLY WAIVE ANY AND ALL RIGHT TO TRIAL BY JURY IN ANY ACTION, SUIT, OR COUNTERCLAIM ARISING IN CONNECTION WITH, OUT OF, OR RELATING TO THIS AGREEMENT.

14. Miscellaneous: This Agreement shall be binding upon and inure to the benefit of the parties hereto, their heirs, executors, administrators, successors, assigns, affiliates and subsidiaries, and shall be governed by the laws of the State of Florida, with exclusive venue in the courts in and for Palm Beach County, Florida. This Agreement constitutes the entire agreement between the parties on the subject matter contained herein. This Agreement may be signed in counterparts and each of the counterparts shall constitute an original document and the counterparts, taken together, shall constitute one and the same instrument. The parties agree that a facsimile or a scanned email copy of a party's signature may be deemed as an original for all purposes. The Parties agree that if any provision of this Agreement is held to be illegal, invalid, or unenforceable, such provision will not be a part of this Agreement and the remaining provisions will not be affected by a finding that any provision of this Agreement is illegal, invalid, or unenforceable. This Agreement may not be terminated, modified or amended orally or by any course of conduct. This Agreement may be modified or amended only by a writing expressly referring to this Agreement and executed by the parties. All representations, warranties, and covenants made by the Parties in this Agreement shall be deemed made for the purpose of inducing the other to enter into this Agreement and shall survive and remain in full force and effect. All representations, warranties, and covenants made by the Parties in this Agreement shall be deemed made for the purpose of inducing the other to enter into this Agreement and shall survive and remain in full force and effect.

IN WITNESS THEREOF, the parties have executed this Agreement as of the date set forth after each party's name below.

"Client"

Client Signature_____ Date:_____

Print:_____

"Company"

Company Signature:_____ Date:_____

Print:_____

"Guarantor"

Guarantor/Financial Responsible Party:_____ Date:_____

Print:_____

Client's Emergency Contact: Emergency Contact:_____ Phone:_____