SERVICE AGREEMENT

Please review this agreement carefully, as it sets forth the understanding between you ("Patient") and Full Scope Home Health LLC ("Agency") regarding the services you have requested and we will provide for you. If you have any questions, concerns or issues about the content of this Agreement please contact us for clarification before signing it.

THIS AGREEMENT made this day of_____("Effective Date") by and between Full Scope Home Health LLC and

_____

Name of Patient and/or Responsible Person

_____

City *State* *Zip*

_____

Home Phone *Cell* *Other*

_____

Emergency Contact(s) name and relationship *Phone* *Alternate phone*

("Patient") on the terms and conditions set out below:

1. **Term of Agreement**. The term of this agreement will start on the Effective Date, and will on an as-needed basis until the Agreement is terminated by either party, as provided hereunder.

2. **Services Requested**. We will provide the services ("Services") requested and agreed upon in the Services Request Form and as set out in the Care Plan enclosed. The preferred day, time and duration of services will be mutually agreed upon by you and/or your representative and the agency.

3. **Rates, Fees & Deposits**. We will provide the services at the following rates:

$	**> 3.0 hrs.**	**< 3.0 hrs.**	**24 hrs.** **(hourly rate)**

Weekdays			
Weekends			

The minimum shift length is 2 hours. Weekends begin at 7pm on Friday and end at 7am Monday morning. Holidays are billed at 50% greater than the above or "time-and-a-half". Designated holidays are New Year's Day, Memorial Day, July Fourth, Labor Day, Thanksgiving and Christmas Day. Live-in rates noted above assume that the caregiver's food comes from the family pantry. If for any reason this is not practical, then there will be an additional charge of $10 per day for the caregiver to supply his/her own food. If multiple service types or hours are requested, or if the service request changes, the rates may change accordingly. Rates for services are subject to review from time to time, but increases will be subject to at least a four-week advance notice. We are required by law to pay our employees time-and-a-half if they work more than 40 hours per week. To accommodate the rates you have been quoted, we will manage your care in such a way that the employee does not work more than 40 hours in any Monday through Sunday timesheet period. If you would like a given caregiver to be assigned to work when it means they will be accruing overtime pay (and they are willing to work the overtime), you will be charged time-and-a-half. Flat rate shifts (e.g. Live-In) assume the caregiver gets 8 hours sleep per night and do not attract overtime. Two or three disturbances are acceptable. If the caregiver is required to be awake all night then both the hourly rate (24 hr care) and overtime rule will apply.

1. Deposits. A deposit equivalent to two week's service charge will be expected upon execution of this contract before the start of services. The agreed total deposit is $. The deposit will be held by the agency without interest for the duration of services. Any unused portion of that amount will be promptly refunded to the patient upon termination of services. If you request an increase in services, the deposit will be increased proportionately.

2. Billing. The caregiver will fill out a timesheet daily. At the end of the caregiver's work week (Monday to Sunday), you will be expected to sign the timesheet as acceptance of the hours service delivered. Please sign it promptly so the caregiver can be paid promptly. After the start of services, invoices will be sent bi-weekly after completion of each service

period. Any questions regarding timesheets or your invoice should be directed to our office.

3. Payment and Overdue Accounts. Fees for services rendered are payable upon receipt of invoice. Payment may be made by check, money order or credit card. It is Full Scope Home Health LLC's policy not to accept checks endorsed over to the agency. All payments must be remitted to the address noted above; direct care workers are not permitted to accept payment. An account is considered overdue if not paid within 10 days of the billing date. Interest will be charged on account balances which remain unpaid for 5 days or more after the same becomes due at the rate of 1.5 % per month (18 % per annum), until paid. We reserve the right to discontinue providing services until the account is paid in full, including any additional charges and accrued interest. A $25.00 returned check fee will be charged. Checks are to be made payable to Four Season Healthcare.

4. Cancellations. Cancellations may be made up to 24 hours in advance of a scheduled visit without charge. We reserve the right to charge for a scheduled visit if insufficient notice is not given. In the event that a referred caregiver fails to arrive at the care recipient's home, we will make every effort to find a replacement as quickly as possible. If a replacement is not found or if the caregiver alters the predetermined weekly schedule in some way, we will adjust the amount that you are billed accordingly.

5. Termination. Either "Patient" or "Agency" may terminate this agreement upon two (2) calendar-week's written notice to the other party. If either party terminates this Agreement, all fees due at time of termination will be due and payable by you immediately. We will immediately refund any prepaid fees. Exception to the two week notice provision would include:

a. When care needs undergo a change which necessitates transfer to a higher level of care.

b. When there is documented non-compliance of the Care Plan or Service Agreement (including, non-payment of justified charges).

c. When the activities or circumstances in the home jeopardize the welfare and safety of the home health aide.

Patient or patient's representative shall have the right to appeal the discharge decision during the two week notice period and will be notified of this in the discharge statement. The Appeal panel will be led by the Director of Care Services and include both the Supervisor and Caregiver. The panel will review the patient file with the patient or patient's representative.

The Director of Care Services decision is final.

6. Governing Law. The laws of the State of Wisconsin shall govern this agreement.

7. Agency's Responsibilities. Full Scope Home Health LLC's responsibilities are outlined on the enclosed "Rights and Responsibilities" form.

8. Patient's Responsibilities. Your responsibilities are outlined on the enclosed "Rights and Responsibilities" form. You will be required to sign it.

9. Light Housekeeping Defined: The caregiver employee is not required to provide a general housekeeping service. Typical ""light" housekeeping tasks to be provided by the caregiver employee would include: tidying up of rooms in which the care recipient spends his/her time (bedroom, living room, kitchen), washing dishes after meals (wiping spills on sink or floor, "spot cleaning"), sweeping kitchen floor when needed, passing the vacuum in rooms used by care recipient, tidying bathrooms after use by care recipient (rinsing tub or shower after use, wiping spills on sink or floor). It is recommended that you hire an independent cleaning service for tasks such as scrubbing floors in kitchen and bathrooms, window or mirror washing, dusting behind and under furniture, drape cleaning and heavy laundry.

10. Transportation. Requested transportation services should be outlined in your Care Plan. A vehicle is not to be driven by the caregiver employee without prior written authorization from the patient to the agency. Full Scope Home Health LLC's insurance does not cover loss or damage caused by employees operating the patient's owner or leased vehicle. The patient accepts full responsibility for any and all claims. If an employee of the Agency transports a patient in their own vehicle, company vehicle or the patient's vehicle, the patient will release the Agency and/or that employee from all liability should an injury or accident occur. If the agency employee drives her/his own vehicle in order to perform services to the patient, the patient will be billed at $0.57 per mile (passed along in full to the caregiver). It is also your responsibility to pay for or reimburse the caregiver directly for any expenses incurred in the course of

providing services, such as tolls and parking, and the cost of food or entertainment undertaken as part of services. If the caregiver drives to your residence, a space safe from towing must be provided. If meters are to be used, then the caregiver must be allowed time to feed the meter at appropriate intervals. Such reimbursable expenses will be claimed by the caregiver and included in regular invoices.

4. **Private/Direct Hiring**. The overriding business relationship is strictly between you and Full Scope Home Health LLC, and by agreeing to this proposal you are confirming to us that you

will abstain from making or accepting any offers whereby any of the caregivers/employees we have referred to you would provide services other than as sanctioned by Full Scope Home Health LLC LLC (whether you still have an ongoing relationship with Full Scope Home Health LLC LLC, or not) for a period of two years after the date of the final fee that you pay to us. If you violate this provision, you will immediately pay Full Scope Home Health LLC a sum of $10,000 for each affected individual employee.

5. **Insurances.** We will maintain worker's compensation insurance coverage for any and all referred caregivers, and they will be bonded. In good faith, you agree to maintain homeowner's insurance, medical insurance and/or other coverage as may be necessary to provide protection for the care recipient.

6. **Severe/Bad Weather.** In severe weather, we may determine it is not safe for our Home Care Workers to travel and provide services to your home that day and may have to cancel that day's service. When this occurs we will notify you and reschedule. We appreciate your understanding regarding this matter.

7. **Supplies and Equipment.** You are responsible for supplying all supplies (i.e. cleaning, personal care etc. including latex gloves needed for the safe execution of any kind of personal care) and equipment which may be necessary in the provision of services. Extra charges will apply if the Agency provides the supplies and/or equipment.

Your signature and /or your representative's signature below indicate that you and/or your representative have read, understand and are in agreement with the terms and conditions of this Service Agreement.

_____ _____

Patient/Patient's Representative Signature Date

_____ _____

Agency Authorized Signature & Position Date

The following information has been provided to and/or discussed with the Patient:

_____Rights & Responsibilities,

_____Costs & Billing,
_____Confidentiality of Patient Information,
_____Contact Information,
_____Admission Policies,
_____Emergency Planning
_____Complaints & Compliments,
_____Gifts,
_____Equal Employment Opportunity is the Law,
_____Hours of Operation

Documentation & Information:
I acknowledge that the information and documentation as noted above has been discussed with me and I will be provided with a copy.

Monitoring and Follow-up:
I understand that my service requests/needs will be reviewed by the Supervisor at least every 60 days, or as needed, and that the service(s) may be changed according to my needs, wants or wishes.

I acknowledge receipt of the information noted above:

_____

Patient's Signature Date

_____

Patient's Representative's Signature Date

_____

Print Patient Representative's Name & Relationship

_____

Supervisor Signature Date