Consent, Service Agreement, and Financial Authorization

Consent for Services

World of Words Speech & Feeding Services LLC (the Agency) is my primary home care agency. I understand it is licensed to provide Personal Assistance Services and I accept these services from the Agency. I know I can be involved in my care and I can work with the Supervisor to develop my Individualized Service Plan (ISP). It has been explained to me what the Attendant/Caregiver can and can't do for me.

I can contact the Agency 24/7 at 361-220-6455 if I have any questions. I understand this is not an emergency number. I understand the Agency's Attendants/Caregivers do not perform CPR. If I have an emergency, I will call 911.

I give my consent for services from the Agency. I have been informed of the services, care, and any procedures to be carried out by the Agency for me. This consent is valid from the date signed and I understand that I may withdraw my consent at any time, after which services will not be provided.

Advance Directives for Health Care

☐ I have received an explanation and the Agency's Policy on Advance Directives. I understand that the Agency respects individual choice and will not discriminate based on whether or not I have Advance Directives.

☐ I do not have Advance Directives in place.

☐ I have Advance Directives for: ☐Living Will/Directive to Physician ☐Out of Hospital DNR ☐Medical Power of Attorney - Name of Medical POA: _____ Phone #: _____

☐ I am ☐ I am not providing a copy for my record. I understand the Agency is not liable for failure to act as required by the Advance Directives if a copy is not provided to the Agency.

My Rights and Responsibilities

☐ The contents of the Admission packet from the Agency, which sets forth my rights and responsibilities, was explained to me prior to the start of care and left in my home as a reference.

☐ I have received written and verbal information and understand my rights and the following:

- ☐ Rights of the Elderly ☐ Client Rights ☐ Agency's Policy on Abuse, Neglect, Exploitation
- ☐ HIPAA- I have received and read the Notice of Privacy Practices and consent to the Agency's use and/or disclosure of protected health information for payment, treatment, and the Agency's health care operations.
- ☐ Agency's Drug Testing Policy
- ☐ Hazardous Waste Disposal in the Home ☐ Home Safety Checklist
- ☐ Emergency Preparedness was discussed, I was given information about registering with 2-1-1, and I have been informed about what to do in an emergency/natural disaster.
- ☐ Client Information & Emergency/Disaster Preparedness Plan
- ☐ Responsibilities of Client and Agency During a Disaster
- ☐ Emergency Preparedness tips and resources
- ☐ State of Texas Emergency Assistance Registry (STEAR)
- ☐ I have the right to lodge complaints with the Administrator and with any other person or regulatory agency:

The Texas Health and Human Services Commission's Consumer Rights and Services Division; PO Box 149030; Austin, TX 78714-9030; or by calling toll free 24 hours a day at 1.800.458.9858;

The Office for Civil Rights; U. S. Department of Health and Human Services; 200 Independence Avenue, SW, Room 509F, HHH Building; Washington, D. C. 20201; https://ocrportal.hhs.gov/ocr/portal/lobby.jsf; ocrmail@hhs.gov; 1.800.368.1019; TDD 1.800.537.7697;

The Texas Attorney General's Consumer Protection Hotline at 1.800.621.0508;

The Texas Department of Insurance; PO Box 149091; Austin, TX 78714; Consumer Help Line at 1-800-252-3439; online at http://www.tdi.texas.gov/consumer/complfrm.html, or email to ConsumerProtection@tdi.texas.gov for complaints related to insurance carriers; and

Service Interruption

☐ I understand the Agency uses its best efforts to provide uninterrupted services; however, sometimes interruptions are unavoidable. Backup services may be provided by another Attendant/Caregiver from the Agency, a contractor the Agency hires, or someone I have designated. My designee will sign a written agreement with the Agency to be my backup service provider.

FINANCIAL INFORMATION AND AUTHORIZATION

There is a one–time only application fee of $_____ to be paid directly to the Agency.

Deposit Explanation

DEPOSIT WITH CONTRACT: $ _____

You or your representative agrees to pay a deposit at the signing of the contract in the amount commensurate with the cost of one week of service. This deposit will be held in escrow. This deposit will be applied to your outstanding balance when services are terminated and noted on the final invoice. Any balance due to you will be refunded within 45 days.

Services, Rates, Estimated Frequency and Duration, and Supervision

Services	Rates: ☐ Hourly ☐ Daily ☐ Other	Estimated Frequency and Duration
Attendants		
Caregivers/Companions		
RN Delegation		
☐ N/A Routine Services: Supervisory Visits will be made by an Agency Supervisor every: ☐ 60 Days ☐ 6 Months Other: _____		
☐ N/A RN Delegation: Supervisory Visits will be made by an Agency Registered Nurse every: ☐ 60 Days ☐ 6 Months Other: _____		

☐ The above may be revised based on my condition, according to the payor source, or by my request.

Live-In (If applicable)

☐ I agree with the pay schedule for the Agency's Attendants/Caregivers who provide services to me on a live-in basis. I understand the Agency complies with the Texas Workforce Commission's Payday Law for paying wages for all time worked. The Agency complies with the U. S. Fair Labor Standards Act in excluding sleep time from the Attendant/Caregiver's hours worked.

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Terminations

☐ I understand that I may terminate this Agreement by giving at least twenty-four (24) hours' notice to the Agency to avoid cancellation charges. I understand that the Agency may terminate this Agreement by providing notice as is required under applicable state law. I understand that the Agency may terminate this agreement at any time upon my request; if I no longer live in the Agency's licensure geographic service area; if my medical needs require a discharge, such as for a medical emergency; in the event of a disaster when my health and safety are at risk; for the protection of the Agency's staff or me after the Agency has made a documented reasonable effort to notify me, my family, my practitioner if s/he is involved in the Agency's care of me, and appropriate state or local authorities of the Agency's concerns for the staff's or my safety; according to my practitioner if s/he is involved in the Agency's care of me; if the Agency voluntarily suspends services or permanently closes; or if I or my representative fails to pay for services, except as prohibited by federal law.

Payment for Services

I am LEGALLY RESPONSIBLE for payment for all services rendered by the Agency to me. I agree to pay the Agency for any and all services not paid for by my private insurance and understand that I will be billed for such services rendered and agree to pay all invoices upon receipt; but, no later than within seven (7) days. I authorize the Agency to check my credit.

Billing Information if you, your representative, or your insurance company are paying for the services: ☐ **N/A**

Name_____

Street Address_____

City, State, Zip Code_____

Home Phone:_____ Cell Phone:_____

Your Insurance ID Number:_____

Percent to bill your Insurance:_____ percent

I agree to pay the co-pay of $_____

If applicable, I agree to pay for all supplies and/or equipment except: Personal Protective Equipment (PPE) supplied by the Agency at my request._____

I authorize the Agency to charge my credit card or other Internet payor source for services rendered. I will receive a copy of the invoice.

Credit Card: ☐MC ☐Visa ☐ Other Internet payor source ☐Other:_____

Number:_____ Expiration Date:_____ Security Code:_____

Client Terms

If applicable, all rates are subject to a shift differential, holiday, and/or overtime charges based on current published rates. All holidays will be charged at time and one-half.

I will receive a written notice two (2) days prior to any rate change.

Attendants/Caregivers are paid by the Agency per the Texas Workforce Commission's Payday Law. I am required to certify that the hours recorded on the Service Delivery Record. This Form is the basis for the invoice that will be sent to me.

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If applicable, I understand that unpaid accounts will incur a $20.00 late fee per account. The account is considered in default after 20 days and a default charge will be imposed at 1.5% per month on unpaid balances (Annual Percentage rate of 18%) or the legal interest rate, whichever is lower. I agree to pay the late fee and default charges together with reasonable attorney's fees for the cost of collection.

I WILL NOT pay the Attendant/Caregiver directly. They are not authorized to accept, have custody of, or use cash, credit cards, or other valuables belonging to me. If I do give cash or other items to the Attendant/ Caregiver, I waive the right to offset this amount from the invoice. The Agency is not responsible for claims against it unless I report the claim in writing to the local police and to the Agency within 10 days after noticing the loss.

I acknowledge the considerable expense incurred by the Agency in advertising for, recruiting, training, evaluating, and retaining its employees. Accordingly, in consideration of the services provided, I agree that I will not employ any Attendant/Caregiver sent from the Agency for one (1) year from the last day of work or I agree to pay to the Agency a $2,000.00 placement fee in accordance with the separation fee schedule maintained by the Agency.

Printed name of person signing:_____

_____ Date:_____

Signature (Client, Authorized Representative, or Financially Responsible Person if the Client is unable to sign)

Relationship to the Client _____

Reason the Client cannot sign_____

Agency Representative's Signature_____ Date:_____

Medication Profile

Client Name:					
Height:	Weight:	Pharmacy:		Phone #:	
Medication	Dose	Frequency	Route	Check if New/Changed/DC'd	Date Meds Started/Changed/DC'd
				☐(N) ☐(C) ☐(D/C)	/ /
				☐(N) ☐(C) ☐(D/C)	/ /
				☐(N) ☐(C) ☐(D/C)	/ /
				☐(N) ☐(C) ☐(D/C)	/ /
				☐(N) ☐(C) ☐(D/C)	/ /
				☐(N) ☐(C) ☐(D/C)	/ /
				☐(N) ☐(C) ☐(D/C)	/ /
				☐(N) ☐(C) ☐(D/C)	/ /
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				☐(N) ☐(C) ☐(D/C)	/ /
				☐(N) ☐(C) ☐(D/C)	/ /
				☐(N) ☐(C) ☐(D/C)	/ /
				☐(N) ☐(C) ☐(D/C)	/ /

Reviewed By: ______________________ Date: ____________ Reviewed By: ______________________ Date: ____________
Reviewed By: ______________________ Date: ____________ Reviewed By: ______________________ Date: ____________
Reviewed By: ______________________ Date: ____________ Reviewed By: ______________________ Date: ____________
Reviewed By: ______________________ Date: ____________ Reviewed By: ______________________ Date: ____________
Reviewed By: ______________________ Date: ____________ Reviewed By: ______________________ Date: ____________

Allergies:

Nurse Signature/Credentials: Date:

Coordination of Care

World of Words Speech & Feeding Services LLC **Phone: (361) 220-6455** **Fax: (361) 703-1135**
Client Name: _____ **MR #:** _____

Service (Can be more than one)	Name of Agency	Phone Number	Contact Person
DAHS			
Dialysis Clinic			
DME			
Hospice			
IV Pharmacy			
Medicare Home Health Agency (HHA)			
Outpatient Rehab			
PHC Program			
Practitioner			
Star+Plus			
Veteran's Admin.			
Wound Care Clinic			

1) Coordination with Agency: _____ **Spoke with:** _____
Regarding Their: ☐Tasks and/or ☐ Services Provided:
☐ Bathing ☐ Dressing ☐ Routine Hair/Skin Care ☐ Exercise ☐ Feeding ☐ Grooming ☐ Toileting ☐ Transfer ☐ Ambulation
☐ Cleaning ☐ Laundry ☐ Meal Prep ☐ Escort ☐ Shopping ☐ Assist w/Self Med ☐ Other:_____
☐ Attendant Hours/Schedule:_____SN(Freq)_____
☐ Discipline's Freq: RN_____ LVN_____Aide_____ PT_____ST_____OT_____MSW_____
☐ For DAHS: Days_____ Time picked up_____ Time dropped off at home_____
☐ Diagnosis/Functional Limitations: _____Cert Period:_____/_____
☐ Diet:_____ ☐ Problem/Challenges_____
☐ Other_____
_____

Signature: _____ **Date:** _____

2) Coordination with Agency: _____ **Spoke with:** _____
Regarding Their: ☐Tasks and/or ☐ Services Provided:
☐ Bathing ☐ Dressing ☐ Routine Hair/Skin Care ☐ Exercise ☐ Feeding ☐ Grooming ☐ Toileting ☐ Transfer ☐ Ambulation
☐ Cleaning ☐ Laundry ☐ Meal Prep ☐ Escort ☐ Shopping ☐ Assist w/Self Med ☐ Other:_____
☐ Attendant Hours/Schedule:_____SN(Freq)_____
☐ Discipline's Freq: RN_____ LVN_____Aide_____ PT_____ST_____OT_____MSW_____
☐ For DAHS: Days_____ Time picked up_____ Time dropped off at home_____
☐ Diagnosis/Functional Limitations: _____Cert Period:_____/_____
☐ Diet:_____ ☐ Problem/Challenges_____
☐ Other_____
_____

Signature: _____ **Date:** _____

3) OTHER Coordination with/of:_____
Regarding:_____
_____
_____

Signature: _____ **Date:** _____

Client Information & Triage Plan

World of Words Speech & Feeding Services LLC **(361) 220-6455**
IN EMERGENCY: CALL 911, 211, OR APPROPRIATE EMERGENCY ACCESS

Do you have transportation to evacuate? ☐ Yes ☐ No
By Whom?_____ Phone Number: _____
Client Name: _____ Gender: ☐ Female ☐ Male
Physical Address: _____
City: _____ Zip: _____ Phone Number: _____
Your Practitioner: _____ Phone Number: _____
Pharmacy: _____ Phone Number: _____
In case of emergency contact:
Name: _____ Phone Number: _____
Relationship: _____ Alternate Phone Number: _____
Do you have a pet or service animal? ☐ No ☐ Yes What?_____
Do you have special needs? ☐ No ☐ Yes Describe_____
(One who needs assistance during evacuation and sheltering because of physical or mental disabilities or one who requires a level of care and resources beyond the basic first aid level that is available in shelters for the general population).
If others are evacuating with you, who/how many?_____
Other entities involved in care: _____ **Phone:**_____
Coordination of Care with: _____ **Regarding:** _____ **Spoke to:** _____
Coordination of Care with: _____ **Regarding:** _____ **Spoke to:** _____
Client is registered with 211 ◯ Yes ◯ No ◯ **Client declines assistance with 211 Registration**
◯ **Client requests assistance with 211 registration** ◯ **211 Registration completed**

Emergency

If the client's condition changes significantly or for medical emergencies such as chest pain, difficulty in breathing, paralysis, bleeding, or falls, please call your practitioner, 911, or your appropriate emergency access for immediate attention. The Agency does not operate as an emergency service; therefore, valuable time may be lost by contacting the Agency.

Non-emergency

For a non-emergency, the Agency has a Supervisor "on-call" 24 hours per day, seven days per week. Your call will be answered by an answering service/machine if the office is closed. Please leave your name, the name of the client, the telephone number and address, and a brief description of why you are calling. This message will be forwarded to the "on-call" Supervisor who will return your call within 30 minutes.

Natural Disaster Triage

In the event of a natural disaster (e.g., tornadoes, hurricanes, winter storms/blizzards, nuclear power plant disaster, floods, chemical toxicity, epidemic/pandemic, pollution, fire, etc.), the Agency will prioritize visits according to the following triage classifications based on your needs: Class I____ II____ III____ IV____

Class I - Life threatening (or potentially) requiring ongoing medical treatment to prevent a life threatening episode, the client is unable to withstand any interruption in the power supply, is unable to evacuate/ transport self, or there is no readily available caregiver or the caregiver is unable to provide the needed care. Appropriate arrangements to transfer the client to an acute care facility will be made by the Agency in collaboration with the client/family, the client's physician if applicable for personal assistance services, and the local county or city emergency management authorities.

Class II – Services may be postponed 24-48 hours with minimal adverse effect as conditions are present that are not immediately life threatening; but, the client may suffer adverse effects without service (i.e. new insulin-dependent diabetic unable to self-inject insulin, use of IV medications, or s/he needs sterile wound care because of large amounts of drainage); the client is unable to transfer/transport self or there is no transportation available from caregiver. Appropriate arrangements may be made, if necessary, to send the client to a facility that can meet his/her needs. This will be done in collaboration with the client/family, the client's physician if applicable for personal assistance services, and the local county or city emergency management authorities.

Class III - Services may be postponed 48-72 hours without adverse effect on the client (i.e. new insulin-dependent diabetic who is able to self-inject the insulin, manageable cardiovascular and/or respiratory conditions, or sterile wound care to a wound with minimal to no drainage). The client can drive or transportation is available from family, friends, volunteers, or a caregiver.

Class IV - Services may be postponed 72 hours or more without adverse effect on the client (i.e. routine catheter changes or postoperative with no open wound). The client is independent in most activities of daily living (ADL's) or there is a willing and able caregiver readily available. The client can drive or transportation is available from family, friends, volunteers, or a caregiver.

The client/caregiver has been provided with verbal and written information on Emergency Preparedness.

_____
Agency Representative Signature Date

Invoicing Information

In – House Information

Client's Name: _____

Please circle the method that will be used to invoice client:

Invoice will be: ◎ E-Mailed ◎ Mailed

To Be Completed by The Interviewing World of Words Speech & Feeding Services LLC Agent:

☐ Name of person or institution responsible for payment: _____

Relationship to client: _____

☐ Email Address: _____

☐ Mailing Address: _____

Application Fee Received: ○Yes ○No ○Waived

_____	_____	_____
Amount	Check #	Date

Escrow or (Pre – Approved) Pre – Payment Received:

_____	_____	_____
Amount	Check #	Date

Hourly Rate to be charged: $ _____

Hours per Week agreed upon: _____

Direct Payment Authorization Form

Please complete the following information:

I authorize World of Words Speech & Feeding Services LLC to initiate electronic debit entries to my:

☐ Checking Account (or) ☐ Savings Account

For payment of services rendered by World of Words Speech & Feeding Services LLC, I understand that I will receive an electronic debit entry to my account each week following the weekly billing cycle that services are provided by World of Words Speech & Feeding Services LLC.

I acknowledge that the origination of the Automated Clearing House transaction to my account must comply with the provisions of U.S. law. This authority will remain in effect until I have cancelled in writing.

Date: _____

Name of Financial Institution: _____

Account Number: _____ Routing Number: _____

Address of Financial Institution:

_____ _____ _____

Address City / State Zip

_____

Signature Date

Please attach a voided check here.

Designation of Backup Personnel

Client: _____

The Agency can send a different Attendant/Caregiver as a backup if your regular Attendant/Caregiver is not available due to unforeseen circumstances if you choose for us to do so. The Agency will make every attempt to place a backup Attendant/Caregiver with you as soon as possible in the event of a service break; however, there may be a delay in finding a replacement Attendant/Caregiver.

Note for Primary Home Care (PHC) Program: In the event there is a service break, the Agency has 14 days to place another Attendant unless the client is deemed a Priority One client by the Health and Human Services Case Manager. In that case, there can be no service break.

However, proactively, you may choose to designate your own backup Attendant/Caregiver who is willing and able to provide the necessary services to you. If you decide to do this, your designated backup Attendant/ Caregiver should sign in agreement to fulfill this responsibility for you.

☐ I decline to appoint a Designee and will make the decision at the time to accept or not to accept the Agency's backup Attendant/Caregiver.

☐ I choose to designate a backup Attendant/Caregiver. His/her name and contact information are:

Designee's Name:_____

Designee's Address:_____

Designee's Telephone Number:_____

Designee's Email Address:_____

(Please let your Designee know the Agency might be sending an email so s/he doesn't think it is junk mail.)

I agree to be the Designee to provide backup services if the Agency's Attendant/Caregiver is unavailable.

Designee's Signature:_____ Date:_____

This Agreement will be kept in the client's record at the Agency.

Client's Acknowledgment:

Printed name of person signing:_____

_____ Date:_____

Signature (Client, Authorized Representative, or Financially Responsible Person if the Client is unable to sign)

Relationship to the Client _____

Reason the Client cannot sign_____

Agency Representative's Signature_____ Date:_____

(For Office Use Only):

If the client/consumer chose a Designee, date form sent to the Designee for signature: _____

Date signed form received at the Agency:_____

Individual Responsibility Agreement

This Individual Responsibility Agreement (IRA) is entered into between World of Words Speech & Feeding Services LLC and the Client/Legally

Authorized Representative, _____.

The specific need described below is one that is not provided by the Agency. The Client/Legally

Authorized Representative understands this and will take responsibility for meeting this need.

The Client/Legally Authorized Representative understands that if s/he does not meet this need, there may be significant consequences in his/her health. The Client/Legally Authorized Representative acknowledges that the possible consequences of not addressing this need have been fully explained and, having considered these consequences, chooses to take responsibility to see the need is met. The Agency and Client/Legally Authorized Representative agree that the Client/Legally Authorized Representative will take responsibility for the need.

This IRA is supporting documentation for the decision made. If either party desires to change or terminate this Agreement, the Client/Legally Authorized Representative and a Representative of the Agency must meet to discuss the cause for the change or termination. The decision made will be documented.

Identified need(s): _____

_____

_____

How the Client/Legally Authorized Representative will meet this need:_____

_____

_____

Possible consequences if the need is not met:_____

_____

_____

The Client/Legally Authorized Representative and the Agency=s Representative have each carefully read this Agreement, understand the content, and freely sign it.

Printed name of person signing:_____ Date:_____

Client/Legally Authorized Representative_____

Relationship to the Client: _____

Reason the Client cannot sign: _____

Agency Representative's Signature: _____ Date:_____