Senior Partner Care Services, Inc.
Telephone: 321-253-6336
8085 Spyglass Hill Road
Melbourne, FL 32940

… acting as Billing and Collection Representative and Assignee for Independent Contractor Caregiver referred for contract to Client below.

Independent Contractor Caregiver Information

Caregiver's name: _____ (last name) , _____ (first name)

Work week starting: Sunday, _____ (month) / _____ (day) / _____ (year)

… and ending: Saturday, _____ (month) / _____ (day) / _____ (year)

WEEKLY WORK LOG & CONTRACT FOR CAREGIVER SERVICES

Between: Client's name _____ Client's signature _____

And: Caregiver's name _____ Caregiver's signature _____

Pursuant to Florida Agency for Health Care Administration regulations, any changes in caregiver services must be documented by Senior Partner Care Services. Consequently, it is imperative that Client immediately report any changes in services.

As directed by Client, Caregiver performed the following services:	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Bathing							
Dressing							
Ambulating							
Transferring							
Toileting							
Re-positioning							
Feeding							
Apply lotion							
Oral hygiene							
Shave							
Hair care							
Range of motion assistance							
Change bed linen							
Grocery shopping							
Laundry							
Light housekeeping							
Remind patient of medication							
Observe physical & mental changes							
Accompany to appointments							
Prepare meals							

FAX TO: 321-253-6337

NOTE! All of the information on this form is required.

- This form is for one Client only. Use separate form for each Client
- Caregiver and client signature required (above)
- Client must initial to right of each day worked, (below)
- Completed form must be received by **9am Monday** immediately following the end of the work week. NO EXCEPTIONS!
- Check ✓ each ADL performed under each day worked
- Your signature confirms you have reviewed, understood and agreed to provide services requested by client

NOTE! Forms that are incomplete, incorrect, or received late will result in delay of Caregiver pay until next pay period

NOTE! Inform the office immediately if case ends, if Client is hospitalized, or if you observe significant changes in behavior.

By my signature, above, I (Client) affirm that I contracted with the above Caregiver. I certify that said Caregiver performed all services noted above satisfactorily, and I agree to pay Senior Partner Care Services, Inc. as assignee for Caregiver for the hours approved below. I understand that if services were not performed as requested, I should not sign and should call Senior Partner office immediately.

I understand that if this form is submitted without the checking of ADLs actually performed, if required by the insurance company, may result in the patient/client being billed directly.

Day	Date mo./day/year	Started work, AM or PM	Ended Work, AM or PM	Time Worked Hrs : Minutes	If time worked is different than time scheduled, explain	Miles Driven	List all places driven, and reason for trip	Client's Initials
Sun	___/___/___	___:___ __M	___:___ __M	____ : ____				
Mon	___/___/___	___:___ __M	___:___ __M	____ : ____				
Tue	___/___/___	___:___ __M	___:___ __M	____ : ____				
Wed	___/___/___	___:___ __M	___:___ __M	____ : ____				
Thu	___/___/___	___:___ __M	___:___ __M	____ : ____				
Fri	___/___/___	___:___ __M	___:___ __M	____ : ____				
Sat	___/___/___	___:___ __M	___:___ __M	____ : ____				

> > > > > > > > > > **For office use only -- Do not write below this line.** < < < < < < < < < <

Reviewed by: _____ Date: _____

Senior Partner is a licensed Nurse Registry, Florida AHCA lic. #NR30211049