 **TRINITY CARE XYZ**

***SERVICE AGREEMENT FORM***

**NAME OF CLIENT:**   **DOB:**

TYPE OF SERVICE: PCS IHSN DUAL **PDN**

LEVEL OF SERVICE: CHHA **LPN** RN

*Please check off the following topics after review with the client/family member:*

\_\_\_X\_\_ Initial Assessment

\_\_\_\_\_ Plan of Care

\_\_\_\_\_ 30 day Contract

\_\_\_\_\_ Reassessment

 Plan of Care revisions

\_\_\_\_\_ HIPPA Compliance

\_\_\_\_\_ Patient’s Rights print

\_\_\_\_\_ Release of Information

\_\_\_\_\_ Conditions for Discharge

\_\_\_\_\_ Financial arrangements and a current fee schedule is attached to this document (unless prohibited by payer source, such as Medicaid).

*The above topics have been explained to me in a way that I fully understand and I agree to follow these guidelines and regulations:*

Client/Family Member initials: Date:

Initial Days and Hours of Service: *(These days and hours might change according to client needs): HRS PER WEEK*

Sundays: HRS

Mondays: HRS

Tuesdays: HRS

Wednesdays HRS

Thursdays: HRS

Fridays: HRS

Saturdays: HRS

Conditions for discharge or transfer include: DX:

***I do hereby freely give my consent for the services described above:***

Initial: Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

 Nursing Supervisor: Date: