

FAX ONLY TO: 561-819-6611

Telephone: 561-279-0808
 2605 W. Atlantic Ave., Suite 101B-102B
 Delray Beach, FL. 33445

Caregiver's Name: _____
 Date: _____
 Week Ending Date: _____
 Position: RN LPN AIDE Companion/Sitter
 FL. State License #NR: 30210978, 30211226, 300211293, 30211316, 30211382, 30211390

Acting as Billing and Collection Representative and Assignee for Independent Contractors Caregivers referred for contract to patient below

CONTRACT FOR CAREGIVER SERVICES AND WEEKLY WORK LOG

Between: Caregiver's Name: _____ Caregiver's Signature: _____

And: Patient's Name: _____ Patient's Identification Number: _____

Pursuant to Regulations by the Agency for Health Care Administration, it is mandatory that Whitsyms make documentation of any changes in caregiver services. Consequently, it is imperative that patients/clients report any change(s) in services immediately.

USE ORIGINAL FORM ONLY (Patient to sign below each day services are performed)

As per the direction of Patient, Caregiver did / did not perform the following services:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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 HOUSE-KEEPING							
REMIND PATIENT OF MEDICATION							
OBSERVE PHYSICAL & MENTAL CHANGES							
ACCOMPANY TO APPOINTMENTS							
PREPARE MEALS							
ASSIST WITH OSTOMY CARE							
RECORD VITAL SIGNS							
INTAKE / OUTPUT							
WEIGHT							
INCONTINENCE CARE							

As agreed, I (Patient/Client) contracted with the above Caregiver and whom I certify performed all services noted above satisfactorily and I agree to pay WHITSYMS 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 WHITSYMS immediately. ****Work logs submitted without the checking of ADLs actually performed, and required by the insurance company, may result in the patient/client being billed directly. **Caregiver has reviewed Confirmation of Services Requested by Patient/Client and agrees to same******

DAY	DATE	TIME STARTED	DATE	TIME FINISHED	TOTAL HOURS	CHANGE IN ORIGINAL SCHEDULED HOURS	PATIENT/CLIENT'S SIGNATURE
SUN							
MON							
TUE							
WED							
THUR							
FRI							
SAT							

- Worklog must be signed daily by patient, signed weekly by Caregiver, and submitted to the office by 9 AM every Monday immediately following the end of each work week.
***** Failure to timely submit will result in delay of caregiver payment until next pay period *****
***** Complete with black ink pen ONLY *****

