

Divine Home Health Care Agency, LLC
Homemaker/Companion Services

SERVICE AGREEMENT
Caregiver Information & Orientation

The following contract is between, _____, hereafter referred to as "I" and Divine Home Health Care Agency LLC, and hereafter referred to as "DHHCA", "agency", or "the office".

1. **I understand that DHHCA, is a temporary agency and cannot guarantee full-time, part-time, or steady assignments.** I understand that I can be registered with other agencies.
2. I further understand that I work for DHHCA and CANNOT work for, or accept private payment from any client, family member, and hospital or community organization assigned to me by the agency. I agree to report any attempts of offers by clients of the agency to encourage me to break this agreement. If I accept any private payment or assignment from a client of the agency this may be grounds for immediate removal from the roster and legal actions.
3. I understand that **if I enter into a direct employment with a client provided by Divine Home Health Care, LLC that the agency will no longer provide me with any future clients.**
4. I agree to perform the duties specified in the Service Description for DHHCA Caregivers to the best of my ability on every assignment I work for the agency (See Service Description).
5. I understand that Divine Home Health Care Agency, LLC can dismiss me for violation of any of the standards of conduct/work that are presented to me in this orientation packet.

Caregiver's Signature _____

Social Security Number _____ - _____ - _____ Date _____

Timesheets

1. In order to receive my check, I understand I must submit a complete and accurate bi-weekly time sheet for each assignment I work for the agency, and that it must be signed and dated by the client (or responsible party) and myself.
2. **I should view the timesheet as MY INVOICE to the agency. NO TIMESHEETS, NO PAYCHECKS! NO EXCEPTIONS!**
3. If I run out of timesheet forms, it is my responsibility to arrange to get more from the office so that I may still turn in my timesheet in on time. They are on-line on the website in a doc format at divinehomehealthcare1@yahoo.com
4. I understand I must submit the completed timesheet to the office every other **Monday** in accordance with the Pay Period Schedule and on the **First day of the month.**
5. I understand that falsifying hour, signatures, dates worked, etc. on my timesheet can result in disciplinary action up to termination of my services.
6. Additionally, all timesheets MUST be filled out accurately, with DAILY documentation of all duties

CGs Initials _____

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Scheduled Check Periods

1. I understand the agency's check period is every two weeks, beginning on Monday and ending on Sunday of the second week. I will refer to the Check Period Schedule for each year, provided by the agency. To determine the dates included in each check period and the date of each check.
2. The agency will pay me every other Friday for all work performed up to the Pay Period ending date.

CGs Initials _____

Receiving Checks by Mail

1. All checks are sent by mail or direct deposit.
2. If I do not receive my check within three(3) business days, I will contact the office and give the agency at least three (3) business days to locate or stop payment on the check before receiving another.
3. There will be a \$25.00 fee for making a stop payment on a lost check (this is the fee charged by the agency's bank).

CGs Initials _____

Holiday Rates

1. I understand that I am not paid holiday pay.
2. I understand that working holidays is optional and those hours can be made up with in the week.

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Grievance Procedure

1. If I believe that there is a mistake on my check, I will bring it to the attention of the agency on scheduled check dates or by phone the following Monday or by appointment.
2. If the error is my mistake, I understand the amount will be corrected if necessary on my next check.
3. If the agency has made a legitimate mistake on my check, the amount will be corrected as soon as possible.
4. I understand that failure to comply with any or all of the company guidelines set forth may delay my check.

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Insurance

Divine Home Health Care Agency, LLC does not supply any sub-contractors' insurance. You as a sub-contractor will supply Divine Home Health and Care, LLC with a copy of a workman's comp insurance policy.

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Standards for Professional Conduct

It is the policy of Constant Companions Home Care to expect all caregivers working for the agency to observe certain standards of behavior. These standards are not intended to restrict an employee's legitimate rights, but to apply the same standards to everyone so that Constant Companions Home Care continues to foster a good reputation and image in the community.

1. I will provide every client with courtesy, dignity, and respect.
2. I will not neglect or be careless in the performance of my assigned duties or in the care and use of the client's property.
3. I will not discuss my earnings or other peoples' earnings, company policies, or any information concerning my client(s) with anyone other than the office for the purpose of protecting the health and welfare of my client.
4. I will not use the client's telephone OR my personal cell phone for personal calls while on-duty. I will only use a telephone for emergencies related to my client, for example: to call the client's doctor, family member, agency, or the paramedics or hospital.
5. I agree to advocate for the client's rights in the home.
6. I will not open client's mail without their authorization, will not take their personal funds, personal belongings, credit cards, etc., doing so is ***a criminal offense***.
7. I will refrain from any inappropriate discussion of my personal problems or circumstances with my client or their family while on duty.
8. I will never invite my friends, family, boyfriend/girlfriend, into the home of any client I work for with the agency, as this is a liability risk to the company and grounds for termination from my assignment.
9. If I enter into a direct employment agreement with a client provided by Divine Home Health Care Agency LLC., my client will be responsible to pay a finder's fee for my placement and DHHCA will not provide me with any future clients.
10. If I am dismissed from a case for ANY reason, I will have **NO FURTHER CONTACT** with the client or family members.

CGs Initials _____

Absences

THIS IS SO IMPORTANT – I had to make it BOTH bold and italic and BIG!!! ☺

When accepting an assignment from the agency, I agree to stay on the case for the entire length of the assignment.

1. ***If any injury occurs while you are out of the home you can be held personally liable under the law and the family of the client or the client can file criminal and civil charges. Notify the agency if you have to leave. We will contact the responsible family members.***
2. If I must quit my work on a case before the case has ended, I will notify the office ***immediately*** to give them enough time to find a replacement.
3. Legitimate reasons not to be able to report to work are family emergencies, medical emergencies, death of a relative, and illness.
4. ***No call, no show to any case will result in immediate termination.***
5. ***Frequent absences cause the loss of clients for the agency, force the client to endure staffing changes and will affect the reputation of the agency. THEREFORE, if you have frequent absences, we will not work with you any longer.***

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Illness

1. If you are truly too ill to report to work, you must call the office AT LEAST 12 hours prior to the start of your shift, **24 is preferable** to enable the agency to find a replacement and contact the client.

CGs Initials _____

Pre-Authorized Relief

1. I agree that if I know in advance that I will need time off for an appointment, or I would like days off for a non-emergency reason, I will give the office at least 48 hours (2) days' notice or more. If the office can arrange for a reliever for my scheduled shift(s) on the day I need off.
2. I will not make independent arrangements with friends, family members, or even other co-workers, to relieve me on a case when I need time off. ONLY the Divine Home HealthCare Agency, LLC office can schedule relievers for clients.
3. If I wish to have a day off on a major holiday, I will notify the agency's staffing department **1 week** in advance.

CGs Initials _____

Communication with the Office

The communication circle must always be caregiver (myself) to agency, agency to client and family. I must keep the agency informed of ANYTHING affecting my case(s) in a negative way.

I like to send texts. It is fast and accurate. Please have texting capability if you want an opportunity to work.

Cell Number: _____

Email: _____

CGs Initials _____

Dress Code

It is required that you adhere to the following suggestions.

1. Wear clean and neat nursing uniform (scrubs) or other appropriate clothing **if** requested by the client. No tears, holes, or stains. Scrubs are inexpensive and can be found used or new in many locations. If you need help in locating where you can find them please call the office.
2. Wear clean and comfortable shoes. No high heels or sandals.
3. No heavy make-up fancy or large jewelry, perfume, short skirts, short shorts, or any article that would prevent you from completing your duties or could injure a client.
4. Fingernails **MUST** be clean and **SHORT**.

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Safety

1. I will report immediately to the agency if my client is injured or falls, even if she/he is not seriously hurt, so appropriate action including an Incident Report may take place. All falls must be reported to 911 FIRST and then the office. The office will follow up with family members and you will stay with the client until 911 arrives.
2. I will report all unsafe conditions in the client's home, or any behavior of the client or his/her family member(s) that endangers my safety or that of the client.

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Money, Gifts, and Bonuses

1. I will not accept any form of payment directly from a client. If it is offered I will notify the office immediately.
2. If there is any form of money, i.e. credit cards, cash or checks that are not adequately put away and need attention, I will notify the office so that the Care Manager can make sure that these items are secured. Failure to do this could result in the wrongful implication of me in the event that these things go missing.
3. I understand that if a client accuses me of stealing or abuse, that the office is obligated to report this accusation immediately to the Adult Protective Services, no exceptions.
4. I will report all gifts to the office so that they may be adequately noted and reported to responsible parties so there are no misunderstandings and I am not accused of stealing.
5. I agree to PROTECT MYSELF AND THE AGENCY!!!!!!!!!!!!!!!!!!!!!!

CGs Initials _____

I understand this company orientation and if I need to review this document or any other form or document pertaining to my position with Divine Home Health Care Agency, LLC. They are all available on line at any time at Divinehomehealthcareagcy.com

Caregiver's Signature

Date:

Caregiver's Printed

Phone Number:

Caregiver's Address

City, State Zip