

HCAB
Home Care Agency Blueprint
Building Successful Home Care Businesses

Client Forms Bundle

Complete Documentation Package for Home Care Clients

Professional Bundle

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01

Client Intake Forms

Essential forms for gathering client information,
medical history, and assessing care needs

[Your Agency Name]

[Address] | [Phone] | [Email]

This form is used to capture initial information from prospective clients or their representatives when they first contact your agency. Complete during phone calls or in-person inquiries.

Inquiry Information

DATE OF INQUIRY

INQUIRY METHOD

REFERRAL SOURCE

INQUIRY TAKEN BY

Contact Person Information

CONTACT PERSON NAME

RELATIONSHIP TO CLIENT

PHONE NUMBER

ALTERNATE PHONE

EMAIL ADDRESS

BEST TIME TO CONTACT

Prospective Client Information

CLIENT NAME

DATE OF BIRTH

AGE

SERVICE ADDRESS

CITY

STATE

ZIP CODE

Service Needs Overview

PRIMARY REASON FOR SEEKING CARE

CURRENT LIVING SITUATION

- Lives alone
- Lives with spouse/partner
- Lives with family member
- Assisted living facility
- Other: _____

TYPE OF SERVICES INTERESTED IN (CHECK ALL THAT APPLY)

- Personal care (bathing, dressing, grooming)
- Companionship/Socialization
- Meal preparation
- Light housekeeping
- Transportation/Errands
- Medication reminders
- Overnight/24-hour care
- Respite care
- Hospice support

DESIRED START DATE

HOURS PER WEEK NEEDED

PREFERRED SCHEDULE

Payment Information

EXPECTED PAYMENT METHOD

- Private pay
- Long-term care insurance
- Veterans benefits
- Medicaid waiver
- Workers compensation
- Other: _____

Additional Notes

SPECIAL REQUESTS, CONCERNS, OR QUESTIONS

Follow-Up Actions

- Schedule in-home assessment
- Send information packet
- Follow-up call scheduled for: _____
- Referred to another agency/service

[Your Agency Name]

[Address] | [Phone] | [Email]

Complete this form to capture comprehensive demographic and contact information for the client. This serves as the primary client profile in your records.

Client Demographics

LAST NAME

FIRST NAME

MIDDLE NAME

PREFERRED NAME/NICKNAME

DATE OF BIRTH

SOCIAL SECURITY NUMBER

GENDER

MARITAL STATUS

PREFERRED LANGUAGE

Address Information

PRIMARY RESIDENCE / SERVICE ADDRESS

CITY

STATE

ZIP CODE

HOME PHONE

CELL PHONE

EMAIL ADDRESS

DIRECTIONS/ACCESS INSTRUCTIONS (GATE CODE, KEY LOCATION, ETC.)

Emergency Contacts

List at least two emergency contacts in order of priority.

#	NAME	RELATIONSHIP	PHONE NUMBER(S)	ADDRESS
1				
2				
3				

Responsible Party / Legal Representative

NAME

RELATIONSHIP TO CLIENT

ADDRESS (IF DIFFERENT FROM CLIENT)

PHONE NUMBER

EMAIL ADDRESS

LEGAL AUTHORITY (CHECK ALL THAT APPLY)

- Power of Attorney (POA)
- Healthcare Power of Attorney
- Legal Guardian
- Conservator
- None - Client is own representative

Healthcare Providers

PRIMARY CARE PHYSICIAN

PHONE NUMBER

ADDRESS

Other Healthcare Providers/Specialists:

PROVIDER NAME	SPECIALTY	PHONE NUMBER

PREFERRED PHARMACY

PHARMACY PHONE

PHARMACY ADDRESS

PREFERRED HOSPITAL

HOSPITAL PHONE

Insurance Information

Primary Insurance:

INSURANCE COMPANY

POLICY/MEMBER ID

GROUP NUMBER

PHONE NUMBER

POLICY HOLDER NAME

Secondary Insurance (if applicable):

INSURANCE COMPANY

POLICY/MEMBER ID

GROUP NUMBER

Additional Information

RELIGION/FAITH (OPTIONAL)

VETERAN STATUS

Yes No

HOBBIES/INTERESTS (HELPFUL FOR COMPANION CARE)

Empty text box for hobbies/interests.

CULTURAL CONSIDERATIONS OR PREFERENCES

Empty text box for cultural considerations or preferences.

I certify that the information provided above is accurate and complete to the best of my knowledge. I agree to notify the agency of any changes to this information.

Client/Representative Signature

Date

Printed Name

Relationship to Client

[Your Agency Name]

[Address] | [Phone] | [Email]

This form documents the client's medical history and current health status. This information helps caregivers provide safe, appropriate care. Complete with input from client, family, and/or physician as needed.

CLIENT NAME

DATE OF BIRTH

DATE COMPLETED

Current Medical Conditions

Check all conditions that apply and provide details where indicated:

CONDITION	DETAILS/NOTES
<input type="checkbox"/> Alzheimer's/Dementia	
<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Asthma/COPD/Respiratory	
<input type="checkbox"/> Cancer (type: _____)	
<input type="checkbox"/> Cardiac/Heart Disease	
<input type="checkbox"/> Diabetes (Type 1 / Type 2)	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Parkinson's Disease	
<input type="checkbox"/> Stroke/CVA	
<input type="checkbox"/> Vision Impairment	

CONDITION		DETAILS/NOTES
<input type="checkbox"/>	Hearing Impairment	
<input type="checkbox"/>	Depression/Anxiety	
<input type="checkbox"/>	Osteoporosis	
<input type="checkbox"/>	Incontinence (bladder/bowel)	

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE

Allergies

ALLERGY (MEDICATION, FOOD, ENVIRONMENTAL)	REACTION/SEVERITY

No Known Allergies (NKA)

CLIENT NAME

DATE OF BIRTH

Current Medications

List all current medications including prescriptions, over-the-counter, vitamins, and supplements:

MEDICATION NAME	DOSAGE	FREQUENCY	PURPOSE	PRESCRIBER

Note: Attach a complete medication list if additional space is needed. Update this list whenever medications change.

Surgical History

SURGERY/PROCEDURE	DATE (APPROXIMATE)	HOSPITAL/FACILITY

Hospitalizations (past 12 months)

REASON FOR HOSPITALIZATION	DATE	HOSPITAL	LENGTH OF STAY

Medical Equipment and Assistive Devices

- Walker
- Wheelchair
- Cane
- Hospital bed
- Oxygen equipment
- CPAP/BiPAP
- Hearing aids
- Glasses/contacts
- Dentures
- Lift/transfer equipment
- Glucose monitor
- Other: _____

Dietary Restrictions/Requirements

- Diabetic diet
- Low sodium
- Low fat/cholesterol
- Mechanical soft/pureed
- Thickened liquids
- Tube feeding
- Food allergies (specify above)
- Vegetarian/Vegan

Religious dietary requirements: _____

Other: _____

CLIENT NAME

DATE OF BIRTH

Pain Assessment

DOES CLIENT EXPERIENCE CHRONIC PAIN?

Yes No

IF YES, DESCRIBE LOCATION AND TYPE OF PAIN

HOW IS PAIN CURRENTLY MANAGED?

Mental Health/Cognitive Status

COGNITIVE STATUS

- Alert and oriented
- Mild cognitive impairment
- Moderate dementia
- Severe dementia

BEHAVIORAL CONSIDERATIONS (CHECK ALL THAT APPLY)

- Wandering risk
- Exit-seeking behavior
- Verbal aggression
- Physical aggression
- Sundowning
- Paranoia/hallucinations
- Depression

- Anxiety
- None of the above

NOTES ON BEHAVIOR MANAGEMENT STRATEGIES

Advance Directives

- Living Will on file
- Do Not Resuscitate (DNR) order
- POLST form completed
- Healthcare proxy designated
- No advance directives

LOCATION OF ADVANCE DIRECTIVE DOCUMENTS

Additional Medical Notes

ANY OTHER RELEVANT MEDICAL INFORMATION CAREGIVERS SHOULD KNOW

I certify that the medical information provided above is accurate and complete to the best of my knowledge.

Client/Representative Signature

Date

Printed Name

Relationship to Client

Form: MHF-001

Review and update every 6 months or as needed

[Your Agency Name]

[Address] | [Phone] | [Email]

Complete this assessment during the initial home visit. Identify potential hazards and document recommendations for improving safety. Review findings with client/family and document follow-up actions.

CLIENT NAME

ASSESSMENT DATE

ASSESSED BY

ADDRESS

TYPE OF RESIDENCE

NUMBER OF FLOORS

House Apartment Condo

Mobile Home Other

Rating Key: S = Satisfactory | NI = Needs Improvement | NA = Not Applicable | H = Hazard (Immediate Attention)

General Home Environment

ITEM	S	NI	NA	H	NOTES
Adequate lighting throughout home					
Light switches accessible at room entrances					
Nightlights in hallways and bathroom					
Smoke detectors present and working					
Carbon monoxide detectors present					
Fire extinguisher accessible					

ITEM	S	NI	NA	H	NOTES
Emergency numbers posted by phone					
Heating/cooling adequate					
Home clean and sanitary					
Clutter minimized in walkways					

Floors and Stairs

ITEM	S	NI	NA	H	NOTES
Floors in good repair (no holes/cracks)					
Carpets secured (no loose edges)					
Throw rugs removed or secured					
Electrical cords out of walkways					
Stairs well-lit					
Handrails present and secure on both sides					
Steps in good condition					
Non-slip treads on stairs					

Bathroom Safety

ITEM	S	NI	NA	H	NOTES
Grab bars at toilet					
Grab bars in tub/shower					
Non-slip mat in tub/shower					

ITEM	S	NI	NA	H	NOTES
Non-slip bath mat outside tub					
Shower chair/bench available					
Hand-held shower head					
Raised toilet seat (if needed)					
Hot water temperature safe (below 120F)					
Medications stored safely					

CLIENT NAME

DATE

Bedroom Safety

ITEM	S	NI	NA	H	NOTES
Bed at appropriate height					
Bed rails (if needed and appropriate)					
Clear path from bed to bathroom					
Nightlight or lamp within reach					
Phone/call system within reach					
Sturdy chair for dressing					

Kitchen Safety

ITEM	S	NI	NA	H	NOTES
Frequently used items within easy reach					
Sturdy step stool available (if needed)					
Stove has automatic shut-off					
No loose/frayed electrical cords					
Food stored properly					
Cleaning supplies stored safely					
Non-slip floor surface					

Outdoor/Entrance Safety

ITEM	S	NI	NA	H	NOTES
Walkways clear and even					
Steps in good repair					
Handrails at entrance steps					
Adequate outdoor lighting					
Ramp available (if needed)					
Doorway width adequate for equipment					
Door locks functioning properly					

Emergency Preparedness

ITEM	S	NI	NA	H	NOTES
Personal emergency response system (PERS)					
Emergency contact list available					
Flashlight accessible					
Clear exit routes identified					
Key/access available for emergency entry					

Summary of Hazards Identified

LIST ALL ITEMS MARKED "H" (HAZARD) OR SIGNIFICANT "NI" (NEEDS IMPROVEMENT)

Recommendations

RECOMMENDED MODIFICATIONS OR EQUIPMENT

Assessor Signature

Date

Client/Representative Signature

Date

Form: HSA-001

Reassess annually or after significant changes

[Your Agency Name]

[Address] | [Phone] | [Email]

This comprehensive assessment determines the client's care needs and helps develop an appropriate care plan. Complete during the initial home visit with input from the client, family members, and any available medical documentation.

CLIENT NAME

DATE OF BIRTH

ASSESSMENT DATE

ASSESSMENT COMPLETED BY

TITLE

OTHERS PRESENT DURING ASSESSMENT

Activities of Daily Living (ADLs) Assessment

Rating Scale: I = Independent | S = Supervision | LA = Limited Assistance | EA = Extensive Assistance | D = Dependent

ACTIVITY	I	S	LA	EA	D	NOTES/SPECIFIC NEEDS
Bathing/Showering						
Dressing						
Grooming (hair, nails, shaving)						
Oral Care						
Toileting						
Eating/Feeding						

ACTIVITY	I	S	LA	EA	D	NOTES/SPECIFIC NEEDS
Transferring (bed/ chair)						
Mobility/ Ambulation						
Contenance Management						

Instrumental Activities of Daily Living (IADLs) Assessment

ACTIVITY	I	S	LA	EA	D	NOTES/SPECIFIC NEEDS
Meal Preparation						
Light Housekeeping						
Laundry						
Shopping						
Transportation						
Medication Management						
Money Management						
Phone Use						

CLIENT NAME

DATE

Physical Function Assessment

MOBILITY STATUS

- Ambulatory without assistance
- Ambulatory with assistive device (specify): _____
- Requires physical assistance of one person
- Requires physical assistance of two persons
- Wheelchair-dependent
- Bedbound

FALL RISK ASSESSMENT

- Low risk
- Moderate risk
- High risk

FALL HISTORY (PAST 12 MONTHS)

Cognitive and Communication Assessment

ORIENTATION

- Oriented to person
- Oriented to place
- Oriented to time
- Oriented to situation

MEMORY

- Intact short-term memory
- Short-term memory impairment
- Intact long-term memory
- Long-term memory impairment

COMMUNICATION ABILITIES

- Able to express needs verbally

- Speech impairment (describe): _____
- Hearing impairment
- Vision impairment
- Uses communication device/board
- Non-verbal - relies on gestures/expressions

Psychosocial Assessment

SOCIAL SUPPORT SYSTEM

- Strong family support
- Limited family support
- No family support
- Friend/neighbor support available
- Socially isolated

EMOTIONAL/MENTAL HEALTH STATUS

- Generally positive mood
- Signs of depression
- Anxiety
- Grief/loss issues
- History of mental health diagnosis

DESCRIBE ANY BEHAVIORAL CONCERNS OR COPING CHALLENGES

CLIENT NAME

DATE

Client Preferences and Goals

CLIENT'S STATED GOALS FOR CARE

FAMILY'S GOALS FOR CARE

CAREGIVER GENDER PREFERENCE

- Female preferred Male preferred No preference

OTHER CAREGIVER PREFERENCES OR REQUIREMENTS

Recommended Services

- Personal care assistance (bathing, dressing, grooming)
- Toileting/incontinence care
- Mobility/transfer assistance
- Medication reminders
- Meal preparation
- Light housekeeping
- Laundry
- Companionship/socialization
- Transportation/errands

- Respite care
- Overnight care
- 24-hour/live-in care

Recommended Schedule

HOURS PER DAY

DAYS PER WEEK

PREFERRED TIMES

SCHEDULE NOTES/FLEXIBILITY

Assessment Summary

OVERALL ASSESSMENT SUMMARY AND KEY FINDINGS

REFERRALS OR ADDITIONAL SERVICES RECOMMENDED

Assessor Signature

Date

Client/Representative Signature

Date

02

Service Agreement Template

Comprehensive service agreement including scope of services, payment terms, policies, and required consents

[Your Agency Name]

[Address] | [Phone] | [Email] | License #: [Number]

This Home Care Service Agreement ("Agreement") is entered into as of the date signed below.

1. Parties to This Agreement

AGENCY:

AGENCY NAME

LICENSE NUMBER

ADDRESS

PHONE

EMAIL

CLIENT:

CLIENT NAME

DATE OF BIRTH

SERVICE ADDRESS

PHONE

EMAIL

RESPONSIBLE PARTY (if different from Client):

NAME

RELATIONSHIP TO CLIENT

ADDRESS

2. Services to Be Provided

The Agency agrees to provide non-medical home care services as indicated below and as further detailed in the attached Care Plan. Services will be performed by trained caregivers who are employees or contractors of the Agency.

- Personal Care:** Bathing, dressing, grooming, oral care, toileting assistance
- Mobility Assistance:** Transfers, ambulation, positioning, exercise assistance
- Companionship:** Socialization, conversation, activities, outings
- Meal Services:** Meal preparation, feeding assistance, nutrition monitoring
- Homemaking:** Light housekeeping, laundry, bed making, organization
- Medication Reminders:** Verbal reminders to take prescribed medications
- Transportation:** Medical appointments, errands, social activities
- Respite Care:** Temporary relief for family caregivers
- Other:** _____

3. Schedule of Services

START DATE

HOURS PER VISIT

VISITS PER WEEK

DAY	START TIME	END TIME	TOTAL HOURS
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

TOTAL ESTIMATED WEEKLY HOURS

Note: Schedule may be modified with mutual agreement. Agency will make reasonable efforts to accommodate schedule change requests with at least 48 hours notice.

4. Services NOT Included

The following services are NOT provided by the Agency and are expressly excluded from this Agreement:

- Medical or nursing care requiring a licensed healthcare professional
- Administration of medications (oral, injection, or otherwise)
- Wound care or medical treatments
- Physical, occupational, or speech therapy
- Heavy housecleaning (moving furniture, washing windows, etc.)
- Care of other household members or pets (unless specifically agreed)

- Financial management or legal services
- Any task that puts the caregiver at risk of injury

5. Agency Responsibilities

The Agency agrees to:

- Provide qualified, trained caregivers who have passed background checks
- Supervise caregivers and ensure quality of services
- Develop and maintain an individualized Care Plan
- Provide substitute caregivers when the regular caregiver is unavailable
- Maintain required insurance coverage (general liability, workers' compensation)
- Respond to Client concerns and complaints in a timely manner
- Protect Client's confidential health information in accordance with HIPAA
- Comply with all applicable state and federal regulations

6. Client/Responsible Party Responsibilities

The Client and/or Responsible Party agrees to:

- Provide accurate and complete information about the Client's condition and needs
- Maintain a safe environment for caregivers to work
- Provide necessary supplies and equipment for care (unless otherwise arranged)
- Notify Agency immediately of any changes in Client's condition
- Notify Agency of any scheduled absences or changes with at least 24 hours notice
- Not request caregivers to perform tasks outside the agreed scope of services
- Pay for services in accordance with the Payment Terms
- Treat caregivers with respect and dignity

7. Payment Terms

HOURLY RATE

\$ _____

MINIMUM HOURS PER VISIT

SERVICE TYPE	RATE
Standard hourly rate (weekdays)	\$ _____ per hour
Weekend rate	\$ _____ per hour
Holiday rate	\$ _____ per hour
Overnight rate (per night)	\$ _____ per night
Live-in rate (per day)	\$ _____ per day
Transportation (per mile)	\$ _____ per mile

PAYMENT METHOD

Check Credit Card ACH/Bank Transfer Long-Term Care Insurance

Other: _____

BILLING FREQUENCY

Weekly Bi-weekly Monthly

Payment Terms and Conditions

Payment is due upon receipt of invoice unless other arrangements have been made in writing. A late fee of \$_____ or _____% (whichever is greater) will be applied to balances unpaid after 15 days. Returned checks will incur a \$35 fee. The Agency reserves the right to suspend services if payment is more than 30 days past due. Client is responsible for all collection costs, including attorney fees, if collection action becomes necessary.

8. Cancellation Policy

Client Cancellation

Client must provide at least **24 hours notice** to cancel or reschedule a visit. Cancellations with less than 24 hours notice will be charged at **50%** of the scheduled visit rate. Same-day cancellations or no-shows will be charged at **100%** of the scheduled visit rate.

Agency Cancellation

If the Agency is unable to provide a caregiver due to circumstances within its control, the Client will not be charged. The Agency will make every reasonable effort to provide a substitute caregiver. In the event of extreme weather, natural disaster, or other circumstances beyond the Agency's control, the Agency will work with the Client to reschedule services.

9. Termination

By Client: Client may terminate this Agreement at any time by providing written notice to the Agency. A minimum of **7 days written notice** is requested but not required. Client is responsible for payment of all services provided through the termination date.

By Agency: Agency may terminate this Agreement with **14 days written notice** for any reason. Agency may terminate immediately if: (a) Client's needs exceed the scope of non-medical care; (b) the care environment becomes unsafe; (c) Client or household members engage in abusive behavior toward caregivers; or (d) payment is more than 30 days past due.

10. Liability and Limitations

Insurance: The Agency maintains general liability insurance and workers' compensation insurance for all caregivers. Caregivers are employees or contractors of the Agency and are not employees of the Client.

Limitation of Liability: The Agency's liability for any claim arising from services provided under this Agreement shall not exceed the total amount paid by Client for services during the three (3) months preceding the claim. The Agency is not liable for injuries or damages resulting from: (a) the Client's failure to follow the Care Plan; (b) pre-existing conditions; (c) hazards in the home that were not disclosed; or (d) circumstances beyond the Agency's reasonable control.

Hold Harmless: Client agrees to hold the Agency harmless from any claims, damages, or expenses arising from the Client's or family members' negligent acts, misrepresentations, or failure to comply with this Agreement.

11. Confidentiality and HIPAA

The Agency will protect Client's personal and health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws. Information will only be shared with: (a) Agency staff involved in Client's care; (b) healthcare providers as necessary for coordination of care; (c) emergency personnel in an emergency; or (d) others as authorized in writing by Client or as required by law. A separate HIPAA Notice of Privacy Practices is attached to this Agreement.

12. Non-Solicitation

Client agrees not to directly hire, employ, or contract with any caregiver introduced by the Agency for a period of **12 months** following the last date of service. If Client hires an Agency caregiver during this period, Client agrees to pay the Agency a placement fee equal to **\$2,500 or 25% of the caregiver's first-year compensation**, whichever is greater.

13. Dispute Resolution

Any disputes arising from this Agreement shall first be addressed through good-faith negotiation between the parties. If a resolution cannot be reached within 30 days, the parties agree to participate in mediation before pursuing any other legal remedies. This Agreement shall be governed by the laws of the State of _____.

14. Entire Agreement

This Agreement, together with any attached schedules, addenda, and the Care Plan, constitutes the entire agreement between the parties. Any modifications must be in writing and signed by both parties. If any provision is found to be unenforceable, the remaining provisions shall remain in effect.

15. Acknowledgment and Signatures

By signing below, the parties acknowledge that they have read, understand, and agree to all terms and conditions of this Agreement. Client/Responsible Party confirms they have received copies of the Agency's policies including the Notice of Privacy Practices.

CLIENT OR AUTHORIZED REPRESENTATIVE:

Signature

Date

Printed Name

Relationship to Client (if applicable)

AGENCY REPRESENTATIVE:

Signature

Date

Printed Name

Title

Form: SA-001

Provide copy to Client; retain original in file

[Your Agency Name]

[Address] | [Phone] | [Email]

This addendum details the specific services to be provided under the Service Agreement. It should be completed in conjunction with the Care Plan and updated as client needs change.

CLIENT NAME

EFFECTIVE DATE

Personal Care Services

SERVICE	SPECIFIC INSTRUCTIONS
<input type="checkbox"/> Bathing (shower/tub/sponge)	
<input type="checkbox"/> Shampoo/hair care	
<input type="checkbox"/> Dressing assistance	
<input type="checkbox"/> Grooming (shaving, makeup)	
<input type="checkbox"/> Oral/denture care	
<input type="checkbox"/> Nail care (filing only)	
<input type="checkbox"/> Skin care/lotion application	
<input type="checkbox"/> Toileting assistance	
<input type="checkbox"/> Incontinence care	
<input type="checkbox"/> Catheter care (external only)	

Mobility and Exercise

SERVICE	SPECIFIC INSTRUCTIONS
<input type="checkbox"/> Transfer assistance	
<input type="checkbox"/> Ambulation assistance	
<input type="checkbox"/> Wheelchair assistance	
<input type="checkbox"/> Positioning/turning	
<input type="checkbox"/> Range of motion exercises	
<input type="checkbox"/> Escort on walks	

Nutrition and Meal Services

SERVICE	SPECIFIC INSTRUCTIONS
<input type="checkbox"/> Meal planning	
<input type="checkbox"/> Meal preparation	
<input type="checkbox"/> Feeding assistance	
<input type="checkbox"/> Grocery shopping	
<input type="checkbox"/> Special diet prep (specify):	
<input type="checkbox"/> Fluid intake monitoring	

Homemaking Services

SERVICE	SPECIFIC INSTRUCTIONS
<input type="checkbox"/> Light housekeeping	
<input type="checkbox"/>	

SERVICE		SPECIFIC INSTRUCTIONS
	Vacuuming/mopping	
<input type="checkbox"/>	Dusting	
<input type="checkbox"/>	Laundry	
<input type="checkbox"/>	Changing bed linens	
<input type="checkbox"/>	Dishwashing	
<input type="checkbox"/>	Trash removal	
<input type="checkbox"/>	Organizing/decluttering	

CLIENT NAME

DATE

Companionship and Social Services

SERVICE	SPECIFIC INSTRUCTIONS
<input type="checkbox"/> Conversation/companionship	
<input type="checkbox"/> Reading to client	
<input type="checkbox"/> Games/puzzles/activities	
<input type="checkbox"/> Letter writing/correspondence	
<input type="checkbox"/> Accompany on outings	
<input type="checkbox"/> Escort to appointments	

Health Support Services

SERVICE	SPECIFIC INSTRUCTIONS
<input type="checkbox"/> Medication reminders	
<input type="checkbox"/> Vital signs monitoring	
<input type="checkbox"/> Blood glucose monitoring	
<input type="checkbox"/> Oxygen equipment monitoring	
<input type="checkbox"/> Appointment scheduling	
<input type="checkbox"/> Pharmacy pickup	

Transportation Services

SERVICE	SPECIFIC INSTRUCTIONS
<input type="checkbox"/>	Medical appointments
<input type="checkbox"/>	Errands (bank, post office)
<input type="checkbox"/>	Social outings
<input type="checkbox"/>	Religious services
<input type="checkbox"/>	Shopping trips

Special Instructions

ADDITIONAL SERVICES OR SPECIFIC INSTRUCTIONS NOT LISTED ABOVE

Client/Representative Signature

Date

Agency Representative Signature

Date

Form: SOS-001

Update as care needs change

[Your Agency Name]

[Address] | [Phone] | [Email]

This document outlines the payment terms, rates, and billing procedures for home care services. This is an addendum to the Service Agreement.

CLIENT NAME

AGREEMENT DATE

Service Rates

SERVICE TYPE	RATE	MINIMUM
Hourly Care - Weekday (Mon-Fri)	\$_____/hour	_____ hours
Hourly Care - Weekend (Sat-Sun)	\$_____/hour	_____ hours
Hourly Care - Holiday	\$_____/hour	_____ hours
Overnight Care (10pm-7am)	\$_____/night	N/A
24-Hour Care	\$_____/day	N/A
Live-In Care (per day)	\$_____/day	_____ days
Respite Care	\$_____/hour	_____ hours

Additional Charges

ITEM	RATE
Transportation/Mileage	\$_____ per mile (IRS rate or specify)
Rush/Last-minute scheduling (less than 24 hrs)	\$_____ additional per hour

ITEM	RATE
Initial assessment/intake	\$_____ (or Waived)
Care plan updates	\$_____ (or Included)
After-hours office calls	\$_____ per call

Holiday Schedule

Holiday rates apply on the following days:

- | | |
|---|---|
| <input type="checkbox"/> New Year's Day | <input type="checkbox"/> Labor Day |
| <input type="checkbox"/> Martin Luther King Jr. Day | <input type="checkbox"/> Thanksgiving Day |
| <input type="checkbox"/> Presidents' Day | <input type="checkbox"/> Day After Thanksgiving |
| <input type="checkbox"/> Memorial Day | <input type="checkbox"/> Christmas Eve |
| <input type="checkbox"/> Independence Day | <input type="checkbox"/> Christmas Day |

Billing and Payment

BILLING FREQUENCY

- Weekly Bi-weekly Monthly

PAYMENT DUE

- Upon receipt Net 7 days Net 15 days Net 30 days

ACCEPTED PAYMENT METHODS

- Check Cash Credit/Debit Card ACH/Bank Transfer PayPal/Venmo Zelle

Late Payment Policy

Invoices not paid within _____ days of the due date will incur a late fee of \$_____ or _____% of the outstanding balance, whichever is greater. If payment is not received within 30 days, services may be suspended. Client is responsible for any collection costs, including attorney fees, in the event of non-payment.

Client/Representative Signature

Date

Form: PRS-001

Rates subject to change with 30 days notice

[Your Agency Name]

[Address] | [Phone] | [Email]

The Health Insurance Portability and Accountability Act (HIPAA) requires that we protect your personal health information (PHI). This form acknowledges receipt of our Notice of Privacy Practices and authorizes use and disclosure of your information as described.

CLIENT NAME

DATE OF BIRTH

Notice of Privacy Practices Acknowledgment

I acknowledge that I have received a copy of [Agency Name]'s Notice of Privacy Practices, which describes how my health information may be used and disclosed, and how I can access this information. I understand that I have the right to review the Notice before signing this acknowledgment.

I have received and reviewed a copy of the Notice of Privacy Practices.

Authorization for Use and Disclosure of Health Information

I authorize [Agency Name] to use and disclose my protected health information for the following purposes:

- Treatment:** To provide, coordinate, or manage my care, including consultations with other healthcare providers.
- Payment:** To bill and collect payment for services provided, including submitting claims to insurance.
- Healthcare Operations:** For quality assessment, staff training, and other agency operations.
- Care Coordination:** To communicate with family members, physicians, and other care providers involved in my care.

Authorized Individuals

I authorize [Agency Name] to discuss my care and share information with the following individuals:

NAME	RELATIONSHIP	PHONE NUMBER	FULL/ LIMITED

Full = May receive all information; Limited = Specify restrictions below

RESTRICTIONS ON DISCLOSURE (IF ANY)

Client Rights Under HIPAA

I understand that I have the following rights regarding my health information:

- **Right to Access:** I may request copies of my health records.
- **Right to Amend:** I may request corrections to my health information.
- **Right to Restrict:** I may request restrictions on certain uses and disclosures.
- **Right to Confidential Communications:** I may request to receive communications in a particular manner.
- **Right to Accounting:** I may request a list of certain disclosures of my information.
- **Right to Revoke:** I may revoke this authorization in writing at any time.

Communication Preferences

I AUTHORIZE CONTACT VIA THE FOLLOWING METHODS:

- Home phone
 Cell phone (voice)
 Text message
 Email
 Mail

MESSAGES MAY BE LEFT AT:

- Voicemail (detailed message OK)
 Voicemail (callback only)
 With household member

I understand that I may revoke this authorization at any time by providing written notice to the Agency. I understand that revocation will not affect any actions taken before the revocation. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA.

Client/Representative Signature

Date

Printed Name

Relationship to Client (if representative)

For Office Use Only:

PRIVACY NOTICE PROVIDED BY

DATE

Form: HIPAA-001

Retain in client file; provide copy to client

03

Care Plan Templates

Comprehensive templates for developing and
managing individualized care plans

[Your Agency Name]

[Address] | [Phone] | [Email]

The Care Plan is developed based on the initial assessment and outlines the specific care to be provided. It should be reviewed with caregivers and updated regularly as client needs change.

Client Information

CLIENT NAME

DATE OF BIRTH

CARE PLAN DATE

ADDRESS

PRIMARY DIAGNOSIS/CONDITION

SECONDARY DIAGNOSES

PHYSICIAN

PHYSICIAN PHONE

Emergency Information

EMERGENCY CONTACT 1

RELATIONSHIP

PHONE

EMERGENCY CONTACT 2

RELATIONSHIP

PHONE

ALLERGIES: _____

Care Goals

OVERALL CARE GOALS (WHAT DOES THE CLIENT/FAMILY HOPE TO ACHIEVE?)

--

Daily Care Schedule

TIME	TASKS/ACTIVITIES	SPECIAL INSTRUCTIONS
Morning (wake-up)		
Late Morning		
Lunch		
Afternoon		
Dinner		
Evening/ Bedtime		

CLIENT NAME

CARE PLAN DATE

Personal Care Instructions

TASK	FREQUENCY	ASSISTANCE LEVEL	DETAILED INSTRUCTIONS/PREFERENCES
Bathing			
Dressing			
Grooming			
Oral Care			
Toileting			
Skin Care			

Mobility and Safety

MOBILITY STATUS

ASSISTIVE DEVICES USED

TRANSFER METHOD/TECHNIQUE

FALL RISK LEVEL AND PRECAUTIONS

Nutrition and Meals

DIET TYPE

FOOD ALLERGIES/RESTRICTIONS

FOOD PREFERENCES (LIKES)

FOOD DISLIKES

FEEDING ASSISTANCE NEEDED

FLUID INTAKE REQUIREMENTS/RESTRICTIONS

Cognitive and Behavioral Considerations

COGNITIVE STATUS AND CONSIDERATIONS

BEHAVIORAL TRIGGERS TO AVOID

CALMING TECHNIQUES THAT WORK

CLIENT NAME

CARE PLAN DATE

Homemaking Tasks

TASK	FREQUENCY	SPECIFIC INSTRUCTIONS
Vacuuming/Floors		
Dusting		
Kitchen cleaning		
Bathroom cleaning		
Laundry		
Bed making/linens		
Dishes		
Trash		

Communication and Social

PREFERRED ACTIVITIES AND HOBBIES

TOPICS OF INTEREST FOR CONVERSATION

TOPICS TO AVOID

Important Notes for Caregivers

MUST KNOW INFORMATION

CLIENT PREFERENCES AND PET PEEVES

Emergency Procedures

IN CASE OF EMERGENCY, FOLLOW THESE STEPS:

1. Call 911 if life-threatening emergency
2. Begin first aid/CPR if trained and needed
3. Contact emergency contact
4. Contact agency office
5. Document incident

This care plan has been reviewed and agreed upon by all parties.

Client/Representative Signature

Date

Care Coordinator Signature

Date

[Your Agency Name]

[Address] | [Phone] | [Email]

This form provides a detailed assessment and care plan for Activities of Daily Living. Use this to document specific assistance needed and techniques to be used for each ADL.

CLIENT NAME

ASSESSMENT DATE

ASSESSED BY

Assistance Level Key: I = Independent | S = Setup/Supervision | MA = Minimal Assist (25%) | MO = Moderate Assist (50%) | MX = Maximum Assist (75%) | T = Total Assist (100%)

Bathing

ASSISTANCE LEVEL

BATH TYPE

Shower Tub bath Bed bath Sponge bath

FREQUENCY

PREFERRED TIME

WATER TEMP PREFERENCE

EQUIPMENT NEEDED (GRAB BARS, SHOWER CHAIR, HAND-HELD SHOWER, ETC.)

STEP-BY-STEP BATHING PROCEDURE

Dressing

UPPER BODY ASSISTANCE LEVEL

LOWER BODY ASSISTANCE LEVEL

ADAPTIVE EQUIPMENT USED

CLOTHING PREFERENCES AND CONSIDERATIONS

Grooming

TASK	ASSIST LEVEL	FREQUENCY	SPECIAL INSTRUCTIONS
Hair care			
Shaving			
Nail care			
Makeup (if applicable)			

ADL Assessment and Care Plan (continued)

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CLIENT NAME

DATE

Oral Care

ASSISTANCE LEVEL

FREQUENCY

DENTURES?

Yes No Partial

ORAL CARE INSTRUCTIONS

Toileting

ASSISTANCE LEVEL

TOILETING METHOD

Toilet Commode Bedpan Urinal

INCONTINENCE STATUS

Continent Occasional bladder incontinence Frequent bladder incontinence

Bowel incontinence Uses briefs/pads Catheter

TOILETING SCHEDULE AND INSTRUCTIONS

Eating/Feeding

ASSISTANCE LEVEL

DIET TEXTURE

Regular Soft Mechanical soft

Pureed

LIQUID CONSISTENCY

Thin Nectar-thick Honey-thick Pudding-thick

ADAPTIVE EATING EQUIPMENT

FEEDING INSTRUCTIONS AND PRECAUTIONS

Mobility/Transfers

BED MOBILITY ASSISTANCE

TRANSFER ASSISTANCE

AMBULATION ASSISTANCE

EQUIPMENT USED

WEIGHT-BEARING STATUS

Full weight bearing Partial weight bearing Non-weight bearing

TRANSFER TECHNIQUE (STEP-BY-STEP)

Assessor Signature

Date

Form: ADL-001

Reassess with any change in condition

[Your Agency Name]

[Address] | [Phone] | [Email]

Important: Caregivers may provide medication REMINDERS only. Caregivers may NOT administer medications, fill pill boxes, or make decisions about medications. All medication questions should be directed to the client's physician or pharmacist.

CLIENT NAME

DATE

PRIMARY PHARMACY

PHARMACY PHONE

Medication Assistance Level

- Self-administers independently** - No assistance needed
- Needs reminders only** - Client can take medications once reminded
- Needs setup assistance** - Pill box is filled by family/pharmacy; caregiver provides reminders
- Needs physical assistance** - Client needs help opening bottles, bringing medications
- Total assistance** - Requires licensed professional (not provided by home care)

Current Medication List

MEDICATION NAME	DOSAGE	TIME(S)	PURPOSE	SPECIAL INSTRUCTIONS	PRESCRIBER

MEDICATION NAME	DOSAGE	TIME(S)	PURPOSE	SPECIAL INSTRUCTIONS	PRESCRIBER

Medication Schedule

TIME	MEDICATIONS TO TAKE	WITH FOOD?	NOTES
Morning			
Noon			
Afternoon			
Evening			
Bedtime			
As Needed			

CLIENT NAME

DATE

Medication Storage Location

WHERE ARE MEDICATIONS STORED?

WHO FILLS THE PILL ORGANIZER?

WHO ORDERS/PICKS UP REFILLS?

PRN (As Needed) Medications

MEDICATION	DOSAGE	WHEN TO TAKE	MAX FREQUENCY	NOTES

Signs and Symptoms to Watch For

SIDE EFFECTS TO MONITOR AND REPORT

SIGNS OF ADVERSE REACTION (SEEK IMMEDIATE HELP)

Caregiver Instructions

Caregivers SHOULD:

- Remind client when it's time to take medications
- Bring medications and water to client if needed
- Open bottles if client has difficulty (do not handle pills)
- Observe and report any missed doses or changes
- Document medication reminders in daily notes

Caregivers should NEVER:

- Administer or give medications to client
- Fill or organize pill boxes
- Crush, split, or alter medications
- Make decisions about skipping or changing doses
- Give medical advice about medications

Client/Representative Signature

Date

Form: MMP-001

Update when medications change

[Your Agency Name]

[Address] | [Phone] | [Email]

Use this template to plan the client's weekly care schedule. Post a copy in the client's home for caregivers to reference.

CLIENT NAME

WEEK OF

Caregiver Schedule

DAY	CAREGIVER NAME	START TIME	END TIME	SPECIAL NOTES
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Weekly Activity Plan

DAY	MORNING ACTIVITIES	AFTERNOON ACTIVITIES	EVENING ACTIVITIES	APPOINTMENTS
Monday				

DAY	MORNING ACTIVITIES	AFTERNOON ACTIVITIES	EVENING ACTIVITIES	APPOINTMENTS
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Weekly Tasks Checklist

TASK	MON	TUE	WED	THU	FRI	SAT	SUN
Bathing							
Shampoo							
Laundry							
Change bed linens							
Grocery shopping							
Vacuum/mop							
Dust							
Bathroom cleaning							

This Week's Notes

APPOINTMENTS, VISITORS, OR SPECIAL EVENTS THIS WEEK

Form: WS-001

Post in client's home; update weekly

[Your Agency Name]

[Address] | [Phone] | [Email]

Complete this form during regular care plan reviews (recommended every 90 days) or whenever the client's condition or needs change. Document all changes and obtain required signatures.

CLIENT NAME

REVIEW DATE

PREVIOUS REVIEW DATE

REVIEW COMPLETED BY

REVIEW TYPE

90-day routine review Annual review Change in condition Hospital discharge

Client/family request Other: _____

Current Status Review

OVERALL CONDITION COMPARED TO LAST REVIEW

Improved Stable Declined

EXPLAIN ANY CHANGES IN CONDITION

Goal Progress Review

GOAL FROM PREVIOUS CARE PLAN	STATUS	NOTES/PROGRESS

GOAL FROM PREVIOUS CARE PLAN	STATUS	NOTES/PROGRESS

Status: Met / In Progress / Modified / Discontinued

ADL Status Changes

ADL	PREVIOUS LEVEL	CURRENT LEVEL	CHANGES/NOTES
Bathing			
Dressing			
Toileting			
Mobility			
Eating			
Cognition			

Care Plan Review/Update Form (continued)

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CLIENT NAME

REVIEW DATE

Care Plan Modifications

SERVICES TO BE ADDED

SERVICES TO BE REMOVED OR REDUCED

SERVICES TO BE MODIFIED (DESCRIBE CHANGES)

Schedule Changes

CURRENT HOURS PER WEEK

NEW HOURS PER WEEK

EFFECTIVE DATE

REASON FOR SCHEDULE CHANGE

New Goals

NEW GOAL	INTERVENTIONS	TARGET DATE

Client/Family Input

CLIENT/FAMILY SATISFACTION WITH CURRENT SERVICES

Very satisfied Satisfied Neutral Dissatisfied

CLIENT/FAMILY CONCERNS OR REQUESTS

Next Review

NEXT SCHEDULED REVIEW DATE

REVIEW TO BE CONDUCTED BY

By signing below, all parties acknowledge that this care plan review has been completed and any changes have been discussed and agreed upon.

Client/Representative Signature

Date

Care Coordinator Signature

Date

Form: CPR-001

File in client record; update care plan accordingly

Thank You!

You now have professional, ready-to-use client forms for your home care agency.

Customize these forms with your agency's name, logo, and contact information. Review all legal sections with your attorney to ensure compliance with your state's regulations.

Need more resources?

Visit homecareagencyblueprint.com
for additional templates, training, and support.

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