41550 Eclectic St, Palm Desert, CA 92260 * 888-336-8322

Client Information Form

Client Name:_____ Date of Birth:_____

Physical Address:_____

Mailing Address (if different):_____

Community Name (If any): _____

Gate code instruction (if any):_____

Community entrance cross streets:_____

Email Address:_____

Phone Numbers CELL:_____ HOME:_____

Emergency Contacts:

Name/Relationship:_____Phone:_____

Name/Relationship:_____Phone:_____

How did you hear about Elder Love?_____

Do you have any pets? If so, what kind?_____

Preferred days:_____

Preferred times:_____

How often do you need our services?_____

Client's primary medical condition(s):

Does the client have Medi-Cal? YES or NO If yes, circle provider: IEHP or Kaiser Medi-Cal

List important details about the client:

Client Care Needs - *Mark all that apply (price is not affected)*

Patient/Client Name:_____ Date:_____

Consent to receive services: I hereby authorize Elder Love USA, Inc. to render appropriate home care services to the patient/client named above.

Activities of Daily Living (ADLs)

Mobility:
- Ambulation and transfer
- Walking
- Getting in/out of bed or chair

Bathing:
- In the shower or tub
- Standby assist only
- Bed bath only

Toileting:
- Getting on/off the toilet or commode
- Diaper changing

Dressing and grooming:
- Picking out clothes
- Combing hair
- Brushing teeth

Eating:
- Assistance with feeding self
- Cutting food

Client's Mobility Status:
- Able to walk independently
- Walks with a walker
- Needs assistance in a wheelchair
- Bedbound

Instrumental Activities of Daily Living (IADLs)

Light Housekeeping:
- Empty Trash
- Vacuum
- Swiffer
- Sweep
- Dust
- Mop
- Do Dishes
- Clean Stovetop
- Wipe Counters
- Clean Living Area
- Clean Bathroom
- Make Bed
- Change Bed Linens
- Laundry

Running errands:
- Using caregivers car
- Using clients car

Additional Services:
- Shopping
- Medication reminders
- Preparing meals
- Transportation
- Pet care (walking, feeding)
- Companionship

Elder Love USA, Inc. Consent Form

Patient/Client Name:_____ Date:_____

Consent to receive services: I hereby authorize Elder Love USA, Inc. to render appropriate home care services to the patient/client named above. I understand an appropriate level of home care personnel will provide such care. I recognize and agree that I have the right to refuse treatment or terminate services at any time by notifying the Elder Love USA, Inc. office. In addition, Elder Love USA, Inc. may terminate service by notifying me of the termination and the reason.

Overtime/Holidays: All charges for services rendered on holidays are **charged at one and one-half times** the applicable rate. Services rendered by the same individual, at my request, in excess of forty (40) hours during any work week, or more than eight (8) hours in one calendar day or single shift, are **charged at one and one-half times** the applicable rate up to 12 hours. Hours in excess of twelve (12) per calendar day or twelve (12) per single shift are charged at two times the applicable rate. Holidays applicable for overtime rates are: New Year's Day, Memorial Day, July 4th, Thanksgiving Day, and Christmas Day.

Gifts, Gratuities, and Loans: Employees may **not** accept gifts, gratuities, or loans from clients. Elder Love employees are **never** to discuss their personal financial situations and if they do so, it should be reported to Elder Love USA **immediately**.

Fall Risk: Falls are the leading cause of injury and accidental death in adults over the age of 65. I understand Elder Love employees will make every effort to reduce the risk of a fall, however it is not possible to prevent every fall. If falling is a major concern, the use of a gait belt and walker or wheelchair will reduce the risk of a fall. Elder Love employees are **never** to assist a client off the floor and will call your emergency contact or 911. **I acknowledge that falls cannot be prevented at all times and I release Elder Love from any, and all, liability.**

Vehicle Liability Release: Should I permit an Elder Love USA, Inc. employee/contractor to operate my automobile, I understand and agree that it is my responsibility to maintain automobile liability insurance at the minimum level established by the state covering my automobile and authorized drivers, including Elder Love USA, Inc. employees. I understand and agree that Elder Love USA, Inc. does not provide insurance coverage under any circumstances for any damages to my automobile, bodily injury, or damage to property resulting from the use of my automobile by Elder Love USA, Inc. employees. I hereby release Elder Love USA, Inc. and its employees assigned to me, and hold Elder Love USA, Inc., and such employees harmless, and indemnify them from any claim, liability, or cause of action for any injury to my person (including death), bodily injury to a third party, or property damage resulting from the use of an automobile (whether or not owned by me) if operated by an Elder Love USA, Inc. employee.

Termination of Services: I understand that I may terminate this Agreement by giving at least twenty-four (24) hours' notice to Elder Love USA, Inc. I understand that Elder Love USA, Inc. may terminate this Agreement by providing at least three (3) days' notice or other minimum notice required under applicable state law. I recognize
that notification may be furnished verbally in person or by telephone and that written confirmation will follow by mail. In those circumstances in which the life, safety, or well-being of agency personnel is or may be jeopardized, Elder Love USA, Inc. may terminate this Agreement without prior notice.

Arbitration: Shall be settled in accordance with the rules of the American Arbitration Association.

I have read and fully understand the content of the Consent Form and hereby agree to and authorize Elder Love USA to provide services.

Signature: _____ **Date:** _____

Elder Love USA, Inc. Electronic Visit Verification Signature Authorization

Patient/Client Name:_____ Date:_____

Electronic Visit Verification (EVV) is a method for verifying home healthcare visits to ensure patients are not neglected and to reduce fraudulently documented home visits. Most states require EVV for most providers as part of the 21st Century Cures Act.

EVV applies to care and health services rendered in the home. States are required to implement EVV for all personal care services and home health services that require an in-home visit by a provider. EVV systems are secure and compliant with the Health Insurance Portability and Accountability Act (HIPAA). EVV is a telephone and computer-based solution that electronically verifies in-home service visits.

EVV solutions must verify the following six data elements:

- Type of service performed
- Individuals receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends.

Elder Love USA uses the software WellSky. WellSky's Personal Care software has obtained HITRUST CSF certification, independent third-party verification of HIPAA compliance, and security and privacy best practices. The HITRUST Alliance requires compliance on over 300 controls in 19 areas such as information protection, password management, and access control. WellSky software is all in one helping with scheduling, caregiver recruitment and retention, client care plans, invoicing, and payroll.

WellSky software also offers a benefit called **The Family Room** (a free and secure access portal) that gives loved ones access to the client care calendar and shift notes, plus the ability to pay or split a portion of the bill. I wish for the following individuals to have access:

Name and Relationship to client:_____

Email for access to The Family Room:_____

By signing below, I authorize Elder Love USA care staff to treat my electronic signature as proof that an in-home visit was performed.

Signature: _____ Date: _____

Elder Love USA Financial Agreement

The undersigned, (herein referred to as "Billing Party/ Guarantor") wishes to enter into this Financial Responsibility Agreement (the "Agreement") with Elder Love USA, Inc. to provide_____ ("Client") with homecare services. The standard rate for services quoted at the time of inquiry is for one person, when caring for two people, the rate is 1.5 times the rate quoted (see below). Transportation when using the caregiver's vehicle, is billable at the current IRS standard rate of .725 per mile as of January 2026.

Standard hourly rate for one person: $30.00
Overtime/holiday rate for one person: $44.00
Standard hourly rate for couples: $54.00
Overtime/holiday rate for couple: $81.00

Minimum Service Requirement

Elder Love USA, Inc. has a two-hour minimum service requirement per scheduled visit. In the event that a caregiver provides services for less than two hours, the client acknowledges and agrees that they will be billed for the full two-hour minimum. No exceptions will be made to this policy.

GUARANTEE

I acknowledge that Elder Love USA, Inc. is relying upon my unconditional commitment to guarantee payment for homecare services rendered to the Client, irrespective of the Client's ability to pay for the services. I acknowledge that I will pay my invoices promptly for services rendered by Elder Love USA.

PAYMENTS

The client will be invoiced weekly on Mondays via email. Invoices cover the seven (7) day period that ends the Saturday before the Monday. For example, if the billing period is Sunday the 22nd through Saturday the 28th, then the invoice will be generated on Monday the 30th. All invoices are due upon receipt. For your convenience, invoices can be auto-debited using your credit card or ACH each Monday. Invoices can also be paid online by credit card or ACH. You may also pay by check or e-bill through your bank. **However, a valid credit card or bank account must be kept on file (see Credit Card / ACH Authorization Form).** Rates for service on holidays are paid at a rate of one and one-half the standard rate. Elder Love pays and charges holiday pay on the following five days: New Year's Day, Memorial Day, July 4th, Thanksgiving Day, and Christmas Day.

REIMBURSEMENT OF EXPENSES

If the caregiver makes small payments (under $10) on behalf of the client such as groceries, supplies, or medications for the client, such payments will be added to the invoice total. The client should provide payment for goods upfront.

CHANGES IN SCHEDULE

I acknowledge that I can change the schedule at any time as long as I give Elder Love USA, Inc. 24 hours prior notice. If 24-hour notice is not given, there is a service charge of two hours at the standard rate. However, if there is an unforeseen emergency such as a hospital stay, etc. This fee will be waived. If the caregiver shows up for a scheduled shift and the client is either not home or refuses the visit, there will be a 2-hour charge applied (and the caregiver will be paid for 2 hours).

CANCELLATION

I acknowledge that I can completely cancel all services at any time; however, a 24-hour notice would be appreciated.

Signature of Client_____ Date:_____

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Credit Card / ACH Authorization Form

Elder Love USA, Inc. requires that a credit card or ACH (bank account draft) remain on file. Once entered into our system, your financial information will be redacted.

CHOOSE ONE:

_____I wish to have my credit card used to pay my invoices each Monday and a copy of the paid invoice sent to me via email. I understand that credit card transactions may include a transaction fee of 3% of the total.

_____I wish to use ACH (bank account) to pay my invoices each Monday and a copy of the paid invoice to be sent to me via email. ***ACH bank drafts have NO transaction fees.***

_____I would like to have my invoice emailed to me and I will pay online each Monday.

Email address for invoice delivery_____

◯ I UNDERSTAND THAT AN ELDER LOVE USA, INC. REPRESENTATIVE WILL CONTACT ME TO COLLECT MY CREDIT CARD/ ACH INFORMATION.

If not using autopay, I authorize Elder Love USA, Inc. to keep my information on file in a secure location and to charge my credit card or bank account for invoices that become past due over 14 days.

Signature of Patient or Authorized Representative: _____

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

Reason Patient Unable to Sign: _____
Date: _____

"If signed by a representative, documentation of authority to act on behalf of the patient (e.g., Power of Attorney, Legal Guardianship, Advance Directive) must be provided upon request."