J.O.Y CompanionshipLC

Home Care Service Agreement

Non-Medical Home Care Business

Home Care Service Agreement

The following **"Terms of Home Care Service Agreement"** is effective [MM/DD/YYYY]			
This agreement will be in effect from		To	

BETWEEN: CAREGIVER NAME / COMPANY otherwise known as the **("service provider")**

Company Name:	
Registered Name or Business Number:	
Full Address	
Phone:	
Email:	

AND: CARE RECIPIENT is otherwise known as the **("client")**

Client's Full Name:	
Full Address:	
Authorized Person for Care Decisions:	
Phone: (#to use for emergency)	
Email:	

WHEREAS the **"service provider"** is in the business of services relating to **(non-medical care).**

WHEREAS this **"agreement"** contains the **"service provider"** terms of engagement.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, the parties hereto intending. To be legally bound, agree as follows:

The "service provider" is prepared to provide the following non-medical home care services to the "client" paid for by the "client", or authorized person in charge of client's care.

1. HOME CARE SERVICES REQUIRED:

☐	Activity Outings	☐	Housekeeping
☐	Mobility Assistance	☐	Meal Preparation
☐	Personal Care	☐	Exercise
☐	Shopping / Errands	☐	Scheduling Management
☐	Appointments	☐	Pet Care
NOTES:			

2. INSURANCE: (NOT AVAILABLE YET)

The “service provider” is insured with business liability insurance in the amount of **[ENTER $]**. This coverage includes:

☐Inside “client” home
☐Outings with a “client” while in the care of a “service provider”

3. CALCULATION OF SERVICE FEES AND CHARGES:

Service rate is calculated on the time spent attending to said services.

The rate for service provided to “client” **Based off clients needs**

☐PER VISIT ☐HOUR ☒WEEK ☐MONTH ☐SALARY

- Minimum **2** HRS per visit

4. STATUTORY HOLIDAYS: Statutory holidays will be subject to additional fees.

Holiday hourly Rate:	Time and a half
Cancellation of Services Requires Notice of:	12 hours in advance

RECOGNIZED PAID HOLIDAYS	
DATE [MM/DD/YY]	LIST HOLIDAY(S)
January 2025	New Year and New Year Eve President Day
February	TBA
April	Good Friday and Easter
May	Memorial Day
June	Juneteenth
July	Fourth of July
September	Labor Day
November	Thanksgiving Eve and Thanksgiving day
December	Christmas Eve and Christmas

ADDITIONAL NOTES:

5. INSURANCE: “Client” Vehicle used by “Service Provider.”

All information will be required regarding the vehicle if it plans to be driven by “service provider.”

Car Make & Model:			
Year:			
Insurance:		Expiry Date:	
Registration		Expiry Date:	
License:		Expiry Date:	
Spare Key Location:			

Should the “client” require transportation in a “service provider’s” vehicle for an outing or appointment, the mileage fee is **.75 mi**. This will be clearly calculated and written down per visit in the service bill.

ADDITIONAL NOTES:

6. HOME ACCESS REQUIREMENTS:

Any key(s)- regular/electronic, any codes required for entry to doors, parking passes, verbal, or written communication to facilities to permit visitation to “client” are required upon signing the agreement.

Front Door Building Code:				
Lock Box	What is the Lock Box Used For?		Location:	
Parking Pass Required				
Gov’t Issued Pass for disabled Person Parking:			Expiry Date:	
Spare Key Location:				
Alarm Code:				
Internet WIFI Password:				
Access Card Required:	☐YES ☐NO	Location(s):		
NOTES:				

7. CAREGIVER VISIT EXPENSES:

"Service provider" will pay upfront costs for "client" and charge for reimbursement on service invoice.

ALLOWABLE SERVICE CHARGES	
List Charges	**Restrictions**

☐The "service provider" is required to handle expenses and charge accordingly.
☐The "service provider" will have access to an expense or credit account while on duty:
☐Direct Bank Account ☐Cash ☐Credit Card ☐Pre-paid Credit Card

8. INVOICING:

1. Billing frequency: **☒Weekly ☐Bi-Weekly ☐Monthly**
2. Payments Due: **3 Days** upon receipt of invoice.
3. Taxes: **Applicable taxes will be added** to the invoice and collected in accordance with government laws.

9. PAYMENT OPTIONS:

☐Mail a Check:

Check Payable to:	
Address to send check to:	

☐E-Transfer

Email address for payment:			
Set up for automatic deposit:	☐YES ☐NO	NOTE:	
Password Required	☐YES ☐NO	Password	

☐Credit Card

Credit card Number:		Expiry Date:	
Type of Credit Card:		3 Digits on back of card	

NOTES:

10. NON-PAYMENT:

Should the “client” not pay an invoice sent by the “service provider” or does not comply with a request for payment within **five** days after the invoice has been received, it may result in an interruption of services provided to the “client”.

11. LATE CHARGES:

Late charges of **8 percent** will be applied on the total amount of the invoice before taxes if payment is not received by the indicated due date. Checks that are returned with insufficient funds are subject to an immediate additional fee of **40 percent.**

12. RETAIN SERVICES FEE: “Holding Fee” [TEMPORARY INTERRUPTION IN SERVICES]:

If the “client” cannot receive services for a routine schedule day and time, or the services are temporarily interrupted due to the reasons below:

☐	Client will not allow the caregiver to enter the place of residence
☐	Client not home to receive services when caregiver arrives
☐	Closure of floor in residence / hospital due to outbreak of illness
☐	Gov’t visitation restrictions in residence
☐	Lock down / Stay at home order issued by gov’t to non-medical caregivers
☐	Client admitted to hospital / rehabilitation center
☐	Client goes on vacation
☐	Family visiting would like to take over normal routine visits for a period
☐	Client is in isolation due to contracting covid-19 and visitors including caregiver is not permitted to enter premises to continue to provide care services.

Applicable Fees to maintain routine scheduled visits:
Average compensation for the days & hours of previous **four** weeks.

A fee of **50 percent**of the routine scheduled time will be charged until the “service provider” is able to return to providing services to the “client”. If the “client” should decide to not hold the reserved allocated day and time the fee will be waived, and this contract will be terminated.

ADDITIONAL NOTES
Based off of clients situation

13. TERMINATION OF AGREEMENT BY SERVICE PROVIDER:

The “service provider” may terminate this agreement and stop acting for the “client” if:
The “client” or person acting on client’s behalf does not comply with this agreement. The “service provider” forms the opinion, on reasonable grounds, that mutual confidence and trust do not exist between both parties.

14. OFFERING EMPLOYEES OF J.O.Y Companionship is TO BE PAID PRIVATELY:

The “Client” agrees to under no circumstances privately employ a current employee of **J.O.Y Companionship** for the complete duration of this agreement. This also includes when the employee of **J.O.Y Companionship** is off scheduled duty. Should the “client” breach this agreement, a total of **100 percent** of the remainder of this care contract will be invoiced and required to be paid in full by the “client” before termination of this agreement. Upon complete payment of the invoice no legal action by **J.O.Y Companionship** will be taken against the “client”. **J.O.Y Companionship** reserves the right to take legal action if the final invoice is not paid in full within **45 days** from the date that the invoice was sent to the “client”.

15. TERMINATION OF AGREEMENT BY CLIENT OR AUTHORIZED PERSON(S):

Agreement may be terminated at any time for a fee of **750 dollars** +applicable taxes, and that the services provided by “service provider” be rendered up until the date of agreement termination.

16. VISIT CANCELLATION POLICY:

If for any reason a scheduled visit is cancelled by the “client”, at least **12-16 hours notice** is required. If notice is not provided a charge of **100 percent** will be applied to the following scheduled invoice.

17. ACKNOWLEDGEMENT OF RECEIPT:

In witness whereof, each party has signed the agreement in the city of _____, and the State/Province_____, on the Day _____**]** Month____, and year _____.

X	X
Signature of Authorized personnel of service provider	**Signature of senior client OR Authorized Signature on behalf of client who will be responsible for and held accountable to all terms of this agreement**
Authorized Personnel in Print	**Client’s Full Name in Print**
	Relationship to client if signing on behalf as the authorized person