Hand in Hand Care

Care Management and Concierge Nursing

(941) 363-1809 info@handinhandcare.net

Caregiver Assurance Program Service Agreement

Date: _____

Care Recipient's Name: _____ Date of Birth: _____
(Last) (First) (MM/DD/YY)

Address: _____
(Street) (City) (State) (Zip Code)

Phone No. (____) _____ E-Mail Address: _____

Client's Name: _____
(Last) (First)

Client's Address: _____
(Street) (City) (State) (Zip Code)

Client's Phone No. (____) _____ Client's Email: _____

Service Provider: Hand in Hand Care, LLC (hereinafter referred to as "HIHC")
PO Box 91 (941) 363-1809
Laurel, FL 34272 info@handinhandcare.net

This caregiver assurance program agreement shall begin on _____.
(Date of Commencement of Services)

Description of Caregiver Assurance Program Services
The Service Provider agrees to provide the following services to the Client under the Caregiver Assurance Program:

- One (1) in-person visit per month by a RN Care Manager to check on caregiving conditions, offer support, and provide consultation or referrals, as needed.
- Ongoing support via phone, text, and email communication during standard business hours (Monday–Friday, 9:00 AM – 7:00 PM) for general inquiries, emotional support, and caregiving guidance.
- Basic wellness check-in and summary report following each in-person visit.

Service Schedule

- In-person visits shall be scheduled in advance on a mutually agreed date each month. It is the responsibility of the Client to initiate the visit.
- Remote support (phone/text/email) shall be responded to within 1 business day.

Fees and Payment

- The Client agrees to pay $125 per month for services under this agreement.
- Payment is due on the 1st of each month and will be processed by automatic payment ACH or Credit Card (10 days' notice must be made to stop the automatic payment and credit card payment is subject to a 3% convenience fee).
- Additional in-person visits can be arranged at the regular hourly rate of $115/hr., plus mileage charges.

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Terms and Termination

- This Agreement shall commence on the date above and continue on a month-to-month basis.
- Either party may terminate this Agreement at any time.

Confidentiality

HIHC agrees that all private information obtained about the Care Recipient, Client or Client's family/relatives, including but not limited to medical, financial, legal, career and asset information shall remain strictly confidential and may not be disclosed, except as noted herein. HIHC complies with all applicable federal and Florida privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). A copy of HIHC's Notice of Privacy Practices is available upon request.

Limitation of Liability

The Client agrees to hold HIHC harmless for services provided, except to the extent such claims arise from gross negligence or willful misconduct by HIHC. Services include, but are not limited to, ADL's, medication management, nursing oversight, recommendations based on best practices, referrals of independent contractors, companies providing contracted services. The Client, Care Recipient, heirs, successors and all other parties involved shall hold HIHC harmless from and against all claims, damages, lawsuits, charges, liabilities, costs and expenses (including legal fees) arising as a result of services provided. This includes injury to the Care Recipient, a third party, and personal property damage related to the use of an automobile or any other personal property (whether or not owned by the Client or Care Recipient) if operated by a HIHC employee/subcontractor.

Governing Law

This agreement shall be governed by the laws of the State of Florida.

Client Signature	Date
Client Printed Name	
Signature of Authorized HIHC Representative	Date
Printed Name of Authorized HIHC Representative	