# Affinity Home Care Inc.

# Service Log

Payroll Department - **Phone:** 954-782-3741 Option 5
440 E. Sample Rd., Suite 206, Pompano Beach, FL 33064
**Email:** Payroll@AffinityHomeCare.com
**Fax#:** 954-782-3643, 561-483-4045, 305-705-2695

**TO BE PAID,** this document must be signed and submitted using the **AffinityHCA** App

Other available delivery options: ♦ **Fax** ♦ **Drop Off** ♦ **Mail** ♦ **PDF** (Genius Scan App) delivered by email

**NO LATER THAN MONDAY at 5PM of the week following services**

*CAREGIVER: I hereby certify that the dates and hours recorded below were worked by me, and were properly certified by an authorized representative of the named client. I understand that I am a contractor of AFFINITY HOME CARE and cannot privately accept work from their clients. I will not solicit any AFFINITY HOME CARE patient or client for home health services. In the event I violate this non-solicitation clause, both parties hereby agree that I shall pay the sum of two thousand dollars ($2,000) to AFFINITY HOME CARE as liquidated damages for each violation. I understand that in order to complete this assignment and to be paid, I must turn in this document no later than Monday at 5pm the next week after performing services. My hours worked on any given day will not exceed the hours authorized by AFFINITY HOME CARE for that day. I understand that I will not be paid for hours worked in excess of the total hours authorized on any given day. I have not had a work related accident/incident in the past month.*

**Notify Affinity Home Care of any other information concerning this patient that needs to be reported**

**Caregiver Name** _____ **Caregiver Signature** _____

| Year: 20 ___ ___ | Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|---|---|---|---|---|---|---|---|
| Date of Service (MM / DD) | / | / | / | / | / | / | / |
| Time In | | | | | | | |
| Time Out | | | | | | | |
| **Hours per Day** | | | | | | | |

☐ RN/LPN Visit

**Week Total (hours):** _____

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mobility/Walking/Moving | | | | | | | |
| Bathing/Showering | | | | | | | |
| Dressing | | | | | | | |
| Toileting | | | | | | | |
| Eating | | | | | | | |
| Continence Bladder/Bowel | | | | | | | |
| Meal Preparation also including Kitchen Cleanup | | | | | | | |
| Laundry | | | | | | | |
| Light Housekeeping also including Making Beds, Linen Change and Cleaning Client's Bathroom | | | | | | | |

**Client Name**_____ **Client/Authorized Signature** _____

*CLIENT: I certify that the hours recorded above are correct, the caregiver's performance was satisfactory, and AFFINITY HOME CARE can pay this caregiver for the hours approved by me. I further agree if I terminate home health services from AFFINITY HOME CARE, I cannot hire, neither directly nor indirectly, any AFFINITY HOME CARE contractor to perform home health services for a period of one (1) year from the last day AFFINITY HOME CARE provided services. If I breach this condition, I will be liable to AFFINITY HOME CARE for a finder's fee in the amount of $5,000, plus reasonable attorney's fees and costs.*

| | S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|---|
| HMK | | | | | | | |
| COMP | | | | | | | |
| PECA | | | | | | | |
| RESP | | | | | | | |
| MISC | | | | | | | |

AB: ___ ___

**OFFICE USE ONLY**

**LN** _____ **FN** ___ **PGM CODE** _____ ( ) **MAX AUTH** _____ **Inv #** _____ **Page #** ___

**Coder:** ___ ___ **Date:** ___ ___ ___ **NPY?** ☐ ___ ___ _____

White Copy - AHC OFFICE Yellow Copy - Caregiver Pink Copy - Client