Affinity Home Care Inc.

Service Log

Payroll Department - **Phone:** 954-782-3741 Option 5
100 E. Sample Rd., Suite 330, 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 caregiver 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 also 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. 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 must sign for every visit in the boxes below						
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 must sign for every visit in the boxes above

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