# CONTRACTOR INVOICE 2021

Phone: 561-998-3211
Fax: 561-998-3250

**CONTRACTORS NAME** ______________________________

Client: ______________________________
Address: ______________________________
______________________________

| Month/Year: | Sat | Sun | Mon | Tues | Wed | Thurs | Fri |
|---|---|---|---|---|---|---|---|
| Date: | | | | | | | |
| **PERSONAL CARE** Bath | | | | | | | |
| Oral Hygiene | | | | | | | |
| Hair Care | | | | | | | |
| Assist Dressing | | | | | | | |
| Shave | | | | | | | |
| Skin Care | | | | | | | |
| Toileting | | | | | | | |
| **NUTRITION** Prepare Breakfast | | | | | | | |
| Prepare Lunch | | | | | | | |
| Prepare Dinner | | | | | | | |
| Prepare Snack | | | | | | | |
| Assist Eating | | | | | | | |
| Grocery Shopping | | | | | | | |
| | | | | | | | |
| **ACTIVITIES** Ambulation | | | | | | | |
| Transfer: Bed/Chair | | | | | | | |
| Turn/Reposition | | | | | | | |
| ROM Exercises | | | | | | | |
| | | | | | | | |
| **RECORD** TPR | | | | | | | |
| Assist with Meds | | | | | | | |
| Food Intake | | | | | | | |
| Fluid Intake | | | | | | | |
| Urinary Output | | | | | | | |
| Bowel Movements | | | | | | | |
| | | | | | | | |
| **HOMEMAKING** Linen Change | | | | | | | |
| Laundry | | | | | | | |
| Wash Dishes | | | | | | | |
| Light Housework | | | | | | | |
| **ELIMINATION** Bowel Movement | | | | | | | |
| Incontinence | | | | | | | |
| Urination | | | | | | | |
| Catheter Care | | | | | | | |
| Ostomy Care | | | | | | | |

WEEK OF ______________________________

| Report All Times to the Nearest ¼ Hour | | | | | Client Initials |
|---|---|---|---|---|---|
| Day | Date | Time Started | Time Finished | Daily Total | |
| SAT | | | | | |
| SUN | | | | | |
| MON | | | | | |
| TUES | | | | | |
| WED | | | | | |
| THURS | | | | | |
| FRI | | | | | |
| Total Hours for Week to Nearest ¼ Hour → | | | | | |

Type of Service Rendered: ____________________

CONTRACTOR: My signature indicates accurate time worked by me. I understand this Client Care Record must be signed by me and the client or his/her representative for me to be paid for this job.

CLIENT: My signature indicates that the contractor's work was performed satisfactorily and the times indicated above are accurate. I agree to pay for the services immediately upon receipt of invoice. Should collection procedures be necessary, I agree to pay all costs, including reasonable attorney's fees. I further agree not to employ this Home Health Aide privately for a period of two (2) years from this date. If I violate this agreement, I will pay Platinum Select Nursing LLC, upon demand, $20,000 in liquidated damages. I acknowledge and agree that the payment required by this liquidated damages clause is a reasonable forecast of the damages likely to result from my breach of this agreement and is not a penalty of any kind. I acknowledge that I will be charged time and ½ for any caregiver working more than 40 hours in a given week.

Client Signature ____________________

Contractor Signature ____________________

License # if applicable ____________________

Comments: ____________________
______________________________
______________________________
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**A completed copy of this Client Care Record is due to the office each SUNDAY by 5pm the latest.**