INTAKE FORM

PRIVACY NOTICE AND CONSENT TO COLLECTIONS, USE, AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Date		**Name of Client**	
Date of Birth		**Name of POA (If Any)**	

- I have been informed of the purpose for which my personal health information is collected, used, and disclosed by CareOnDemand, including determination of my needs, coordination of my services, ongoing review of my support and services, directly or indirectly providing me with health and related social services, monitoring the quality of services received by me, complying with other purpose permitted by law, planning, and evaluation of services, and planning for my safety in an emergency.
- I am aware of how to contact CareOnDemand should I have any questions or comments about my privacy or personal health information.
- I understand that CareOnDemand may share my personal health information with staff, with other healthcare providers, healthcare organizations, and healthcare professionals who may be involved in client's care and who need personal health information to properly treat the client.
- I understand that my consent can be revoked at any time either verbally or in writing.
- In an emergency, I authorize CareOnDemand to provide health care information needed for my health and safety to emergency care and other healthcare providers.
- I agree that CareOnDemand may use my personal health information in aggregate form, that is, without personal identifiers, for CareOnDemand administration, management, and continuing education programs.

If you have any questions about the collection, use, and disclosure of your personal health information, please contact CareOnDemand at **info@CareOnDemand.ca | 647-219-1432** or the information and privacy commissioner at **info@ipc.on.ca | 1-800-387-0073**.

By signing the consent form, I confirm that I, as a client or as a substitute decision-maker for the client, consent to the collection, use, and disclosure of personal health information as set out above.

Client Signature (If Able)	
Name of the Substitute Decision Maker/POA (If Any)	
Relationship of the Substitute Decision Maker/POA	
Signature of POA	

INTAKE FORM

CareOnDemand
Home Healthcare and Staffing Services

CLIENT INTAKE INFORMATION

Date

Name of Client

Home Phone

Cell No.

Age

Gender

Email

Home Address

City

Province

Postal Code

Emergency Contact Person

Emergency Contact Number

Reason for Service Request

Diagnosis

INTAKE FORM

CareOnDemand
Home Healthcare and Staffing Services

CLIENT INTAKE INFORMATION

Transfer Method (Lift, Sit-to-Stand, Supervised, Board)

Other Information we need to know about the client

SCHEDULING REQUIREMENTS

Days of Service	Time of Service *(e.g. 7am-3pm/3pm-11pm/11pm-7am)*
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Proposed Start Date

Special Instructions

INTAKE FORM

CareOnDemand
Home Healthcare and Staffing Services

TYPE OF SERVICE NEEDED

Personal Support Worker (PSW/DSW/CSW/HSW)	Per Hour / Hourly Rate		$28.00
	Live-In/Out Rate (Daily Rate / 10 Hours)		$280.00
Registered Practical Nurse (RPN)	Hourly Rate (Min 3 hours)		$45.00
Registered Nurse (RN)	Hourly Rate (Min 3 hours)		$55.00

PSW CARE NEEDED *(Check All That Apply)*

- [ ] Bathing and Personal Care
- [ ] Bladder/Bowel/Toileting
- [ ] Dressing/Undressing Clothes
- [ ] Light Housekeeping/Tidying Up
- [ ] Laundry
- [ ] Meal Prep/Support/Feeding
- [ ] Medication Assist
- [ ] Companionship
- [ ] Transportation Arrangement
- [ ] Supplies/Products Ordering & Delivery
- [ ] Vent/Breathing Support Assist
- [ ] Lift/Transfer/Repositioning
- [ ] Range of Motion Exercises
- [ ] Equipment Support (Oxygen, Machines, Etc.)
- [ ] Grocery Shopping/Ordering & Delivery
- [ ] Administrative/Household Management
- [ ] Supply Run/Errands
- [ ] Coordination of Appointment/Escort
- [ ] Activity/Recreation
- [ ] Others:

Special Instructions

INTAKE FORM

CareOnDemand
Home Healthcare and Staffing Services

TYPE OF SERVICE NEEDED

RPN CARE NEEDED *(Check All That Apply)*

- [ ] Assessing and Monitoring of the Health Status
- [ ] Administering Medications and Treatments
- [ ] Wound Care, Injections, & Medical Procedures
- [ ] Monitoring Vital Signs, BP, HR, and Temp
- [ ] Maintaining and Updating Client Records
- [ ] Documenting Observations & Interventions
- [ ] Communicating Changes to the Healthcare Team
- [ ] Updating Families of the Clients Conditions
- [ ] Emotional Support to Clients and Families
- [ ] Advice on Healthy Choices & Disease Prevention
- [ ] Participating in Care Planning for the Client
- [ ] Others within the Scope of an RPN Role (CNO):

Special Instructions

RN CARE NEEDED *(Check All That Apply)*

- [ ] Client Comprehensive Assessment
- [ ] Recommend Treatments
- [ ] Administering Medications and Treatments
- [ ] Monitor Patient Progress
- [ ] Report Any Changes in Client's Health Status
- [ ] Communicating Changes to the Healthcare Team
- [ ] Inspect Wounds and Change Dressings
- [ ] Test for Infection, Weakness, and Bedsores
- [ ] Collaborate with Physicians
- [ ] Monitor Client & Keep Physician Updated
- [ ] Updating Families of the Clients Conditions
- [ ] Emotional Support to Clients and Families
- [ ] Advice on Healthy Choices & Disease Prevention
- [ ] Others within the Scope of an RN Role (CNO):

Special Instructions

INTAKE FORM

Other Remarks

How did you hear about us?

Referred by:

I agree that the above services require the assistance of a Personal Support Worker. Should there be any changes in the services requested, I shall notify CareOnDemand right away.

Client Signature (If Able)	
Name of the Substitute Decision Maker/POA (If Any)	
Relationship of the Substitute Decision Maker/POA	
Signature of POA	

INTAKE FORM

SERVICE AGREEMENT

Date		Name of Client	

Engagement of Services
I agree to engage CareOnDemand (hereinafter referred to as COD) to provide appropriate home healthcare services to the above-named client. It is agreed that:

- COD will retain quality healthcare personnel.
- I retain the right to decline or discontinue COD's services at any time by giving COD notice.
- COD shall have the right to discontinue its services by giving me notice.

Emergency Medical Treatment
If, while under the care of COD, I require emergency medical treatment:

- I hereby consent and authorize COD or any of its employees to obtain and provide such treatment as they may deem advisable.
- I shall be responsible for all costs of such services.

Authorization to Obtain Medical Records
I authorize COD to:

- Obtain my previous medical records for the purpose of providing their services.
- Release and provide any of my medical information to any other healthcare agency or physician involved in my care.

Services Outside of Individualized Care Plan

- I agree to obtain consent from the management of COD before permitting any COD employees to perform any services outside of the client's individualized care plan.
- I hereby release and forever discharge COD and its employees from all actions, claims, and demands for any damage, loss, or injury to person or property as a consequence of such actions.

Emergency Protocol and Extension of Service

- Duty Extension in Emergencies: In the event of an emergency (e.g., if the client loses consciousness or is in distress and the staff's scheduled duty is ending), the healthcare staff is required to remain with the client until emergency help (e.g., paramedics or family members) arrives.
- This extended service will be considered an emergency extension of duty and shall be billed to the client at the standard hourly rate.

Calling 911: COD follows a strict emergency protocol. In case of any medical emergency, the healthcare staff is required to:

  - Immediately assess the situation and, if necessary, call 911 for emergency medical assistance.
  - Stay with the client until emergency responders arrive and take over the situation.
  - Inform the client's family or substitute decision-maker as soon as possible.
- Client's Refusal of Emergency Help: If the client refuses emergency medical assistance (e.g., refuses to allow the staff to call 911 or declines help from emergency responders), this refusal will be documented in writing and signed by the client, if possible.
- In the event of such a refusal, the healthcare staff must immediately call their supervisor. The supervisor will then contact the client's Point of Authority (POA) to inform them of the refusal.
- In such cases, the client assumes full responsibility for any consequences that may arise from refusing emergency care.
- The healthcare staff will also report the incident to COD management.

INTAKE FORM

SERVICE AGREEMENT

- **Staff Response to Unresponsive Client:**
  - If the healthcare staff arrives and finds the client unresponsive or deceased, they will immediately call 911, follow emergency procedures, and notify COD management.
  - The staff will not attempt any medical intervention beyond their scope of practice unless they are trained and authorized to do so.
  - COD will not assume liability for any circumstances arising before or after the staff's arrival at the client's location.
- **Inability to Access Client's Residence:**
  - If the healthcare staff arrives for a scheduled visit and is unable to access the client's residence (e.g., no response at the door or inability to enter due to safety concerns), the staff will attempt to contact the client, the client's family, or the substitute decision-maker.
  - If there is reasonable concern for the client's wellbeing (e.g., lack of response), the staff will contact COD management and may call 911 to request a wellness check.

Non-Solicitation of COD Staff

I agree not to:

- Encourage, directly or indirectly, any COD staff/employee, contractor, consultant, principal, agent, or representative involved in the care to solicit or hire (or assist in soliciting or hiring) any employee of COD or its affiliates.

Billing and Payment

- Invoices will be rendered and payable on a bi-weekly basis.
- Each billing period will cover two weeks.
- The client and/or substitute decision-maker agrees to pay all fees within the prescribed due dates following the receipt of the respective billing invoice.

Acknowledgment

- I acknowledge that I have read and understand this agreement and agree to the terms herein.

Binding Agreement

- This agreement shall be binding upon me and anyone responsible for or acting on my behalf.

Client Signature (If Able)	
Name of the Substitute Decision Maker/POA (If Any)	
Signature of POA	

INTAKE FORM

PAYMENT DETAILS

☐ ***Credit Card*** VISA mastercard

Cardholder Name

Credit/Debit Card Number

Card Expiration Date *(mm/yy)* **Postal Code** **CVC** *(Number at the back of the card)*

*** Our team will reach out to you if we require your CVV, or you can feel free to contact us directly.*

Cardholder Signature

☐ ***Online Payment***

Invoice to be sent to which email address?

☐ ***Cheque***

Paper Invoice to be mailed at what address?

We Invoice our Clients on a Bi-Weekly basis.

Should there be any discrepancies, adjustment will be made in the next billing cycle.

Invoices can be paid via:

- E-Transfer to admin@careondemand.org (no password is required).
- Cheque to "CareOnDemand" mailed to 150 Duncan Mill Road, Unit 2, North York, ON M3B 3M4
- Credit card – 4.8% surcharge fee

Bank deposit to **CareOnDemand** (CIBC):
Transit Number: 02632
Institution Number: 010
Account Number: 6712819