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 acknowledge that I have been informed of the purposes for which my personal health information is collected, used, and disclosed by CareOnDemand Home Health Care & Staffing Services Inc. These purposes include:

- Assessing my care and support needs;
- Coordinating and delivering health and related social services;
- Conducting ongoing reviews of my care and services;
- Monitoring the quality of care and services provided;
- Complying with legal and regulatory requirements;
- Supporting service planning, evaluation, and emergency preparedness.

I understand that my personal health information may be shared with authorized CareOnDemand staff, as well as with other healthcare providers, organizations, and professionals involved in my care, who require this information to provide appropriate treatment and coordinated support.

I am aware that I can revoke my consent at any time, verbally or in writing, by contacting CareOnDemand. In the event of an emergency, I authorize CareOnDemand to share necessary health information with emergency and healthcare providers to ensure my safety and well-being.

I also consent to the use of my personal health information in aggregate or de-identified form (without personal identifiers) for administrative purposes, quality improvement, management, and staff education within CareOnDemand.

If I have any questions about the collection, use, or disclosure of my personal health information, I may contact:
CareOnDemand

✉ info@CareOnDemand.org | ☎ 647-219-1432 or the Information and Privacy Commissioner of Ontario at ✉ info@ipc.on.ca | ☎ 1-800-387-0073.

By signing this consent form, I confirm that I, as the client or the substitute decision-maker, consent to the collection, use, and disclosure of personal health information as described 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

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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)	Hourly Rate	☐	**$28.00 - $32.00**
	Live-In/Out Rate (Daily 10-12 Hours)	☐	**$280.00 - $300.00**
Registered Practical Nurse (RPN)	Hourly Rate	☐	**$45.00 - $55.00**
Registered Nurse (RN)	Hourly Rate	☐	**$55.00 - $65.00**

FOR PSW CARE PLAN

(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

FOR RPN CARE PLAN *(Check all that apply)*

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

Special Instructions

FOR RN CARE PLAN *(Check all that apply)*

- ☐ Client Comprehensive Assessment
- ☐ Administering Medications and Treatments
- ☐ Report Any Changes in Client's Health Status
- ☐ Inspect Wounds and Change Dressings
- ☐ Collaborate with Physicians
- ☐ Updating Families of the Clients Conditions
- ☐ Advice on Healthy Choices & Disease Prevention
- ☐ Recommend Treatments
- ☐ Monitor Patient Progress
- ☐ Communicating Changes to the Healthcare Team
- ☐ Test for Infection, Weakness, and Bedsores
- ☐ Monitor Client & Keep Physician Updated
- ☐ Emotional Support to Clients and Families
- ☐ 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 Agreement

This Agreement outlines the terms and conditions between CareOnDemand Home Health Care & Staffing Services Inc. ("COD") and the undersigned client (the "Client") for the provision of home healthcare and related support services.

1. Engagement of Services
The Client agrees to engage CareOnDemand (COD) to provide home healthcare services appropriate to their needs. COD will assign qualified, licensed, and screened healthcare personnel. The Client may discontinue services at any time, provided they give notice to COD. COD reserves the right to terminate services with notice to the Client when necessary for safety, staffing, or compliance reasons.

2. Emergency Medical Treatment
In the event of a medical emergency, the Client authorizes COD and its personnel to obtain or provide emergency medical treatment deemed necessary for the Client's safety and well-being. The Client remains financially responsible for any costs incurred.

3. Authorization to Obtain and Release Medical Information
The Client authorizes COD to obtain, use, and disclose personal health information solely for the purposes of providing coordinated care, as permitted under the Personal Health Information Protection Act (PHIPA). COD will share such information only with healthcare professionals or organizations directly involved in the Client's care.

4. Services Outside of the Individualized Care Plan
Any services requested outside the established care plan require prior written approval from COD management. COD assumes no responsibility or liability for activities performed outside the approved plan of care.

5. Emergency Protocol and Extension of Service
COD maintains a strict emergency response protocol consistent with community health and safety standards. In the event of a medical emergency (e.g., the Client becomes unresponsive or distressed near the end of a staff member's shift), the assigned healthcare personnel must remain with the Client until emergency responders or designated family arrive. Any additional time will be billed as an Emergency Duty Extension at the standard hourly rate.

6. Client Refusal of Emergency Help
If the Client refuses emergency assistance (e.g., declines 911 or hospital care), this refusal will be documented in writing and signed by the Client whenever possible. COD staff will immediately notify their supervisor, who will, in turn, inform the Client's Substitute Decision-Maker (SDM) or Power of Attorney (POA). The Client assumes full responsibility for any outcomes resulting from such refusal.

7. Inability to Access Client's Residence
If access cannot be obtained, COD staff will attempt contact through authorized channels. If there is reason to believe the Client's well-being is at risk, emergency services may be contacted to perform a wellness check, in accordance with privacy and safety laws.

8. Non-Solicitation of COD Staff
The Client agrees not to directly or indirectly solicit, hire, or retain the services of any COD employee, contractor, or affiliate for a period of twelve (12) months following the termination of services.

INTAKE FORM

SERVICE AGREEMENT

9. Billing and Payment
Invoices will be issued on a bi-weekly basis and are payable upon receipt, within the specified due date. Break periods are in accordance with Ontario labour standards and COD policy (e.g., one 30-minute unpaid break for every 5 hours of work). Late payments may be subject to administrative fees or service suspension.

10. Service Cancellation and Notice Requirements

To ensure fair scheduling and continuity of care, the following cancellation terms apply:

- Client-Initiated Cancellation: The Client or Substitute Decision-Maker (SDM) must provide a minimum of 24 hours' notice to cancel or reschedule any scheduled visit or shift. Cancellations made less than 24 hours before the scheduled start time will result in a cancellation fee equivalent to three (3) hours of service at the standard hourly rate or the minimum scheduled shift length, whichever is greater. Repeated short-notice cancellations may lead to reassessment of service continuation.

- COD-Initiated Cancellation: In the rare event that CareOnDemand (COD) must cancel a visit (e.g., due to staff illness or an unforeseen emergency), COD will provide as much notice as reasonably possible and will make every effort to offer a qualified replacement. No charge will apply if COD cancels a shift and no replacement is provided.

- Emergency or Exceptional Circumstances: COD may waive cancellation fees at its discretion in verified emergencies (e.g., hospitalization, medical crises, severe weather alerts, or death in the family).

- Service Suspension or Termination: COD reserves the right to suspend or terminate services with reasonable notice if safety, non-payment, or non-compliance issues arise. The Client may also terminate ongoing services by providing five (5) business days' written notice to COD management, unless otherwise agreed.

11. Acknowledgment and Binding Agreement
The Client acknowledges that they have read, understood, and agreed to the terms and conditions of this Agreement. This Agreement is binding upon the Client, their heirs, legal representatives, and assigns.

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

INTAKE FORM

PAYMENT DETAILS

☐ *Credit/Debit 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, adjustments will be made in the next billing cycle.

Invoices can be paid via:

- **Electronic Fund Transfer EFT** also known as **E-Transfer**. To send, kindly send it to the email address **admin@careondemand.org** (no password is needed).
- **Cheque** to "CareOnDemand" mailed to 150 Duncan Mill Road, Unit 2, North York, ON M3B 3M4
- **Credit Card** - Kindly provide the information above
- **Direct Debit** - Kindly provide the information above
- **Online Payment** through Stripe invoice sent to your email.
- **Bank deposit** to CareOnDemand (CIBC):
  - Transit Number: 02632
  - Institution Number: 010
  - Account Number: 6712819