

ELDERPLANNING CONTRACT

Name of Applicant (Last) _____ (First) _____ (Middle) _____

Address _____

Phone # _____ Alternate # _____

Date of Birth _____ Social Security # _____

Medicare # _____ Medicaid # (if applicable) _____

Health Insurance/Plan Name and ID # _____

Long Term Care Insurance Plan Name w/ ID# (if applicable) _____

Responsible Party Name (Last) _____ (First) _____ Relationship _____

Address _____

Phone (home) _____ (work) _____ (Cell) _____

Does applicant have any of the following? Health Care Proxy Living Will Veteran Status POA

Name of Health Proxy _____ Name of POA _____

Name of Primary Physician _____

Bill for Services should be sent to Applicant/Elder Responsible Party Other (below)

Billing Name _____ Phone _____

Address _____

Please complete and return to:
Elderplanning of Arizona P.O. Box 21125 Sedona AZ 86341
CNY Elderplanning P.O. Box 122 Camillus NY 13031
Or simply fax it to us at (888) 387-8188.

By signing the release of information below, you permit and facilitate the exchange of information between Elderplanning and other professionals and care providers.

_____ **I hereby authorize Elderplanning to release information to:**
Community Service agencies, family members, physicians/health professionals,
legal/financial representatives, other _____
Any exceptions will be listed here: _____

_____ **I hereby authorize any community agencies, physicians and other
healthcare professionals, financial, legal and other representatives TO
RELEASE TO ELDERPLANNING** any medical, physical, social, financial or
other pertinent information which may be current or historic and pertinent to my
comprehensive and ongoing care management needs. Any exceptions will be
listed here: _____

This authorization is for an indefinite period of time unless otherwise indicated:

Elderplanning has informed me of the important of discussing financial planning issues even if it seems beyond the realm of possibility that the client will exhaust private funds in the future to pay for care providers. I understand that we can explore insurance and other planning options offered by Elderplanning and/or its representatives and that there is no fee charged for the time it takes for insurance quotes and counseling related specifically to long term care insurance.

X _____
Signature of Client/Guardian/POA

Printed Name

Date

~~~~~**ELDERPLANNING BILLING PROCEDURES**~~~~~

Name of Client (Please Print) \_\_\_\_\_

I understand that the fee for Elderplanning services is **\$100 per hour** which includes telephone and travel time billed in 5 minute increments and ongoing professional services and consultation time billed in 15 minute increments. ***Professional services include travel time, preparation time for Medicaid/benefit programs, nursing home/residential and other applications, written correspondence including fax and email and telephone contacts with all parties pertinent to the client's care management needs.*** Expectations will be discussed and agreed upon at the initial interview by both parties.

For ongoing clients, a retainer of \$500 will be submitted with a completed Elderplanning application. Elderplanning cannot perform any referrals or coordination of care without a signed application which includes the necessary releases of information giving permission to exchange information on the client's behalf. Itemized monthly bills will then be submitted to the party indicated below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Billable parties*** include the client, family, third parties (e.g. bank trust officers/attorneys/POAs), employee assistance programs and long term care insurance companies. If an insurance company is to be billed, protocol will be provided to Elderplanning to ensure a smooth billing process. Special arrangements can be made with such third party agencies to facilitate direct billing – If applicable, third-party arrangements are to be listed here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*In some cases, quarterly bills can be submitted at the request of the billing party.*

Signed \_\_\_\_\_ Date \_\_\_\_\_

Printed Name/Relationship to Client \_\_\_\_\_

## **Pledge of Ethics**

**PROVISION OF SERVICE:** I will provide ongoing service to you only after I have assessed your needs and you, or a person designated to act for you, understand and agree to a plan of service, the results that may be expected from it, and the cost of service.

**SELF-DETERMINATION:** I will base my plan of service on goals you, or a person designated to act for you, have defined, and which enhance the decisions you have made concerning your life.

**LOYALTY:** My first duty is loyalty to you. I will always provide services based on your best interest, even if this conflicts with my interests or the interests of others.

**TERMINATION OF SERVICE:** I will end service to you only after reasonable notice. I will recommend a plan for you to continue to receive the services as needed.

**SUBSTITUTE JUDGMENT:** I will not substitute my judgment for yours unless I am acting in the role of your guardian, appointed by a Court of Law, or with your approval, or the approval of someone designated to act for you.

**CONFIDENTIALITY:** I will hold in trust any confidence you give me, disclosing information to others only with your permission, or if I am compelled to do so by a belief that you will be seriously harmed by my silence, or if the laws of this State require me to do so.

**REFERRALS/DISCLOSURE:** I will refer you only to services and organizations I believe to be appropriate and of good quality. I will fully explain to you any business relationship I have with any service I propose, and give you information on alternatives, if at all possible, so that you, or a person designated to act for you, can make an informed decision to accept or reject the services I recommend to you.

**COOPERATION:** I will strive to ensure cooperation between all individuals involved in providing service and care to you.

**QUALIFICATIONS:** I am fully qualified in my profession to provide the services I undertake. I continue to improve my skills and knowledge by participating in professional development programs and maintaining certification and licensing in my profession.

**DISCRIMINATION:** I will not promote or sanction any form of discrimination.

*Elderplanning has been an advanced member of the National Association of Professional Geriatric Care Managers since 1996.*